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I.	***Federal Register Documents and Agency Guidance and Publications***
0001-0120	Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Proposed Rule, 76 Fed. Reg. 41,866 (July 15, 2011)
0121-0419	Patient Protection and Affordable Care Act; Establishment of Exchange and Qualified Health Plans, Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310 (Mar. 27, 2012)
0420-0480	Patient Protection and Affordable Care Act; Market Stabilization, Final Rule, 82 Fed. Reg. 18,346 (Apr. 18, 2017)
0481-0514	CMS Manual, Federally-facilitated Exchange (FFEs) and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual Excerpts (July 2019)
0515-0519	Memo from Deputy Administrator/Director Randy Pate, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, to All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers (Aug. 9, 2018)
0520-0524	HealthCare.gov, *Special Enrollment Period* (July 13, 2020)
0525-0528	Federal Emergency Management Agency, *President Donald J. Trump Directs FEMA Support Under Emergency Declaration for COVID-19*, Release Number: HQ-20-017 (Mar. 13, 2020)
0529-0532	U.S. Department of Health and Human Services Press Release, *HHS Announces Additional Allocations of CARES Act Provider Relief Fund* (Apr. 22, 2020)
0533-0534	U.S. Department of Health and Human Services Press Release, *HHS Launches COVID-19 Uninsured Program Portal* (Apr. 27, 2020)
0535-0542	Centers for Medicare & Medicaid Services, *Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic* (Apr. 30, 2020)
0543-0545	CMS News Alert (May 19, 2020)
0546-0547	Centers for Medicare & Medicaid Services, FAQs on Essential Health Benefit Coverage and the coronavirus (Mar. 12, 2020)
0548-0549	Centers for Medicare & Medicaid Services, *Information Related to COVID-19 Individual and Small Group Market Insurance Coverage* (Mar. 5, 2020)
0550-0557	Centers for Medicare & Medicaid Services, Current Emergencies – Coronavirus 2019 (accessed July 13, 2020)
0558-0562	HealthCare.gov, *Marketplace Coverage & Coronavirus* (accessed July 10, 2020)
0563-0564	HealthCare.gov, *Affordable Coverage* (accessed July 14, 2020)

0565-0567	HealthCare.gov, *COBRA coverage and the Marketplace* (accessed July 14, 2020)
0568-0570	HealthCare.gov, *How to change, update, or cancel your Marketplace plan* (accessed July 14, 2020)
0571-0574	HealthCare.gov, *The Marketplace in your state* (accessed July 13, 2020)
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0577-0581	Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency* (June 2020)
0582-0588	CMS Report for House Oversight Committee, *Consumers in States Using the Federal Exchange Platform Who Gained Coverage Through A Special Enrollment Period End of Open Enrollment Period through May, Plan Years 2017-2020* (June 25, 2020)
0589-0630	Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019)
0631-0644	U.S. Bureau of Labor Statistics, *FAQs: The impact of the coronavirus (COVID-19) pandemic on The Employment Situation for April 2020* (May 8, 2020)
0645-0648	White House Council of Economic Advisers, *April's Job Losses Show Many Workers Are Still Connected to Their Employers* (May 8, 2020)
0649-0690	U.S. Bureau of Labor Statistics, *The Employment Situation —May 2020* (June 5, 2020)
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0693-0698	Jason Matheny et al., *Financial Effects of an Influenza Pandemic on US Hospitals* (2007)
0699-0716	Sabina Braithwaite et al., *Microsimulation of Financial Impact of Demand Surge on Hospitals: The H1N1 Influenza Pandemic of Fall 2009* (Apr. 2013)
0717-0725	Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid by Rachel Garfield* (Jan. 14, 2020)
0726-0729	DC Health Benefit Exchange Authority, *DC Health Link* to *Offer Even More Opportunities for Residents to Get Covered* (Feb. 11, 2020)
0730-0733	Washington Health Benefit Exchange, *Washington Healthplanfinder Announces Special Enrollment Period in Response to Growing Coronavirus Outbreak* (Mar. 10, 2020)
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0750-0759	Howard P. Forman et al., Health Affairs Blog, *Health Care Priorities for a COVID-19 Stimulus Bill: Recommendations to the Administration, Congress, and Other Federal, State and Local Leaders from Public Health, Medical, Policy and Legal Experts* (Mar. 12, 2020)
0760-0762	Press Release, *Whitmer Administration Expands Telemedicine, Urges President Trump to Permit ACA Special Enrollment Period During COVID-19* (Mar. 12, 2020)
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0771-0772	Media Release, Maryland Health Exchange, *Special Enrollment Opens Next Week During Maryland's Coronavirus State of Emergency* (Mar. 13, 2020)
0773-0777	Mary Ellen McIntire & Lauren Clason, Roll Call, *States reopen insurance enrollment as coronavirus spreads* (Mar. 13, 2020)
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0798-0806	Letter from Richard J. Pollack, President and CEO, American Hospital Association, to Secretary Alex M. Azar II, U.S. Department of Health and Human Services, with attachment (Mar. 16, 2020)
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0830-0832	Press Release, *Uninsured Coloradans Can Enroll during a Special Enrollment Period in Response to COVID-19 Outbreak* (Mar. 19, 2020)
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1058-1059	Letter from U.S. Senator Robert P. Casey, Jr. to Administrator Seema Verma, Centers for Medicare & Medicaid Services (May 18, 2020)
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1091-1094	California Exchange, *Special-Enrollment Period Due to Coronavirus Now Available* (accessed July 13, 2020)
1095-1201	America's Health Insurance Plans, *Health Insurance Providers Respond To Coronavirus (COVID-19)* (accessed July 13, 2020)
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76 FR 41866-01, 2011 WL 2728042(F.R.)
PROPOSED RULES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 155 and 156
[CMS-9989-P]
RIN 0938-AQ67

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Friday, July 15, 2011

AGENCY: Department of Health and Human Services.

***41866** ACTION: Proposed rule.

SUMMARY: This proposed rule would implement the new Affordable Insurance Exchanges ("Exchanges"), consistent with title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.

A detailed Preliminary Regulatory Impact Analysis associated with this proposed rule is available at http://cciio.cms.gov under "Regulations and Guidance." A summary of the aforementioned analysis is included as part of this proposed rule.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on September 28, 2011.

ADDRESSES: In commenting, please refer to file code CMS-9989-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.
You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions under the "More Search Options" tab.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9989-P, P.O. Box 8010, Baltimore, MD 21244-8010.

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

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9989-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

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

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

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

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

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document. For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Laurie McWright at (301) 492-4372 for general information matters.

Alissa DeBoy at (301) 492-4428 for general information and matters related to part 155.

Michelle Strollo at (301) 492-4429 for matters related to enrollment.

Pete Nakahata at (202) 680-9049 for matters related to part 156.

SUPPLEMENTARY INFORMATION:

Abbreviations

Affordable Care Act—The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152))

BHP Basic Health Program

CAHPS Consumer Assessment of Healthcare Providers and Systems

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

DOL U.S. Department of Labor

ERISA Employee Retirement Income Security Act (29 U.S.C. section 1001, et seq.)

FEHBP Federal Employees Health Benefits Program

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HEDIS Healthcare Effectiveness Data and Information Set

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)

HMO Health Maintenance Organization

IHS Indian Health Service

IRS Internal Revenue Service

NAIC National Association of Insurance Commissioners

NCQA National Committee for Quality Assurance

OMB Office of Management and Budget

OPM Office of Personnel Management

PBM Pharmacy Benefit Manager

PHS Act Public Health Service Act

PPO Preferred Provider Organization

QHP Qualified Health Plan

SHOP Small Business Health Options Program

SSA Social Security Administration

The Act Social Security Act

The Code Internal Revenue Code of 1986

Executive Summary: Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges." Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are working in close coordination to release guidance related to Exchanges in several phases. The first in this series was a Request for Comment relating to Exchanges, published in the Federal Register on August 3, 2010 (75 FR 45584). Second, ***41867** Initial Guidance to States on Exchanges was issued on November 18, 2010. Third, a proposed rule for the application, review, and reporting process for waivers for State innovation was published in the Federal Register on March 14, 2011 (76 FR 13553). Fourth, two proposed regulations, including this one, are published in this issue of the Federal Register to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act.

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This proposed rule: (1) Sets forth the Federal requirements that States must meet if they elect to establish and operate an Exchange; (2) outlines minimum requirements that health insurance issuers must meet to participate in an Exchange and offer qualified health plans (QHPs); and (3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP). The intent of this proposed rule is to afford States substantial discretion in the design and operation of an Exchange. Greater standardization is proposed where required by the statute or where there are compelling practical, efficiency or consumer protection reasons. This proposed rule does not address all of the Exchange provisions in the Affordable Care Act; additional guidance on the establishment and operation of Exchanges will be provided in forthcoming proposed rules.

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. Comments will be most useful if they are organized by the section of the proposed rule to which they apply. You can assist us by referencing the file code [CMS-9989-P] and the specific “issue identifier” that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445-G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. to schedule an appointment to view public comments, call 1-800-743-3951.

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I. Background

A. Legislative Overview

1. Legislative Requirements for Establishing Exchanges

Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange(s) that: (1) Facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other requirements specified in the Affordable Care Act.

Section 1321 of the Affordable Care Act discusses State flexibility in the operation and enforcement of Exchanges and related requirements. In this proposed rule, we aim to encourage State flexibility within the boundaries of the law. Each State electing to establish an Exchange must adopt the Federal standards contained in this law and in this proposed rule, or have in effect a State law or regulation that implements these Federal standards. Section 1311(k) further specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321(c)(1) requires the Secretary to establish and operate such Exchange within States that either: (1) Do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

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Unless otherwise specified, the provisions in this proposed rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act. Section 1321(a)(2) requires the Secretary to engage in consultation to ensure balanced representation among interested parties. We describe the consultation activities the Secretary has undertaken later in this introduction.

2. Legislative Requirements for Related Provisions

Subtitle K of title II of the Affordable Care Act, Protections for American Indians and Alaska Natives, section 2901, extends special benefits and protections to Indians including limits on cost sharing and payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and urban Indian organizations. We propose some provisions under this authority in subpart C of part 156, and we expect to address others in future rulemaking.

Section 6005 of the Affordable Care Act creates new section 1150A of the Act, which requires QHP issuers, and sponsors of certain plans offered under part D or title XVIII of the Act, to provide data on the cost and distribution of prescription drugs covered by the plan. We propose to ***41868** codify these requirements under this authority in part 156, subpart C.

B. Stakeholder Consultation and Input

On August 3, 2010, HHS published a Request for Comment (the RFC) inviting the public to provide input regarding the rules that will govern the Exchanges. In particular, HHS asked States, tribal representatives, consumer advocates, employers, insurers, and other interested stakeholders to comment on the types of standards Exchanges should be required to meet. The comment period closed on October 4, 2010. This proposed rule does not directly respond to comments from the RFC; however, the comments received are described at the beginning of each subpart and referred to, where applicable, when discussing specific regulatory proposals.

The public response to the RFC yielded comment submissions from consumer advocacy organizations, medical and health care professional trade associations and societies, medical and health care professional entities, health insurers, insurance trade associations, members of the general public, and employer organizations. The majority of the comments were related to the general functions and requirements for Exchanges, QHPs, eligibility and enrollment, and coordination with Medicaid. We intend to respond to comments from the RFC, along with comments received on this proposed rule, as part of the final rule.

In addition to the RFC, HHS has consulted with stakeholders through weekly meetings with the National Association of Insurance Commissioners (NAIC), regular contact with States through the Exchange grant process, and meetings with tribal representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. This consultation will continue throughout the development of Exchange guidance.

C. Structure of the Proposed Rule

The regulations outlined in this notice of proposed rulemaking will be codified in the new 45 CFR parts 155 and 156. Part 155 outlines the proposed standards for States relative to the establishment of Exchanges and outlines the proposed standards required of Exchanges related to minimum Exchange functions. Part 156 outlines the proposed standards for health insurance issuers with respect to participation in an Exchange, including the minimum certification requirements for QHPs. Many provisions in part 155 have parallel requirements under part 156 because the Affordable Care Act creates complementary responsibilities for Exchanges and QHP issuers. Where possible, there are cross-references between parts 155 and 156 to avoid redundancy.

Subjects included in the Affordable Care Act to be addressed in separate rulemaking include but are not limited to: (1) Standards for individual eligibility for participation in the Exchange, advance payments of the premium tax credit, cost-sharing reductions, and related health programs and appeals of eligibility determinations; (2) standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility requirement and payment under section 1411(a)(4); (3) defining

essential health benefits, actuarial value and other benefit design standards; and (4) standards for Exchanges and QHP issuers related to quality.

We note that the health plan standards set forth under this proposed rule are, for the most part, strictly related to QHPs offered through the Exchange and not the entire individual and small group market. Various sections added to the Public Health Service (PHS) Act, and incorporated by reference into ERISA and the Code, by the Affordable Care Act extend some of the requirements in this proposed rule to the non-QHP market. Such requirements for the entire individual and small and large group markets already have been, and will continue to be, addressed in separate rulemaking issued by HHS, and the Departments of Labor and the Treasury.

II. Provisions of the Proposed Regulation

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

1. Subpart A—General Provisions

a. Basis and Scope (§ 155.10)

Section 155.10 of subpart A specifies the general statutory authority for and scope of standards proposed in part 155 that establish minimum requirements for the State option to establish an Exchange, minimum Exchange functions, enrollment periods, minimum SHOP functions, and certification of QHPs. In general, this NPRM is based on the broad rulemaking authority of 1321(a)(1) as well as other specific statutory provisions identified in the preamble where appropriate.

b. Definitions (§ 155.20)

Under § 155.20, we set forth definitions for terms that are used throughout part 155. For the most part, the definitions presented in § 155.20 are taken directly from the Affordable Care Act or from existing regulations, unless otherwise specified. Some new definitions were created for the purposes of carrying out regulations proposed in part 155. When a term is defined in part 155 other than in subpart A, the definition of the term is applicable only to the relevant subpart or section. The application of the terms defined in this section is limited to this proposed rule.

Several terms are defined by the Affordable Care Act, including “individual market” (section 1304(a)(2)), “small group market” (section 1304(b)(2)), “qualified employer” (section 1312(f)(2)), “qualified individual” (section 1312(f)(1)), “qualified health plan” (section 1301(a)(1)), “cost sharing” (section 1302(c)(3)), “Navigator” (section 1311(i)), “plain language” (section 1311(e)(3)(B)), “health plan” (section 1301(b)(1)), “eligible employer-sponsored plan” and “minimum essential coverage” (section 5000A(f)(1) of the Code, as added by section 1501(f)), “large employer” and “small employer” (section 1304(b)), and “State” (section 1304(d)). The term “Code” refers to the Internal Revenue Code of 1986.

The definition for an “Exchange” in § 155.20 is drawn from the statutory text in section 1311(d)(1) and 1311(d)(2)(A). We interpret section 1321(c) of the Affordable Care Act to mean that this definition includes an Exchange established or operated by the Federal government if a State does not establish an Exchange. Also, pursuant to section 1311(b)(1)(B), we interpret the term “Exchange” to be inclusive of the operation of a SHOP, which we define based on that section as well.

Some definitions were taken from other interim final regulations issued previously pursuant to the Affordable Care Act, including the term “lawfully present” from § 152.2 of this chapter and the term “grandfathered plan” from § 147.140 of this chapter. The definitions for the terms “group health plan,” “health insurance issuer,” and “health insurance coverage” are cross-referenced to the definitions established in § 144.103. The definition for the term “employee” is taken from the PHS Act, which refers to section 3(6) of ERISA. Under ERISA, the term employee means any individual employed by an employer. The definition of “employer” is taken as well from the PHS Act, which refers to section 3(5) of ERISA. We note that coverage for only a sole proprietor, certain owners of S corporations, and certain relatives of ***41869** each of the above would not constitute

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a group health plan under ERISA section 732(a) (29 U.S.C. section 1191a(a)) and would not be entitled to purchase in the small group market under Federal law.

We create several definitions regarding eligibility and enrollment for the purpose of this proposed rule, including "advance payments of the premium tax credit," "annual open enrollment period," "applicant," "cost-sharing reductions," "initial enrollment period," and "special enrollment period." Several other definitions used throughout this proposed rule are established for various purposes, including the terms: "agent or broker," "benefit year," "enrollee," "plan year," and "Exchange service area."

In the following paragraphs, we discuss the proposed definitions where more clarity is warranted. We note that we interpret the term "cost sharing" as defined in section 1302(c)(3) of the Affordable Care Act to apply to payments for deductibles, copayments, coinsurance or similar charges related to the essential health benefits only. This is consistent with the definition of actuarial value in section 1302(d)(2) of the Affordable Care Act, which specifies that actuarial value shall apply only to the essential health benefits; section 1402(c)(4), which applies cost-sharing reductions only to essential health benefits; and section 1302(c)(3)(ii), which applies any other payments only to essential health benefits.

The term "qualified employer" is defined in section 1312(f)(2) of the Affordable Care Act as a small employer that elects to make, at a minimum, all full-time employees eligible for coverage in a qualified health plan. While the definition indicates that a qualified employer is a "small employer," the Affordable Care Act provides that, beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through the SHOP. The Affordable Care Act also defines a small employer, for the purposes of health coverage, as an employer with at least one but not more than 100 employees. Pursuant to 1304(b)(3), each State has the option to limit small employers to having no more than 50 employees until 2016. We clarify that the scope of the term qualified employer is expected to vary among States and over time. The term "qualified employee" refers to employees offered coverage through a SHOP by a qualified employer.

We propose several terms to define an individual's participation in an Exchange at different periods in the process for individuals, employers, or employees. The terms are "applicant," "qualified individual/qualified employer/qualified employee," and "enrollee." An applicant is an individual who is seeking an eligibility determination to enroll in a QHP in the Exchange, to receive advance payments of the premium tax credit or cost-sharing reductions, or to receive benefits through other State health programs. In the context of a SHOP, the term applicant indicates an employer or employee. The term "qualified individual" is based on section 1312(f)(1) of the Affordable Care Act. Although the Affordable Care Act does not specifically indicate in section 1312(f)(1) that a qualified individual is one who has been determined eligible to participate in an Exchange, we have interpreted it and propose to use the term to mean that the individual has been determined eligible based on the context in which the term is used in other provisions. For example, section 1312(d)(3)(C) states that "a qualified individual may enroll in any qualified health plan" and section 1311(d)(2) states that "an Exchange shall make available qualified health plans to qualified individuals and qualified employers." These provisions suggest that a qualified individual is one who is already determined eligible to participate in an Exchange. Similarly, "qualified employee" and "qualified employer" are terms to indicate an employee or employer that has been determined eligible to participate in a SHOP.

We propose to use the term "enrollee" to describe a qualified individual or qualified employee who has enrolled in a QHP. Although not a defined term, we use the word "consumer" throughout discussion in this NPRM. We generally use the term to mean qualified individuals, qualified employers, or qualified employees, as indicated by the context. In some places, the term may be used to generally describe any potential purchaser of health coverage.

For the purposes of this proposed rule, any reference to the term "issuer," meaning a health insurance issuer, qualified health plan issuer, or QHP issuer, is used in making reference to requirements on or actions taken by the entity that offers health plans. A "health plan," "qualified health plan," or "QHP" is defined as a discrete combination of benefits and cost-sharing that is offered by a health insurance issuer and in which an individual or group can enroll.

We propose to define "health plan" in accordance with section 1301(b)(1) of the Affordable Care Act to encompass health insurance coverage and a group health plan. The Affordable Care Act specifies that, except to the extent specified, the term "health plan" shall not include a group health plan or multiple employer welfare arrangement (MEWA) to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of ERISA. However, we recognize that section 514 of ERISA allows State regulations of MEWAs, provided that such regulation does not conflict with standards of ERISA. We request comment on how to reconcile this inconsistency. We have also received questions about whether Taft-Hartley plans and church plans can participate in the Exchange. We request comment on how such plans could potentially provide coverage opportunities through the Exchange.

We recognize that the term health plan is sometimes used colloquially in a way that is interchangeable with health insurance issuer, but for the sake of clarity we refer to the entity offering coverage as the issuer and the coverage being purchased as the health plan within this proposed rule.

For the purposes of this proposed rule, the term "qualified health plan" denotes a health plan that is certified to be offered through an Exchange as a QHP, while a "qualified health plan issuer" is an issuer that is subject to requirements in this proposed rule related to the offering of QHPs through the Exchange. We note that "QHP issuer" and "health insurance issuer" generally refer to the same entity, but the former is used to describe a health insurance issuer that is offering a QHP through an Exchange, and therefore, must meet the requirements set forth in this NPRM related to such offerings. As a general theme, we use the word "qualified" to denote an individual or an entity eligible to participate, where applicable, in an Exchange or a product eligible to be offered through the Exchange. In this proposed rule, "qualified health plan" only refers to those QHPs that are certified by and offered through an Exchange; however, a QHP issuer is not precluded from offering the certified QHP outside of an Exchange.

We include two separate terms related to defining the time an individual or family is covered by health insurance: "Benefit year" and "plan year." Benefit year refers to coverage that begins on January 1 and lasts for the duration of a calendar year. This is typically used to refer to coverage in the individual market. "Plan year" is used to refer to any rolling consecutive 12-month period of coverage. This is typically used when referring to coverage through ***41870** the small group market, which becomes effective on a rolling basis depending on when the small employer first offers or purchases the health plan.

The terms "eligible employer-sponsored plan" and "minimum essential coverage" have the meaning provided in statute and applicable regulations. In accordance with section 36B(c)(2)(B) of the Code, as added by section 1401(a) of the Affordable Care Act, an individual is ineligible for advance payments of the premium tax credit if he or she is eligible for "minimum essential coverage" (other than coverage in the individual market), which includes coverage through an "eligible employer-sponsored plan." However, section 36B(c)(2)(C) of the Code specifies exceptions under which an individual who is eligible for an "eligible employer-sponsored plan" is eligible for advance payments of the premium tax credit; specifically, if such coverage is unaffordable or does not meet a minimum value requirement.

2. Subpart B—General Standards Related to the Establishment of an Exchange by a State

The Affordable Care Act sets forth general standards related to the establishment of a State Exchange and provides a number of areas where States that choose to operate an Exchange may exercise discretion in making decisions about Exchange operations. Under the statute, States have choices regarding the structure and governance of their Exchanges. For example, a State may establish an Exchange as a State agency or as a non-profit organization, and may choose to contract with other eligible entities to carry out various functions of the Exchange. A State may also choose to partner with other States to form a regional Exchange, or may establish one or more subsidiary Exchanges within the State. This subpart sets forth approval standards for State Exchanges as well as the process by which HHS will determine whether a State Exchange meets those standards.

HHS has pursued various forms of collaboration with the States to facilitate, streamline and simplify the establishment of an Exchange in every State. These efforts have made it clear that for a variety of reasons including reducing redundancy, promoting efficiency, and addressing the tight implementation timelines authorized under the Affordable Care Act, States may find it advantageous to draw on a combination of their own work plus business services developed by other States and the Federal

government as they move toward certification. Some States have expressed a preference for a flexible State partnership model combining State-designed and operated business functions with Federally-designed and operated business functions. Examples of such shared business functions might include eligibility and enrollment, financial management, and health plan management systems and services. We note that States have the option to operate an exclusively State-based Exchange. HHS is exploring different partnership models that would meet the needs of States and Exchanges.

In response to the RFC, we received numerous comments related to the establishment of State Exchanges. In general, the comments focused on how to balance the need for State flexibility against the need for consistency. We also received numerous comments related to the governance structure of the Exchanges and the establishment of regional or subsidiary Exchanges. We considered these comments as we developed the proposed rule.

a. Establishment of a State Exchange (§ 155.100)

Sections 1311(b) and 1321(b) of the Affordable Care Act provide each State with the option to elect to establish an Exchange for the individual and small group markets. We propose to codify this option in paragraph (a).

In paragraph (b), we propose to codify section 1311(d)(1) of the Affordable Care Act that an Exchange must be a governmental agency or non-profit entity established by the State. We also propose that the governance structure of the Exchange must be established and operated consistent with the requirements in § 155.110. A governmental agency could be an existing State executive branch agency or an independent public agency. When reviewing the types of governmental agencies that could serve as an Exchange, States should consider the costs and benefits of utilizing the accountability structure within an existing agency versus the need to establish a governing body for an independent public agency. Additionally, each State will need to follow its own laws related to the establishment of non-profit organizations. A State could operate an Exchange through an existing non-profit that was established by a State, or by establishing a new non-profit organization or corporation. Under any scenario, the management structure of the Exchange must be accountable for Exchange oversight and performance.

While a number of commenters on the RFC expressed concern over the operation of Exchanges by non-profit entities, we do not propose to limit the States' discretion to choose this type of entity beyond the minimum standards proposed in § 155.110. However, we note that States should consider the relative merits of operating an Exchange through a non-profit entity. Non-profit entities may be able to operate without some of the restrictions that can limit the flexibility of governmental agencies; however, non-profit entities may face limitations performing functions that are typically governmental in nature. In light of these concerns, we note suggestions by some commenters that States consider establishing independent public/governmental agencies with flexible hiring and operational practices or establishing non-profit entities with governing bodies that are appointed and overseen by States.

b. Approval of a State Exchange (§ 155.105)

In paragraph (a) of proposed § 155.105, we propose to codify section 1321(c)(1)(B) of the Affordable Care Act that directs the Secretary to determine by January 1, 2013 whether a State's Exchange will be fully operational by January 1, 2014. We believe that “fully operational” means that an Exchange is capable of beginning operations by October 1, 2013 to support the initial open enrollment period proposed in § 155.410. HHS will make this determination through applying the State Exchange approval standards and process established in this section.

In paragraph (b), we outline the standards upon which HHS will approve a State Exchange. First, an Exchange must be established consistent with this subpart and be capable of carrying out the required functions of an Exchange consistent with the subparts contained within this part, including: subpart C related to minimum Exchange functions; subpart E related to enrollment; subpart H related to the operation of a SHOP; and subpart K related to certification of QHPs. Second, an Exchange must be able to comply with the information requirements established pursuant to section 36B of the Code with respect to advance payments of the premium tax credit and in accordance with future rulemaking. Third, a State seeking approval of an Exchange must agree to perform its responsibilities related to the operation of a reinsurance program, set forth in the proposed

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rule, the Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment published in this issue of the Federal Register. According to section 1341 of the Affordable Care Act, each State must ***41871** include in the standards it adopts under section 1321(b) related to the election to operate a State Exchange the Federal requirements for State reinsurance programs, and must also establish or enter into a contract with one or more applicable reinsurance entities to carry out the reinsurance program.

Finally, the entire geographic area of a State must be covered by one or more Exchanges. A State could meet this requirement by having a combination of a regional Exchange and one or more subsidiary Exchanges although to minimize consumer confusion, only one Exchange may operate in each geographically distinct area. To the extent that more than one Exchange is established in a State, we encourage each Exchange to ensure that consumers understand which Exchange they should utilize to access health insurance coverage.

In paragraph (c), we outline the process through which HHS will approve a State Exchange. In paragraph (c)(1), we propose that to initiate the State Exchange approval process, a State must elect to establish an Exchange by submitting an Exchange Plan to HHS, which constitutes the State's application for approval of its Exchange. The Exchange Plan will be submitted through a procedure to be described in additional guidance. As part of the Exchange Plan, the State will be asked to provide detailed information on how it will meet each of the standards described in paragraph (b) of this section. We expect that the Exchange Plan will include copies of any agreements into which the Exchange has entered to carry out one or more of the Exchange's responsibilities in accordance with § 155.110, as well as additional supporting documentation. We plan to issue a template outlining the required components of the Exchange Plan, subject to the notice and comment process under the Paperwork Reduction Act. States are encouraged to leverage the implementation plans that are required as part of reporting on State Exchange grant awards when preparing to submit an Exchange Plan.

In paragraph (c)(2), we propose that each State applying for approval of its Exchange be subject to an assessment to be carried out by HHS to evaluate a State's operational readiness to execute its Exchange Plan. HHS will coordinate the readiness assessment process with the grants monitoring process under the State planning and establishment grants. This process may include meetings with State and Exchange officials as well as conference calls and on-site visits. HHS will issue additional guidance on the structure for and schedule of these assessments.

In paragraph (d), we propose that each State must receive written approval or conditional approval of its Exchange Plan in order to be approved to operate. If approved, the Exchange Plan will constitute an agreement between HHS and the Exchange to adhere to the contents of the Exchange Plan. We also note that, although the statute requires HHS to approve State Exchanges no later than January 1, 2013, there will be systems development and contracting activities that continue to occur in 2013 after the statutory deadline for approval. In order to accommodate States that are making progress towards the operational date of January 1, 2014, HHS may issue a conditional approval. The conditional approval would presume that the State's Exchange would be operational by January 1, 2014 even if it cannot demonstrate complete readiness on January 1, 2013. HHS would continue to work with and monitor the progress of States with conditional approval until a determination of full approval is made, or until the conditional approval is revoked.

We also note that we are considering establishment of a review process for the Exchange Plan that is similar to Medicaid and CHIP for which there would be 90 days to review the plan for either approval or denial, or to request comment. If additional information is requested and received from the State, HHS would have 90 days to either approve or disapprove the plan. We seek comments on the appropriateness of this process and timeline.

In paragraph (e), we propose that a State must notify HHS before significant changes are made to the Exchange Plan and that an Exchange must receive written approval of significant changes from HHS before they may be effective. We are considering utilizing the State Plan Amendment process in place for Medicaid and CHIP. We seek comment on this approach. By establishing an ongoing dialogue with each State, HHS will be able to provide technical assistance and support to ensure that each Exchange is operating in compliance with Federal requirements. Significant changes could include altering a key function of the Exchange

operations, changing a crucial timeframe for certain functions, or other changes to the Exchange Plan that would have an impact on the operation of the Exchange. While not exhaustive, changes within this scope could also include changes to: (1) Exchange governance structure, (2) State laws or regulations, (3) IT systems or functionality, (4) the QHP certification process, and (5) the process for enrollment into a QHP. We expect to issue further guidance on this process.

In paragraph (f), we propose to codify the statutory requirement in section 1321(c)(1) of the Affordable Care Act that if a State elects not to establish an Exchange, or if the State's Exchange is not approved, HHS, either directly or through agreement with a non-profit entity, must establish and operate an Exchange in that State. We also identify the standards in this proposed regulation that would apply to a Federally-facilitated Exchange, which generally include all requirements of this part except for Exchange approval requirements and other specific State Exchange requirements.

c. Election To Operate an Exchange After 2014 (§ 155.106)

In paragraph (a), we propose an approval process for a State that does not have in place an approved or conditionally approved Exchange Plan and operational readiness assessment by January 1, 2013. We propose to allow States the flexibility of seeking approval to operate an Exchange even if a State is not approved to operate by January 1, 2013. We propose in paragraph (a)(1) that a State electing to seek initial approval of its Exchange after January 1, 2013 must comply with the standards and process set forth in § 155.105. We propose in paragraph (a)(2) that a State electing to operate an Exchange after 2014 must have in effect an approved or conditionally approved Exchange Plan at least 12 months prior to the first effective date of coverage. We assume that the first effective date of coverage will fall on January 1 of any given year because of the standardized annual open enrollment periods, so the approval or conditional approval would have to be in effect by January 1 of the prior year; these dates would align future Exchange Plan approvals with the initial approval timeline set forth in statute. We note that we expect that an Exchange would have an open enrollment period prior to the first effective date of coverage.

In paragraph (a)(3), we propose that such a State must work with HHS to develop a plan to transition from a Federally-facilitated Exchange to a State Exchange. We anticipate that this would include the smooth transition of operational functions from the Federally-facilitated Exchange to the State Exchange, including transitioning enrollees from QHPs certified by the Federally-facilitated Exchange to QHPs certified by a State Exchange, which may or may not differ.

***41872** In paragraph (b), we propose a process to allow a State-operated Exchange to cease its operations after January 1, 2014 and to elect to have the Federal government establish and operate an Exchange within the State. If a State determines that it will no longer operate an Exchange after January 1, 2014, we propose in paragraph (b)(1) that the State must notify HHS of this determination 12 months prior to ceasing its operations. Also, we propose in paragraph (b)(2) that the Exchange must collaborate with HHS on the development and execution of a transition plan and process to facilitate operation of a Federally-facilitated Exchange. We estimate that we will need 12 months to establish a Federally-facilitated Exchange in a State due to the time required to set up the necessary information technology and QHP certification process.

d. Entities Eligible To Carry Out Exchange Functions (§ 155.110)

Section 1311(f)(3) of the Affordable Care Act provides an Exchange with the authority to contract with eligible entities to carry out one or more of the responsibilities of an Exchange, which we propose to codify in paragraph (a) of § 155.110. The minimum requirements set forth in the statute, and which are proposed in paragraph (a), specify that an eligible entity is one that: (1) Is incorporated under and subject to the laws of one or more States, (2) has demonstrated experience on a State or regional basis in the individual and small group markets and in benefits coverage, and (3) is not a health insurance issuer or treated as a health insurance issuer. An eligible entity also includes the State Medicaid agency. We also interpret this language as allowing an Exchange to contract with the State Medicaid agency through which the State Medicaid agency determines eligibility on behalf of the Exchange. This authority is also provided in section 1413(d)(2) of the Affordable Care Act. We note that there may be ways in which an Exchange and the Federal government can work in partnership to carry out certain activities. Underlying this NPRM and the cooperative agreement funding opportunities provided to States is a philosophy of Federal and State partnership. As States, and the Federal government in connection with the Federally-facilitated Exchange, develop expertise and implement

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the infrastructure for Exchange operations, we anticipate sharing of information and ideas. We welcome comment on how to implement or construct a partnership model consistent with sections 1311(f)(3) and 1311(d)(5) of the Affordable Care Act.

In paragraph (b), to the extent that the Exchange establishes contracting arrangements with outside entities, we propose that the Exchange remains responsible for meeting all Federal requirements related to contracted functions. Pursuant to these provisions, States have flexibility to determine appropriate contracting entities within legal limits. We invite comment on the extent to which we should place conflict of interest requirements on contracted entities.

In paragraph (c), we propose that if the Exchange is an independent State agency or not-for-profit entity established by the State and not an existing State agency, it must have a clearly defined governing board that meets certain minimum requirements outlined in paragraphs (c)(1) through (4). Further, the Exchange must submit detailed information on its accountability structure in its Exchange Plan, as described in § 155.105(c).

In paragraph (c)(1), we propose that the Exchange accountability structure be administered under a formal, publicly-adopted operating charter or by-laws. This provision ensures transparency of the governing board structure for the public. In paragraph (c)(2), we propose that the Exchange board must hold regular public meetings for which the public is provided advance notice to provide them with opportunities to observe and comment on Exchange policies and procedures.

In paragraphs (c)(3) and (c)(4), we propose standards on the membership of an Exchange governing board related to conflicts of interest and management qualifications. Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests. We propose in paragraph (c)(3) that the voting members of an Exchange governing board represent consumer interests by ensuring that membership may not consist of a majority of representatives of health insurance issuers, agents, or brokers, or any other individual licensed to sell health insurance. We invite comment on the extent to which these categories of representatives with potential conflicts of interest should be further specified and on the types of representatives who have potential conflicts of interest. We propose these categories as a minimum Federal standard. A State may wish to adopt more stringent or specialized conflict of interest requirements than those used in connection with regular governmental operations.

In paragraph (c)(4), we propose that the Exchange governing body ensure that a majority of members have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. We invite comment on the types of representatives that should be on Exchange governing boards to ensure that consumer interests are well-represented and that the Exchange board as a whole has the necessary technical expertise to ensure successful operations.

We considered additional options for regulating Exchange governance structures beyond the minimal requirements proposed herein. However, we propose to afford States discretion to select and appoint members of their Exchange boards. As such, a State may choose to include additional membership as long as composition of the board still meets the minimum Federal requirements.

In paragraph (d), we propose two requirements related to governance principles of an Exchange. First, in paragraph (d)(1), we propose that each Exchange publish a set of guiding governance principles that includes ethical and conflict of interest standards and disclosure of financial interests that are posted for public consumption. In paragraph (d)(2), we propose to require that an Exchange have in place procedures for disclosure of financial interest by members of the governing body or governance structure of the Exchange. We invite comment on this proposal and whether additional detail should be proposed. We note that we received numerous comments in response to the RFC on Exchange governance. Some commenters suggested that we establish minimum standards because of the limited statutory requirements in this area. In contrast, other commenters suggested that HHS establish more restrictive standards, citing concerns over conflicts of interest and non-governmental entities carrying out activities that are inherently governmental.

In paragraph (e), we acknowledge a State's option to elect to establish a separate governance and administrative structure for the SHOP. Section 1311(b)(2) of the Affordable Care Act provides each State with flexibility to merge its individual market Exchange and SHOP under a single administrative or governance structure. We interpret this provision to also allow a State to operate these functions under separate governance or administrative structures. ***41873** However, we believe that a single governance structure for both the individual market Exchange functions and SHOP will yield better policy coordination, increased operational efficiencies, and improved operational coordination. In paragraph (e)(1), we propose to allow a State to operate its individual market Exchange and SHOP under separate governance or administrative structures and also require that if it chooses to do so, it must, where applicable, coordinate and share relevant information between the two Exchange bodies. Then, we propose in paragraph (e)(2) to codify the requirement in section 1311(b)(2) of the Affordable Care Act that if a State does choose to operate its individual market Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers.

Finally, in paragraph (f), we propose that HHS may periodically review the accountability structure and governance principles of an Exchange. We request comment on recommended frequency of these reviews.

e. Non-Interference With Federal Law and Non-Discrimination Standards (§ 155.120)

Section 1311(k) of the Affordable Care Act requires that an Exchange may not establish rules that conflict with or prevent the application of Exchange regulations promulgated by HHS, which we propose to codify in paragraph (a).

Section 1321(d) of the Affordable Care Act establishes that nothing in title I may be construed to preempt any State law that does not prevent the application of the provisions set forth under title I of the Affordable Care Act, which we propose to codify and extend to this proposed rule in paragraph (b).

In paragraph (c), we propose that a State must comply with any applicable non-discrimination statutes. Specifically, pursuant to the authority provided in 1321(a)(1)(A) to regulate the establishment and operation of an Exchange, we propose that an Exchange and a State, when fulfilling or carrying out the requirements of this part, must not operate an Exchange in such a way as to discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Examples of actions to which this standard applies include marketing, outreach, and enrollment.

f. Stakeholder Consultation (§ 155.130)

According to section 1311(d)(6) of the Affordable Care Act, Exchanges are required to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations. We propose that the Exchange consult on an ongoing basis with key stakeholders, including:

a. Educated health care consumers who are enrollees in QHPs; “educated” is the term used in Section 1311(d)(6)(A) of the Affordable Care Act to describe consumers who must be consulted. We recommend that Exchanges include in these consultations individuals with disabilities;

b. Individuals and entities with experience in facilitating enrollment in health coverage;

c. Advocates for enrolling hard-to-reach populations, which includes individuals with a mental health or substance abuse disorder. We also encourage Exchanges to include advocates for individuals with disabilities and those who need culturally and linguistically appropriate services;

d. Small businesses and self-employed individuals;

e. State Medicaid and CHIP agencies. We also encourage Exchanges to consult with consumers who are Medicaid or CHIP beneficiaries;

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f. Federally-recognized tribe(s) as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange's geographic area;

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health insurance issuers; and

k. Agents and brokers.

We note that the first five groups are identified in the Affordable Care Act under section 1311(d)(6). We proposed additional groups in response to numerous comments that we received to the RFC indicating that the views of such types of organizations and entities should be considered, which we propose in (f) through (k). We believe that the inclusion of these additional groups will provide diverse input and will be informative of the viewpoints of the various groups impacted by the Exchange.

Each Exchange that has one or more Federally-recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange's geographic area must engage in regular and meaningful consultation and collaboration with such tribes and their tribal officials on all Exchange policies that have tribal implications. We encourage Exchanges to also seek input from all tribal organizations and urban Indian organizations. While the Exchanges will be charged with the consultation, tribal consultation is a government-to-government process, and therefore the State should have a role in the process. We encourage States to develop a tribal consultation policy that is approved by the State, the Exchange, and tribe(s). We anticipate providing additional guidance to both the tribes and States on how the governments may collaborate and build a strong working relationship.

g. Establishment of a Regional Exchange or Subsidiary Exchange (§ 155.140)

Section 1311(f)(1) provides for the operation of an Exchange in more than one State if each State permits such operation and the Secretary approves such an Exchange. In paragraph (a) of § 155.140, we propose criteria that the Secretary will use to approve a regional Exchange. Although the statute uses the phrase “regional or interstate Exchange,” we use only the term “regional Exchange” to mean an Exchange that operates in two or more States for purposes of clarity. In paragraph (a)(1), we propose that a State may participate in a regional Exchange if the Exchange spans two or more States, noting that the States need not be contiguous. In paragraph (a)(2), we propose that a regional Exchange submit a single Exchange Plan for the regional Exchange and receive approval consistent with § 155.105 to demonstrate its readiness to operate an Exchange.

We encourage States to consider how a regional Exchange would meet the Exchange requirements and achieve the cooperation that must occur between the regional Exchange and each participating State's department of insurance. States should also consider how to provide a consistent level of consumer protections across the States, procedures by which a State would withdraw from a regional Exchange, and how each State would contribute to the financing of the regional Exchange.

Section 1311(f)(2) provides that a State may establish one or more subsidiary Exchanges, which we propose to codify in paragraph (b). In paragraph (b)(1), we propose to codify the statutory language in section 1311(f)(2)(A) that a State may establish one or more subsidiary Exchanges if each such Exchange serves a geographically distinct area. In paragraph (b)(2), we propose to codify the statutory requirement that the area served by a subsidiary Exchange must be at least as large as a rating area described in section 2701(a) of the PHS Act, and referenced in section 1311(f)(2)(B) of the Affordable Care Act. ***41874** We note that the Secretary will address the process for States requesting approval of rating areas in future rulemaking.

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We invite comment on operational or policy concerns about the idea of subsidiary Exchanges that cover areas across State lines. We also request comment on the extent to which we should allow more flexibility in the structure of a subsidiary Exchange, for example, related to the combination of subsidiary Exchanges that would be allowed to operate in a State.

We note that several commenters suggested that we consider whether a tribal government could operate a regional or subsidiary Exchange or otherwise carry out some of the functions of an Exchange. Because an Exchange must be established by a State or by a Territory pursuant to sections 1311, 1321, and 1323 of the Affordable Care Act, or be operated by HHS consistent with 1321(c) of the Affordable Care Act, we do not believe that a tribal government itself could establish an Exchange. Instead, we believe that the tribal government could work with the State as the State establishes an Exchange.

In paragraph (c), we propose basic standards for a regional or subsidiary Exchange. First, in paragraph (c)(1), we propose that a regional or subsidiary Exchange must meet all requirements within this part. In paragraph (c)(2), we propose that a regional or subsidiary Exchange perform the functions of a SHOP consistent with subpart H of this part. If a regional or subsidiary Exchange chooses to operate a SHOP through separate governance than the individual market Exchange, we propose in paragraph (c)(2)(ii) that the geographic areas served must be the same. For example, if a State chooses to participate in a regional Exchange, it would need to do so for both the individual market and the small group market. We propose this standard as means to maximize administrative efficiency for the SHOP and to provide consistency for consumers. This consistency would also reduce the burden on entities such as QHPs that would otherwise operate in different service areas depending on whether they offer plans in the individual market or the small group market.

h. Transition Process for Existing State Health Insurance Exchanges (§ 155.150)

Some States have established operational health insurance exchanges that are currently providing access to health insurance coverage to certain individuals in their States. These State exchanges were established prior to passage of the Affordable Care Act and may not meet all the requirements set forth in the Affordable Care Act or this proposed rule. Section 1321(e) requires the establishment of a process for determining any areas in which the State may not be with Federal standards, which we propose in this section.

Consistent with section 1321(e)(1) of the Affordable Care Act, in paragraph (a), we propose that, unless determined to be non-compliant through the process below, a State operating an exchange is presumed to be in compliance with the standards set forth in this part if: (1) The exchange was operating before January 1, 2010; and (2) the State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act.

We are considering which data source to use to determine the applicable percentage of the national population projected to be insured after the implementation of the Affordable Care Act, which we propose to interpret to mean the year 2016. We consider 2016 to be the first full year after implementation of the Affordable Care Act in which health insurance coverage would achieve its steady state. We note that the CMS Office of the Actuary currently estimates that the coverage level of the U.S. population in 2016 will be 93.6 percent; the Congressional Budget Office estimates the coverage level at 95 percent.[FN1] We are considering the use of data from the CMS Office of the Actuary or the Congressional Budget Office to determine the applicable percentage. We invite comments on which proposed threshold should be used and on alternative numbers to be used.

In paragraph (b), we propose that any State that is currently operating a health insurance exchange that meets the description of such a State under paragraph (a) must work with HHS to identify areas of non-compliance with the requirements of this part.

i. Financial Support for Continued Operations (§ 155.160)

Section 1311(d)(5) of the Affordable Care Act provides that a State Exchange must be self-sustaining by January 1, 2015; the statute explicitly lists assessments and user fees on participating issuers as one potential means for a State to secure operational

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funding for Exchanges. In addition, section 1311(d)(5) places certain prohibitions on uses of the funds that are intended for Exchange administration and operations in order to prevent waste.

In paragraph (a), we incorporate the definition of "participating issuer" provided in § 156.50 to this section. In paragraph (b) of § 155.160, we propose to codify the statutory requirement that a State ensure its Exchange has sufficient funding to support ongoing operations beginning January 1, 2015. In addition, we propose that States must develop a plan for ensuring funds will be available. We note that the funding plan is a requirement of Exchange approval under subpart B of this part.

In paragraph (b)(1), we propose to codify the statutory flexibility in section 1311(d)(5)(A) of the Affordable Care Act that allows a State Exchange to fund its ongoing operations by charging user fees or assessments on participating issuers. In paragraph (b)(2), we propose that States may use other forms of funding for Exchange operations, consistent with the reference in section 1311(d)(5)(A) that allows States to "otherwise generate funding." This language provides States with broad flexibility to generate funds beyond charging the "assessments or user fees" identified in the statute. States may use broad-based funding (which may include general State revenues, provider taxes, or other funding that spreads costs beyond imposing assessments or user fees on participating issuers), as long as the use of such funding does not violate other State or Federal laws.

In paragraph (b)(3), we propose to codify the implied statutory requirement established in section 1311(d)(5)(A) of the Affordable Care Act that a State Exchange must be self-sustaining starting on January 1, 2015. Federal funds may not be provided after that time to support its continued operations. This direction is also articulated in section 1311(a)(4)(B), which limits the duration of Federal grants to plan for and establish State Exchanges.

In paragraph (b)(4), we propose that the State Exchange announce the assessment of any user fees on health insurance issuers in advance of the plan year. We invite comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be assessed on an annual basis.

***41875 3. Subpart C—General Functions of an Exchange**

Subpart C outlines the minimum functions of an Exchange, with cross-references in some cases to more detailed standards that are described in subsequent subparts (E, H and K). The proposed minimum functions are designed to provide State flexibility. Uniform standards are proposed where required by the statute or where there are compelling practical, efficiency or consumer protection reasons.

a. Functions of an Exchange (§ 155.200)

Proposed § 155.200 identifies the minimum functions of an Exchange. These functions closely parallel sections 1311(d)(2), (4), and (6), and sections 1402 and 1411-13 of the Affordable Care Act.

In paragraph (a), we propose a general standard that an Exchange must perform the required functions set forth in this subpart and in subparts E, H, and K of this part.

In paragraph (b), we propose, consistent with our interpretation of section 1311(d)(4)(H) and section 1411 of the Affordable Care Act, that an Exchange must grant certifications of exemptions from the individual responsibility requirement and payment. The specific standards and eligibility criteria that apply to such certifications will be addressed in future rulemaking.

In paragraph (c), we propose that the Exchange must perform eligibility determinations. We intend to provide specific standards and eligibility criteria for this Exchange function in future rulemaking to implement sections 1311, 1411, 1412, and 1413 of the Affordable Care Act. Further, it will support and complement rulemaking conducted by the Secretary of the Treasury with respect to section 36B of the Code, as added by section 1401(a) of the Affordable Care Act, and by the Secretary of HHS with respect to several sections of the Affordable Care Act that create new law and amend existing law regarding Medicaid and CHIP.

We note that the aforementioned sections of the Affordable Care Act create a central role for the Exchange in the process of determining an individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and the BHP, if a BHP is operating in the Exchange service area. We interpret Affordable Care Act sections 1311(d)(4)(F), and 1413, and section 1943 of the Act, as added by section 2201 of the Affordable Care Act, to require the establishment of a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP and receive a determination of eligibility for any such program. We also note that we interpret section 1413(b)(2) to mean that the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants.

In paragraph (d), we propose that each Exchange establish a process for appeals of eligibility determinations. These requirements and the appeal process generally, including the requirements of section 1411(f) of the Affordable Care Act, will be addressed in future rulemaking.

In paragraph (e), we propose that an Exchange must perform required functions related to oversight and financial integrity requirements in order to comply with section 1313 of the Affordable Care Act.

In paragraph (f), we propose that the Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act. We anticipate future rulemaking on these topics, but propose here the basic requirement that the Exchange will have a role in the implementation, oversight, and improvement of the quality and enrollee satisfaction initiatives required by the Affordable Care Act. This will include requirements for quality data collection, standards for assessing a QHP issuer's quality improvement strategies, and details on how Exchanges can assess and calculate ratings of health care quality and outcomes using methodologies made available by HHS or alternatives, if applicable.

The functions of an Exchange listed in proposed § 155.200 are important to the achievement of a more stable and accessible health insurance market for consumers and businesses and represent the minimum functions of an Exchange to meet that goal. We encourage States to consider supplemental standards or functionality for their Exchanges that benefit consumers and businesses, and we welcome comments regarding these and other functions that should be required of an Exchange.

b. Required Consumer Assistance Tools and Programs of an Exchange (§ 155.205)

In § 155.205, we outline the standards for a number of consumer assistance tools and activities that Exchanges must provide. In paragraph (a), we propose to codify section 1311(d)(4)(B) of the Affordable Care Act, which requires the Exchange to provide for the operation of a call center to respond to requests for assistance by consumers that is accessible via a toll-free telephone number.

We note that an Exchange has significant latitude in how it structures the call center. To increase accessibility to the call center, we suggest that an Exchange consider operating it outside of normal business hours and adjusting staffing levels in anticipation of periods of higher call volumes (for example, the weeks leading up to and during open enrollment). We also believe that the Exchange call center should have the capability to provide assistance to consumers and businesses on a broad range of issues, including but not limited to:

(1) The types of QHPs offered in the Exchange;

(2) The premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered;

(3) Categories of assistance available, including advance payments of the premium tax credit and cost-sharing reductions as well assistance available through Medicaid and CHIP;

(4) The application process for enrollment in coverage through the Exchange and other programs (for example, Medicaid and CHIP).

The Affordable Care Act includes several programs that aid consumers through the process of acquiring and using health insurance, including the State-based consumer assistance programs (for example, health insurance ombudsman programs created under Section 1002 of the Affordable Care Act) and the Navigator program, which we describe more fully in § 155.210 below. We encourage Exchanges to use call centers as a conduit to these and any other State consumer programs, where appropriate. We also recognize there may be some instances where there is appropriate overlap between information provided by the Exchange call centers and information provided by customer service call centers operated by health insurance issuers, particularly in the area of health plan enrollment. We seek comments on ways to streamline and prevent duplication of effort by the Exchange call center and QHP issuers' customer call centers, but ***41876** ensure that consumers have a variety of ways to learn about their coverage options and receive assistance on other health insurance coverage issues.

In paragraph (b), we propose to codify section 1311(d)(4)(C) of the Affordable Care Act, which requires an Exchange to maintain an Internet Web site. The Affordable Care Act provides two key provisions related to the establishment of an Exchange Web site. First, section 1103(b) of the Affordable Care Act requires the Secretary to establish a standardized format for presenting coverage option information, which is utilized to present comparative health plan information on the current HealthCare.gov Web site. Second, section 1311(c)(5) requires the Secretary to make available to all Exchanges a model Exchange Web site template developed by the Secretary. We are currently evaluating the extent to which the Exchange Web site may satisfy the need to provide plan comparison functionality using HealthCare.gov, and invite comments on this issue.

Generally, we envision the Exchange Web site to be an easy-to-use access point that serves as a primary source of information about available QHPs, Exchange activities, and other sources of health coverage. We believe that the Exchange Web site is an appropriate venue to post QHP information as required by other sections of the Affordable Care Act that require disclosure of information that would be helpful for consumers in comparing QHPs, including the medical loss ratio (section 2718 of the PHS Act), transparency in coverage data (section 1311(e)(3) of the Affordable Care Act), summary of benefits and coverage (section 2715 of the PHS Act) [FN2] and levels of coverage (section 1302(d) of the Affordable Care Act).

We specifically propose in § 155.205(b)(1) through (6) that an Exchange must maintain an up-to-date Internet Web site that:

1. Presents standardized comparative information on each available QHP. Such information must include:

i. Premium and cost-sharing information;

ii. The summary of benefits and coverage required by section 2715 of the PHS Act. Exchanges may consider making this information available through a link from their Web site to each QHP's Web site or Exchanges could require QHPs to submit this information in a manner that supports a searchable format;

iii. The level of coverage of a QHP (that is, bronze, silver, gold, platinum, or catastrophic coverage consistent with section 1302(d) and 1302(e) of the Affordable Care Act);

iv. The results of enrollee satisfaction surveys described in section 1311(c)(4) of the Affordable Care Act;

v. Quality ratings assigned to QHPs described in section 1311(c)(3) of the Affordable Care Act;

vi. The medical loss ratio as reported in accordance with interim final rule 75 FR 74921, December 1, 2010, amended 75 FR 82278, December 30, 2010;

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vii. Transparency of coverage measures reported to the Exchange as required under § 155.1040; and

viii. The provider directory reported to the Exchange during certification pursuant to § 156.230;

2. Provides meaningful access to information for individuals with limited English proficiency. Such accessibility needs may be met by providing language assistance services, which may include translated information and “tag lines” directing individuals to translated materials and/or telephone numbers to call to reach interpreters for assistance. Web sites must also be accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. HHS has issued guidance regarding the requirements of section 504 with respect to Web site accessibility.[FN3] The guidance states that at this time, the Department will consider a recipient's Web sites, interactive kiosks, and other information systems addressed by section 508 standards as being in compliance with section 504 if such technologies meet those standards. We encourage States to follow either the 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities. States may wish to consult the latest section 508 guidelines issued by the U.S. Access Board or W3C's Web Content Accessibility Guidelines (WCAG) 2.0; [FN4]

3. Publishes the following financial information: the average cost of licensing required by the Exchange, any regulatory fees required by the Exchange, any other payments required by the Exchange, administrative costs of the Exchange, and monies lost to fraud, waste, and abuse in accordance with section 1311(d)(7) of the Affordable Care Act.

4. Provides contact information for Navigators and other consumer assistance services, including the telephone number of the Exchange call center;

5. Allows for an eligibility determination pursuant to the standards established in accordance with § 155.200(c) of this subpart; and

6. Allows for enrollment in coverage pursuant to subpart E of this part.

We are considering a Web site requirement that would allow applicants and enrollees to store and access their personal account information and make changes, provided that the Web site complied with the standards developed by the Secretary pursuant to section 3021(b)(3) of the PHS Act, as added by section 1561 of the Affordable Care Act. The standards [FN5] address electronic enrollment systems for Federal and State health and human services, provide for the submission and storage of electronic documents, and permit reuse of stored information. To minimize administrative burden, we would encourage Exchanges to develop a feature whereby eligibility and enrollment experts, caseworkers, Navigators, agents and brokers, and other application assisters are able to maintain records of individuals they have assisted with the application process. We request comment on this proposal.

In paragraph (c), we propose to codify section 1311(d)(4)(G) of the Affordable Care Act that requires an Exchange to establish an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. We invite comment on the extent to which States would benefit from a model calculator and suggestions on its design.

In paragraph (d), we propose that the Exchange have a consumer assistance function (including but not limited to a Navigator program described more fully in § 155.210) that provides assistance services to consumers. Exchanges will receive various types of requests for assistance from consumers, including assistance with eligibility and enrollment, appeals, and handling complaints, and must be able to direct consumers accordingly. We note that if an Exchange receives complaints of ***41877** race, color national origin, disability, age, or sex discrimination, it may refer these individuals to the HHS Office for Civil Rights (OCR).

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In paragraph (e), we propose that the Exchange conduct outreach and education activities to educate consumers about the Exchange and to encourage participation, separate from the implementation of a Navigator program described in § 155.210. Exchanges should aim to maximize enrollment of eligible individuals into QHPs to increase QHP participation and competition which in turn increases consumer choice and purchasing clout. This will also reduce the number of individuals without health insurance coverage. We encourage Exchanges to conduct outreach broadly as well as in ways that are accessible to people with disabilities, individuals with low literacy, and those with limited English proficiency. In addition, we encourage Exchanges to target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders.

c. Navigator Program Standards (§ 155.210)

In § 155.210, we propose the standards for the Navigator program, consistent with section 1311(i) of the Affordable Care Act. The Navigator standards apply to the Exchange including both the individual market and SHOP. In paragraph (a), we propose the general standard that Exchanges must award grant funds to public or private entities to serve as Navigators. In paragraph (b)(1), we propose the eligibility requirements for and the types of entities to which the Exchange may award Navigator grants. We propose that Navigators must be capable of carrying out those duties established in paragraph (d) of this subsection. In addition, a Navigator must demonstrate to the Exchange, as required by section 1311(i)(2)(A) of the Affordable Care Act, that the entity has existing relationships, or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a QHP through the Exchange. We note that an entity need not have the ability to form relationships with all relevant groups in order to be eligible for Navigator funding; for example, an entity that can effectively conduct outreach to rural areas may not be as effective in urban areas.

We further propose in paragraph (b)(1)(iii) that a Navigator must meet any licensing, certification or other standards prescribed by the State or Exchange, as appropriate, consistent with section 1311(i)(4)(A) of the Affordable Care Act. This will allow the State or Exchange to enforce existing licensure standards (such as verifying that agents who seek to be Navigators are licensed), certification standards, or regulations for selling or assisting with enrollment in health plans and to establish new standards or licensing requirements tailored to Navigators (such as participating in periodic trainings), as appropriate.

We further propose in paragraph (b)(1)(iv) that any entity that serves as a Navigator may not have conflict of interest during the term as Navigator. We specify "during the term as a Navigator" because we want to ensure that an entity that might have formerly had a conflict would not be excluded from consideration if that conflict no longer exists. We clarify that these standards would not exclude, for example, a non-profit community organization that previously received grant funding from a health insurance issuer from serving as a Navigator. We seek comment on whether we should propose additional requirements on Exchanges to make determinations regarding conflicts of interest.

Section 1311(i)(2)(B) of the Affordable Care Act identifies entities which may be eligible to serve as Navigators, including "other entities" pursuant to section 1311(i)(2)(B) insofar as they meet the requirements of section 1311(i)(4). In paragraph (b)(2), we propose that the Exchange include at least two of the types of entities listed in Section 1311(i)(2)(B) as Navigators. We seek comment as to whether we should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization, or whether we should require that Navigator grantees reflect a cross section of stakeholders. We note that Indian tribes, tribal organizations, and urban Indian organizations may be eligible, along with State or local human service agencies.

In paragraph (c), we codify the statutory prohibitions on Navigator conduct in the Exchange. Consistent with 1311(i)(4) of the Affordable Care Act, health insurance issuers are prohibited from serving as Navigators and a Navigator must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. Such consideration includes, without limitation, any monetary or non-monetary commission, kick-back, salary, hourly-wage or payment made directly or indirectly to the entity or individual from the QHP issuer. These provisions would not preclude a Navigator from receiving compensation from health insurance issuers

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in connection with enrolling individuals, small employers or large employers in non-QHPs. We seek comment on this issue and whether there are ways to manage any potential conflict of interest that might arise.

In paragraph (d), we set forth the minimum duties of a Navigator. The Exchange may require that a Navigator meet additional standards and carry out duties so long as such standards are consistent with requirements set forth herein. We clarify that as part of its obligation to establish the Navigator program and oversee the grants, the Exchange must ensure that Navigators are performing their duties as required. Duties include maintaining expertise in eligibility, enrollment, and program specifications and conducting public education activities to raise awareness of the availability of QHPs.

We also propose that the information and services provided by the Navigator be fair, accurate, and impartial and acknowledge other health programs. The Affordable Care Act requires the Secretary to collaborate with the States to develop standards related to this requirement. We are considering standards related to content of information shared, referral strategies, and training requirements to include in grant award conditions. We welcome comment on potential standards to ensure that information made available by Navigators is fair, accurate, and impartial.

The Navigator must also facilitate enrollment in a QHP through the Exchange and provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate State agency or agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage. Further the Navigator must provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. We seek comment regarding any specific standards we might issue through future rulemaking or additional guidance on these proposed requirements that we might further develop.

In paragraph (e), we codify the statutory restriction from section ***41878** 1311(i)(5) of the Affordable Care Act that the Exchange is prohibited from supporting the Navigator program with Federal funds received by the State for the establishment of Exchanges. Thus, the Exchange must use operational funds generated through non-Federal sources (pursuant to section 1311(d)(5)) including general operating funds, to fund the Navigator program. If the State chooses to permit or require Navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities at the administrative Federal financial participation rate described in 42 CFR 433.15 for Medicaid and 42 CFR 457.618 for CHIP.

Finally, we are considering a requirement that the Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. Since consumers will likely require significant assistance to understand options and make informed choices when selecting health coverage, we believe it is important that Exchanges begin the process of establishing the Navigator program by awarding grants and training grantees in time to ensure that Navigators can assist consumers in obtaining coverage throughout the initial open enrollment period. We seek comment on this timeframe under consideration.

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

Section 1312(e) of the Affordable Care Act gives States the option to permit agents or brokers to assist individuals enrolling in QHPs through the Exchange. This includes allowing agents and brokers to enroll qualified individuals, qualified employers, or qualified employees in QHPs and to assist individuals with applications for advance payments of the premium tax credit and cost-sharing reductions. We propose to codify this option under paragraph (a) of § 155.220.

We note that the standards described in this section would not apply to agents and brokers acting as Navigators. Any entity serving as a Navigator, including an agent or broker, may not receive any financial compensation from an issuer for helping an individual or small group select a specific QHP, consistent with § 155.210. We also clarify that the statute permits agents and brokers to assist with applications for advance payments of the premium tax credit and cost-sharing reductions.

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To ensure that individuals and small groups have access to information about agents and brokers should they wish to use one, in paragraph (b) we propose to permit an Exchange to display information about agents and brokers on its Web site or in other publicly available materials.

We recognize that there are web-based entities and other entities with experience in health plan enrollment that are seeking to assist in QHP enrollment in several ways, including: by contracting with an Exchange to carry out outreach and enrollment functions, or by acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange. To the extent that an Exchange contracts with such an entity, the Exchange would need to adhere to the requirements proposed for eligible contracting entities at § 155.110(a).

In the event that the Exchange contracts with such web-based entities, the Exchange would remain responsible for ensuring that the statutory and regulatory requirements pertinent to the relevant contracted functions are met. We understand that such entities may provide an additional avenue for the public to become aware of and access QHPs, but we also note that advance payments of the premium tax credit and cost-sharing reductions may only be accessed through an Exchange. We seek comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange. We also seek comment on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any security- or privacy-related implications of such an arrangement.

e. General Standards for Exchange Notices (§ 155.230)

Notices are developed to ensure that applicants, qualified individuals, and enrollees understand their eligibility and enrollment status, including the reason for receipt of the notice and information about any subsequent action(s) they must take.

In paragraph (a), we propose that any notice sent by an Exchange pursuant to this part must be in writing and include (1) contact information for customer service resources, which might include web-based information, call center, Navigators, or consumer assistance programs; (2) an explanation of rights to appeal, if applicable; and (3) a citation to the specific regulation serving as the cause for notice.

In paragraph (b), we propose all applications, forms, and notices must be provided in plain language. In addition, applications, forms and notices should be written in a manner that meets the needs of diverse populations by providing meaningful access to limited English proficient individuals and ensuring effective communication for people with disabilities. As such, there are a number of ways that the Exchange may provide such access including provision of information about the availability and steps to obtain oral interpretation services, information about the languages in which written materials are available, and the availability of materials in alternate formats for persons with disabilities. We seek comment regarding whether we should codify these examples as requirements in the final rule as well as any other requirements we might consider to provide meaningful access to limited English proficient individuals and to ensure effective communication for people with disabilities.

In paragraph (c), we propose that the Exchange annually re-evaluate the appropriateness and usability of the applications, forms, and notices and in consultation with HHS in instances when changes are made. As the program evolves, we anticipate that the Exchange may be able to improve the tools used to collect information and inform individuals about their eligibility and coverage options.

f. Payment of Premiums (§ 155.240)

The Affordable Care Act includes some references to payment of premiums through an Exchange. While we do not require or limit the methods of premium payment in connection with individual market coverage, we note that an Exchange generally has three options: (1) Take no part in payment of premiums, which means that enrollees must pay premiums directly to a QHP issuer; (2) facilitate the payment of premiums by enrollees by creating an electronic "pass-through" of premiums without

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directly retaining any of the payments; or (3) establish a payment option where the Exchange collects premiums from enrollees and pays an aggregated sum to the QHP issuers.

Section 1312(b) of the Affordable Care Act states that a qualified individual enrolled in a QHP may pay any applicable premium directly to the ***41879** issuer. We propose to codify this Exchange requirement in paragraph (a) of § 155.240. We interpret this to mean that while an Exchange may exercise any of the options listed above, pursuant to section 1312(b), it must always allow an individual to pay directly to the QHP issuer if he or she chooses, regardless of whether an Exchange has elected to establish another option for premium payment. This requirement does not preclude an Exchange from facilitating or aggregating premium payments, if it chooses to do so.

In paragraph (b), we propose that an Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals, subject to the terms and conditions determined by the Exchange. Comments in response to the November 12, 2010 HHS tribal consultation letter and the RFC suggest that premiums may present an obstacle for Indians and suggested that we consider implementation of a process for a tribe to pay premiums on behalf of its members since premiums cannot be waived for Indians.

An Exchange may consider setting-up an upfront group payment mechanism similar to the mechanism currently used by some tribes to enroll members in the Medicare Prescription Drug Program. Under that program, tribes offer a selection of plans from which their members may choose, thus limiting the members' options. We seek comment on whether this approach would work in an Exchange and how such an approach might be tailored to fit the Exchange.

We note that section 402 of the Indian Health Care Improvement Act (IHCIA) permits Indian tribes, tribal organizations, and urban Indian organizations to purchase health benefits coverage for IHS beneficiaries. As a result, the payment of premiums that we propose under this section is more inclusive than other Exchange provisions (special enrollment periods and cost-sharing rules) that pertain to Indians. We invite comment on how to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of “Indian” that apply for other Exchange provisions.

In paragraph (c), we propose that, in the operation of a SHOP, an Exchange must accept payment of an aggregate premium by a qualified employer pursuant to the standards set forth in § 155.705(b)(4).

In paragraph (d), we propose that an Exchange may facilitate through electronic means the collection and payment of premiums. This could include the Exchange acting as a simple pass-through or the Exchange collecting and distributing premiums to QHP issuers.

Additionally, we propose in paragraph (e) that an Exchange choosing to offer enrollees payment through electronic means must conform to any standards and protocols (including privacy and security) required under § 155.260 and § 155.270.

If an Exchange elects to facilitate the collection and payment of premiums, it must establish administrative protocols to ensure the integrity of the financial transactions. We clarify that premium collection by the Exchange does not make the Exchange liable for payment. For example, if an individual is late making a payment or misses a premium payment, the Exchange would not have to make a payment on behalf of the individual. We seek comments concerning Exchange flexibility in establishing the premium payment process and what standards would be appropriate for the Federal government to establish in regulations to ensure fiduciary accountability in the case of an Exchange that collects premiums.

g. Privacy and Security of Information (§ 155.260)

In § 155.260, we address the privacy and security standards Exchanges must establish and follow. Each Exchange will need to obtain applicants' personally identifiable information, such as names, social security numbers, addresses, dates of birth, and tax returns or other financial information during the application process discussed in § 155.405 as part of the eligibility

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determination process required by § 155.200(c) of this subpart. In addition to the proposals in this part, part 156 requires QHP issuers to provide personally identifiable information to the Exchange on a regular basis. We propose to require that the Exchange apply appropriate security and privacy protections when collecting, using, disclosing or disposing of personally identifiable information it collects. In addition, we propose to require contractual terms that impose these standards on contractors or sub-contractors that fulfill Exchange functions or access information from or on behalf of the Exchange.

In paragraph (a), we propose to define the term "personally identifiable information" in this context as information that, alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, can reasonably be used to distinguish or trace an individual's identity. We propose that the term applies to information collected, received or used by the Exchange as part of its operations. Consistent with section 1411(g) of the Affordable Care Act, in paragraph (b), we propose limiting the collection, use, and disclosure of personally identifiable information to what is specifically required or permitted by § 155.260, other applicable law, subpart E of this part, the standards established in accordance with § 155.200(c) of this subpart, and section 1942(b) of the Act. We note that Exchanges may not collect, use, or disclose personally identifiable information if prohibited by another law. We invite comment as to whether and how we should restrict the method of disposal in this section as well.

The Affordable Care Act provides specific privacy and security standards at sections 1411(g), 1413(c)(2), and 1414(a)(1) for some, but not all, types of information flowing to and from the Exchange. Furthermore, we recognize that some or all of the Exchanges may be HIPAA covered entities (health plans, health care clearinghouses and health care providers that conduct certain electronic transactions covered by HIPAA) or business associates of HIPAA covered entities; in such cases, some or all exchange privacy and security responsibilities regarding individuals' health information may be governed by HIPAA. Therefore, in addition to other standards mentioned directly by the Affordable Care Act, HIPAA may dictate the appropriate privacy and security standards for some Exchanges, and may serve as guidance on appropriate privacy and security practices for others. Each Exchange should engage in an analysis of its operations and functions and determine its HIPAA status based on the definitions in § 160.103 in subchapter C of 45 CFR. That analysis will be fact-intensive and will depend heavily on the decisions of each State about how the Exchange will be set up and on the functions and services the Exchange performs, including those functions it performs with respect to QHPs, Medicaid and CHIP. Regardless of whether an Exchange is subject to HIPAA as a covered entity or as a business associate, we propose that the Exchanges implement safeguards to ensure that any and all personally identifiable information received, used, stored, transferred, or prepared for disposal by an Exchange is subject to adequate privacy and security protections. For an Exchange that is subject to HIPAA, the privacy and security standards imposed by HIPAA ***41880** must be followed with respect to information that is "protected health information."

Because each Exchange may have different needs and structures and work in different capacities, it is difficult to create a uniform set of detailed privacy and security standards that we could propose to apply to all Exchanges. That said, we believe that HIPAA provides certain universally appropriate security standards. We therefore propose to require that the security standards of the Exchange (and which the Exchange must contractually impose on contractors and subcontractors) are consistent with HIPAA security rules described at 45 CFR 164.306, 164.308, 164.310, 164.312, and 164.314. These rules provide tested and familiar guidelines that should ensure the proper handling of applicant and enrollee information. Again, and as explained below, we propose to require contractual requirements that apply these security standards to contractors or sub-contractors that receive information from the Exchange or fulfill Exchange functions.

Privacy policies for the Exchanges will need to allow for the appropriate collection, receipt, use, disclosure and disposal of the various kinds of information including health, financial and other types of personally identifiable information. For Exchanges not subject to HIPAA as covered entities or as business associates, while HIPAA may provide an appropriate model for the protection of the privacy of health information, we are concerned about its applicability to all data passing through Exchanges —specifically, tax return information protected by 6103 of the Code. As such, we are not proposing to adopt a selection of HIPAA privacy standards as the minimum protections for data at all Exchanges. Rather, we propose to provide States with the flexibility to create a more appropriate and tailored standard. We are considering requiring each Exchange to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs). We believe that FIPPs will afford an appropriate

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baseline of privacy protections regarding the use, disclosure and disposal of personally identifiable information.[FN6] The FIPPs have been incorporated into both the privacy laws of many States with regard to government-held records [FN7] and numerous international frameworks, including the OECD's privacy guidelines, the EU Data Protection Directive, and the APEC Privacy Framework.[FN8] Specifically, the principles include: (1) Individual Access; (2) Correction; (3) Openness and Transparency; (4) Individual Choice; and (5) Collection, Use, and Disclosure Limitations. We note that we plan to address collection limitations in the eligibility standards established pursuant to § 155.200(c) of this part. We welcome comments on the appropriateness of the FIPPs in this context and the best means to integrate FIPPs into the privacy policies and operating procedures of individual Exchanges while allowing for adaptability to each Exchange's particular structure and operations. We also solicit comment on the aptness of adopting the HIPAA privacy model for Exchanges. Again, we note that an Exchange that is subject to HIPAA must comply with both the privacy and security standards imposed by HIPAA with respect to protected health information.

We also propose in paragraph (b) to adopt several additional requirements for the privacy and security policies and procedures of Exchanges. We propose requiring that the policies and procedures be in writing and available to the Secretary of HHS, and that this writing identify any applicable laws that the Exchange will need to follow. We also propose to require that the Exchange must, in any contract or agreement with a contractor, require that information provided to, created by, received by, and subsequently disposed of by the contractor or any of its subcontractors be protected by the same or higher privacy and security standards than are applicable to the Exchange. We believe that this will ensure that all contractors and subcontractors that fulfill Exchange functions are subject to adequate privacy and security standards. Last, we are considering imposing a requirement that each Exchange implement some form of authentication procedure for ensuring that all entities interacting with Exchanges are who they claim. We are currently working with other Federal agencies to determine the best methods of authentication to ensure the identities of parties accessing information in or furnishing information to Exchanges.

In paragraph (c), we propose an additional requirement related to data matching arrangements that are made between the Exchange and agencies that administer Medicaid and CHIP in States for the exchange of eligibility information. The Exchange must participate in the data matching program required by section 1413(c)(2) of the Affordable Care Act consistent with the privacy and security standards described in section 1942(b) of the Act and in other applicable laws. We expect Exchanges and the Medicaid and CHIP agencies to execute data use agreements that prevent the unauthorized use or disclosure of personally identifiable information and prohibit the Exchange or State agency from seeking to obtain or provide information that it will not, or does not reasonably expect to, use. We propose to adopt these same requirements as data privacy and security requirements for Exchanges.

In paragraph (d), we also propose to require Exchanges to adopt privacy and security policies and procedures that meet the standards in section 6103 of the Code that protect the confidentiality of tax returns and tax return information. Section 1414(a)(1) of the Affordable Care Act added section 6103(l)(2) to the Code to authorize the disclosure of certain tax return information to carry out eligibility determinations for advance payments of the premium tax credit and certain other government-sponsored health programs, subject to the confidentiality and safeguarding requirements of section 6103 of the Code. We are currently working with the Secretary of the Treasury and States to ensure that Treasury-required safeguards for tax information will be met across the information technology architecture.

Finally, in paragraph (e), we propose to codify the requirement in section 1411(h)(2) of the Affordable Care Act that provides that any person that knowingly and willfully uses or discloses personally identifiable information in violation of section 1411(g) of the Affordable Care Act will be subject to a civil money penalty of not more than $25,000 per disclosure and be subject to any other applicable penalties that may be prescribed by law. We propose to interpret section 1411(h) ***41881** to apply the civil money penalty of $25,000 to each violation of section 1411(g).

h. Use of Standards and Protocols for Electronic Transactions (§ 155.270)

In this section, we propose to apply certain standards and protocols to the operation of Exchanges. We consider these requirements to be important considerations in the development and operation of Exchange information technology systems, and as such, propose them here as requirements for Exchanges.

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In paragraph (a), we propose to apply the HIPAA administrative simplification requirements. To the extent that the Exchange performs electronic transactions with a covered entity, including State Medicaid programs and QHP issuers, the Exchange must use standards and operating rules adopted by the Secretary pursuant to 45 CFR parts 160 and 162.

In paragraph (b), we propose to codify the HIT enrollment standards and protocols that were developed pursuant to section 3021 of the PHS Act, which was added by section 1561 of the Affordable Care Act, and that were adopted by the Secretary. [FN9] Such standards and protocols will be incorporated within Exchange information technology systems as required under the Exchange cooperative agreements awarded pursuant to section 1311(a) of the Affordable Care Act.

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

In subpart E, we outline the initial, annual, and special enrollment periods as well as the enrollment process and the termination of coverage process. The standards established by the Exchange in accordance with this subpart will facilitate the enrollment of qualified individuals into QHPs and the transfer of enrollees from one QHP to another. For the purposes of this subpart, any reference to enrollee means a qualified individual who enrolls in a QHP through the Exchange.

In response to the RFC, many commenters suggested that States should design systems for the Exchange by either building off of existing systems that are in place for Medicaid and CHIP or, alternatively, developing new systems that would serve the Exchange as well as advance payments of the premium tax credit, cost-sharing reductions, Medicaid and CHIP. Comments also focused on the importance of a streamlined enrollment process. In addition, many commenters recommended that the initial open enrollment period be longer and more flexible than subsequent annual open enrollment periods while others suggested enrollment periods be structured so as not to encourage migration in and out of the Exchange.

Commenters also suggested that we follow HIPAA and Medicare guidelines when establishing qualifying events that trigger special enrollment periods. Some suggested that there should not be a single open enrollment period for all eligible individuals but instead, a staggered open enrollment so as not to place excessive administrative burdens on Exchanges, States, and QHP issuers. We also received comments supporting a lag between enrollment periods and effective dates to provide time for enrollment, billing, and other information to be processed, as well as to allow time for QHP issuers to produce and mail consumer identification cards and any necessary start-up communications.

a. Enrollment of Qualified Individuals into QHPs (§ 155.400).

Section 155.400 addresses that the Exchange must: Accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP, notify the issuer of the applicant's selected QHP, and transmit information necessary to enable the QHP issuer to enroll the applicant.

In paragraph (b), we propose that the Exchange must send QHP issuers enrollment information on a timely basis; we anticipate issuing further guidance on this timing. In addition, the Exchange will be required to develop a process by which QHP issuers can verify and acknowledge the receipt of enrollment information. While it would be ideal for information sharing to occur on a real-time basis, we are not certain that all parties will have the necessary functionality for real-time information sharing by 2014. As such, we encourage real-time processing and acknowledgement of enrollment information; we seek comment as to whether we should consider codifying a requirement for a specific frequency for enrollment transactions such as in real time or daily in our final rule.

To ensure that the Exchange and QHP issuers have identical plan enrollment records, we propose under paragraphs (c) and (d) that the Exchange maintain records of enrollment, submit enrollment information to HHS, and reconcile the enrollment files with the QHP issuers no less than on a monthly basis.

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b. Single Streamlined Application (§ 155.405)

Section 1413(b)(1)(A) of the Affordable Care Act requires that the Secretary develop and provide to each State a single, streamlined form that may be used to apply for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the BHP, if a BHP is operating in the Exchange service area, and that must be structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs. Section 1311(c)(1)(F) of the Affordable Care Act states that an issuer shall use a uniform enrollment form for qualified individuals and employers to enroll in QHPs through the Exchange, and that the enrollment form must take into account criteria developed by the NAIC. In § 155.405 we describe a single streamlined application and standards for any alternative application developed by the Exchange that incorporate both eligibility and enrollment, in order to facilitate an efficient process.

In paragraph (a), we propose that the Exchange use a single streamlined application to collect information necessary for QHP enrollment, advance payments of the premium tax credit, cost-sharing reductions, and Medicaid, CHIP, and the BHP, if a BHP is operating in the Exchange service area. We propose use of a single streamlined application to limit the amount of information and number of times an individual must make submissions to receive an eligibility determination and complete the enrollment process. HHS plans to create both a paper-based and web-based dynamic application. We anticipate that the electronic application will enable many applicants to complete the eligibility and QHP selection process in a single online session.

In paragraph (b), we propose that if the Exchange seeks to use an alternative application it must be approved by HHS. The alternative application should collect the information necessary to support an eligibility determination and to process enrollment through the programs described in paragraph (a). Our intent is to simplify the application process and reduce, if not eliminate, the collection of extraneous information. We seek comment regarding whether we should codify a requirement that applicants may not be required to answer questions that are not pertinent to the eligibility and enrollment process.

***41882** In paragraph (c), we propose that the Exchange must accept applications from multiple sources, including the applicant; an authorized representative (we propose this to be defined by State law); or someone acting responsibly for the applicant. In addition, section 1413(b)(1)(A)(ii) of the Affordable Care Act sets forth requirements regarding mechanisms by which an individual may file an application. In paragraph (c)(2), we propose that an individual must be able to file an application online, by telephone, by mail, or in person. We solicit comments on the requirement that an individual must be able to file an application in person.

We reserve paragraphs (d) and (e) for future rulemaking.

In regard to requests for personally identifiable information that the Exchange will collect during the application process, we are contemplating standards for the final rule for information collection based on the Fair Information Practices Principles (FIPPs) framework. For a more detailed discussion on FIPPs, see the preamble to 155.260. According to FIPPs, applicants should be given notice of an entity's information practices before any personal information is collected from them so that they are able to make an informed decision about whether and to what extent to disclose their personal information.

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

Section 1311(c)(6) of the Affordable Care Act directs the Secretary to establish an initial open enrollment period and an annual open enrollment period. In § 155.410, we propose standards for Exchanges related to the initial and annual open enrollment periods. Our proposed timeframes are informed by both the experience implementing Medicare Advantage and the Medicare Prescription Drug Benefit Program, as well as information from FEHBP.

In paragraph (a)(1), we propose that the Exchange adhere to the initial and annual open enrollment periods set forth in this section and indicate that qualified individuals and enrollees may begin or change coverage in a QHP at such times. In paragraph (a)(2), we propose that the Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during

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the initial open enrollment period specified in paragraph (b), the annual open enrollment period specified in paragraph (e), or a special enrollment period described in § 155.420 for which the qualified individual or enrollee has been determined eligible.

In paragraph (b), we propose an initial open enrollment period that allows a qualified individual to enroll in a QHP from October 1, 2013 through February 28, 2014. We want to ensure that qualified individuals have sufficient time to learn about Exchange coverage, compare options, and ultimately enroll. In addition, we seek to provide the maximum flexibility for the information management system of the Exchange to be designed, built, tested, and ready for January 1, 2014 coverage in addition to the time needed to certify QHPs.

We believe that consumers should have an initial open enrollment period that extends beyond January 1, 2014 to allow for outreach and education beyond the first potential date of coverage. We recognize that extending the initial open enrollment period into 2014 will require flexibility on the part of QHPs because some enrollees will have fewer than 12 months of coverage in the first year. As such, we seek to balance the needs of consumers with the interest of QHPs to have individuals enrolled for as close to a full coverage year as possible. We seek comment on the duration of the initial open enrollment period.

In paragraph (c), we propose rules regarding the effective date of coverage for the initial open enrollment period based on the date on which the Exchange receives a QHP selection from an individual, in order to allow appropriate time for QHP issuers to process QHP selections. In paragraph (c)(1), we propose that for a QHP selection received by the Exchange on or before December 22, 2013, the Exchange must ensure an effective date of January 1, 2014. In paragraph (c)(2), we propose that for a QHP selection received by the Exchange between the first and twenty-second day of any subsequent month during the initial open enrollment period, the Exchange must ensure an effective date on the first day of the following month. In paragraph (c)(3), we propose that for a QHP selection received by the Exchange between the twenty-third and last day of the month for any month between December, 2013 and February 28, 2014, the Exchange must ensure an effective date of either the first day of the following month or the first day of the second following month.

In general, we propose to apply this approach to effective dates for the annual open enrollment period and for special enrollment periods as well. This proposal is designed to minimize the time between enrollment and coverage effective dates, while leaving sufficient time to ensure that QHP selections can be fully processed by QHP issuers. In addition, the proposal provides the Exchange with flexibility to work with QHP issuers to implement selections received between the twenty-third and last day of the month on either the first of the following month or the first of the second following month, which allows the Exchange and QHP issuers to choose to process enrollments more quickly to the extent possible.

We note that the coverage effective date may not be set or enrollment information sent from the Exchange to the QHP until the individual is determined eligible to purchase coverage through the Exchange. Section 36B(c)(2)(A)(i) of the Affordable Care Act specifies that advance payments of the premium tax credit may only be provided for an enrollee who is enrolled in a QHP on the first of the month. As such, in order to coordinate coverage in a QHP with the advance payments of the premium tax credit that support the purchase such coverage, we propose to establish that coverage in a QHP may only begin on the first of the month. However, we seek comment as to whether we should consider allowing at least twice-monthly effective dates of coverage or complete flexibility to allow for coverage to begin any day for individuals who forego receipt of such credit for their first partial month or who are not eligible to receive advance payments of the premium tax credit.

In paragraph (d), we propose that the Exchange must send written notification to enrollees about the annual open enrollment period. We are considering codifying the requirement that such notice must be sent no later than 30 days before the start of the annual open enrollment period in our final rule. Further, we believe the notice may require inclusion of specific information and we seek comment regarding whether we should codify such requirements for information pertaining to: (1) The date annual open enrollment begins and ends, (2) where individuals may obtain information about available QHPs, including the Web site, call center, and through Navigator assistance, and (3) other relevant information.

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In paragraph (e), we propose an annual open enrollment period from October 15 through December 7 of each year, starting in October 2014 for coverage beginning January 1, 2015. As an alternative annual open enrollment period, we considered November 1 through December 15 of each year to provide a 45-day window close to the end of the year that would be easy to remember. We welcome comments ***41883** regarding our proposed and alternative approach for the annual open enrollment period.

In paragraph (f), we propose that the Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

We seek comment regarding whether we should require Exchanges to automatically enroll individuals who received advance payments of the premium tax credit and are then disenrolled from a QHP because the QHP is no longer offered if such individual does not make a new QHP selection. We also seek comment regarding whether we should codify requirements in the final rule regarding automatic enrollment of individuals into new QHPs when there are mergers between issuers or when one QHP offered through a specific issuer is no longer offered but there are other options available to the individual through the same issuer. Further, if we were to provide for automatic enrollment, we seek comment as to how far such automatic enrollment should extend.

We reserve paragraph (g) for future rulemaking.

d. Special Enrollment Periods (§ 155.420)

In accordance with section 1311(c)(6)(C) of the Affordable Care Act, the Secretary must establish special enrollment periods. The statute requires use of the special enrollment periods in section 9801 of the Code and, where relevant, special enrollment periods similar to those in the Medicare Prescription Drug Program. In § 155.420, we propose standards to address this statutory requirement. In paragraph (a) of this section, we specify that the Exchange must allow a qualified individual or enrollee to enroll in a QHP or change from one QHP to another outside of the annual open enrollment period, if such individual qualifies for a special enrollment period.

In paragraph (b), we propose that, in general, the effective dates for QHP selections based on special enrollment periods follow the proposed effective dates for QHP selections during the initial or annual open enrollment periods described in § 155.410(c) of this subpart. First, in paragraph (b)(1), we propose that once determined eligible for a special enrollment period, the Exchange must ensure that a qualified individual or enrollee's effective date is on the first day of the following month for all QHP selections made by the 22nd of the previous month, and on either the first day of the following month or the first day of the second following month for all QHP selections made between the 23rd and last day of a given month. We provide an exception in the case of birth, adoption or placement for adoption, for which coverage must be effective on the date of birth, adoption, or placement for adoption.

In paragraph (c), we propose a standard length of 60 days for each special enrollment period from the date of the triggering event unless the applicable regulation provides otherwise. We believe that having a standardized length for special enrollment periods will simplify administrative processes and accommodate the needs of individuals undergoing significant life changes, although we note that we raise alternatives for the special enrollment periods proposed in paragraphs (d)(6) and (d)(7) of this section in the preamble associated with those paragraphs. We request comment on the alternatives raised for the special enrollment periods described in paragraphs (d)(6) and (d)(7) and whether others, such as (d)(4), should have an alternate start date.

In paragraph (d), we propose specific special enrollment periods. We note that all requests for special enrollment periods must be evaluated by the Exchange as part of the eligibility determination process established pursuant to § 155.200(c) of this part. For purposes of special enrollment periods provided herein, we interpret dependent to mean any individual who is or may become eligible for coverage under the terms of a QHP because of a relationship to an enrollee (including the enrollee's spouse). In paragraph (d)(1), we propose that the Exchange permit a qualified individual and any dependents to enroll in a QHP due to loss of other minimum essential coverage. We interpret loss of coverage to include any event that triggers a loss of eligibility

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for other minimum essential coverage. We further propose that a dependent of a current enrollee in a QHP and the enrollee are each eligible for a special enrollment period if the dependent loses other minimum essential coverage. Examples of loss of coverage include decertification of a QHP that occurs outside of the annual open enrollment period. In such cases, an enrollee would be allowed to select and enroll in a new QHP upon notification of plan decertification. If the enrollee does not select a new QHP before the effective date of plan termination, he or she would be provided 60 days from the date of plan termination, which is the triggering event, to select a new QHP.

Other examples of events that would qualify as loss of coverage include but are not limited to the following: legal separation or divorce ending eligibility of a spouse or step-child enrolled in other minimum essential coverage as a dependent; end of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan); death of an individual enrolled in minimum essential coverage ending eligibility for covered dependents; termination of employment or reduction in the number of hours of employment necessary to maintain coverage; or relocation outside of the service area of the QHP. Examples of relocation include relocation to the United States (US) in the case of a US citizen, national, or lawfully present individual who was not previously eligible for Exchange participation while residing outside of the US; release from incarceration; moving from the jurisdiction of one Exchange to another; or relocating outside of the individual's QHP's service area.

In accordance with section 9801(f) of the Code, we propose that loss of coverage also include: termination of employer contributions for a qualified individual or dependent who has coverage that is not COBRA continuation coverage by any current or former employee, exhaustion of COBRA continuation coverage, reaching a lifetime limit on all benefits in a grandfathered plan, and termination of Medicaid or CHIP. We vary from the Code for this first special enrollment period by specifying only loss of minimum essential coverage rather than loss of any coverage because of the requirement in section 5000A of the Affordable Care Act that qualified individuals and their dependents must maintain essential coverage. If otherwise qualified individuals who maintained less than minimum essential coverage were granted a special enrollment period based on termination of such coverage, such individuals might wait until experiencing a significant health care need to enroll in a QHP through the Exchange by using a special enrollment period. Such allowance could create a problem of adverse selection; we solicit comment on this provision.

Similar to the provisions outlined in section 9801 of the Code, we propose in paragraph (d)(2) a special enrollment period for a qualified individual who gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption. We welcome comment as to whether States might consider expanding the special ***41884** enrollment period to include gaining dependents through other life events.

Similar to when an individual is newly eligible for Medicare and has a period of time to begin coverage in Medicare and to select a Medicare Prescription Drug Plan, we propose in paragraph (d)(3) that upon gaining status as a citizen, national, or lawfully present individual in the US, a qualified individual qualifies for a special enrollment period because the individual is newly eligible to purchase coverage. We view this initial enrollment period as the functional equivalent of a special enrollment period since it occurs outside of the annual open enrollment period and provides an opportunity for eligible individuals to gain access to coverage through a QHP.

The special enrollment periods that are proposed in paragraphs (d)(4) through (d)(7) are also patterned on the Medicare Prescription Drug Program. In paragraph (d)(4), we propose that qualified individuals who experience an error in enrollment receive a special enrollment period. This applies in any case where the Exchange finds that a qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange.

In paragraph (d)(5), we propose a special enrollment period for an individual enrolled in a QHP who adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to such individual and their dependents. One example of such a violation is material misrepresentation by the QHP issuer (or its agent, representative, or plan provider) when marketing the plan to the individual.

In paragraph (d)(6), we propose a special enrollment period for individuals who are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions. This proposal allows new enrollment or movement from one QHP to another. This special enrollment period would be granted for individuals who receive an eligibility determination for the first time for coverage through the Exchange or for individuals who experience a mid-year change in circumstance that changes their eligibility, including a change that ends their eligibility for advance payments of the premium tax credit. We propose this special enrollment period because we anticipate that individuals will decide whether to enroll in a QHP and choose a specific plan based in part on financial status and how financial status impacts eligibility. Additionally, qualified individuals and enrollees may wish to enroll in or change plans to take advantage of different benefit designs and plan cost structures as their eligibility changes. We seek comment as to whether the start of the 60 day special enrollment period, as discussed in 155.420(c), should be based on the date on which an individual experiences a change in eligibility or based upon the date of the eligibility determination.

In addition, sections 36B(c)(2)(C)(i) and (ii) of the Code specify that an individual may be determined eligible for advance payments of the premium tax credit or cost-sharing reductions in situations in which minimum essential coverage offered through an eligible employer-sponsored plan, as defined in section 5000A(f)(2) of the Code, is determined to no longer meet the minimum value requirement or be affordable for the upcoming plan year. We note that even if there is a special enrollment period, advance payments of the premium tax credit only apply if the individual is not enrolled in employer coverage. The proposal in paragraph (d)(6) would allow an individual in this situation to be determined eligible for this special enrollment period during the open enrollment period for the employer-sponsored health coverage or when the employee learns of the change in his or her eligible employer-sponsored plan, even if he or she is still covered by the eligible employer-sponsored plan at the time of eligibility determination. This is designed to ensure that such individuals will not be required to be uninsured prior to receiving a determination of eligibility for a special enrollment period. We request comment on the timing of the special enrollment period in this situation and whether the 60 day period should begin when the employee learns of the change(s) in the employer-sponsored coverage or when the employee terminates coverage by the employer-sponsored plan.

In paragraph (d)(7), we propose that if new QHPs offered through the Exchange are available to a qualified individual or enrollee as a result of a permanent move, such enrollee receives a special enrollment period. We propose that the special enrollment period begin on either the date of the permanent move or on the date the individual provides notification of such move and request comment on these alternatives. Individuals who move and have new QHP available to them as a result of the move, but continue to reside in the current plan service area, may use this special enrollment period to enroll in any QHP for which they are newly eligible in their new place of residence. It is the individual's responsibility to notify the Exchange or QHP that he/she is permanently moving.

We considered several options with respect to the start date for the special enrollment period proposed in paragraph (d)(7) regarding an individual or enrollee who gains access to new QHPs as a result of a permanent move. One option that we considered for the start date of this special enrollment period was either the date of the individual's permanent move, or the date on which the individual provides notice of the move, if an individual provides notice of his or her move within a reasonable timeframe. Under this option, we could establish the length of this special enrollment period either as 60 days from the start date or as 60 days from the date of the move or his or her notice of the move, whichever is later. We solicit comments on these options.

In paragraph (d)(8), we propose to codify the statutory special enrollment period that Indians receive a monthly special enrollment period as specified in section 1311(c)(6)(D) of the Affordable Care Act. We interpret the monthly special enrollment period to allow for an Indian to join or change plans one time per month. For purposes of this special enrollment period, section 1311(c)(6)(D) defines an Indian as specified in section 4 of the Indian Health Care Improvement Act (IHCIA). Section 4 of the IHCIA defines "Indian" as a member of a Federally-recognized tribe. We solicit comment on the potential implications on the process for verifying Indian status.

In paragraph (d)(9) we propose a special enrollment period for exceptional circumstances, as determined by the Exchange or HHS. This special enrollment period could be used for a variety of situations, including natural disasters such as hurricanes or floods. Exceptional circumstances include circumstances that would impede an individual's ability to enroll on a timely basis, through no fault of his or her own.

In paragraph (e), similar to section 9801 of the Code, we propose that loss of coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission as specified in 45 CFR § 147.128.

***41885** In paragraph (f) we propose that upon qualifying for a special enrollment period, the Exchange may only allow an existing enrollee of a QHP to change plans within levels of coverage as defined by 1302(d) of the Affordable Care Act. As an example, if an enrollee is in a silver level plan and gives birth to a child outside of the annual open enrollment period, the enrollee may add the child to her existing plan or change from one silver level plan to another; however, she may not move to a gold level plan. We propose this limitation to maintain a single level of coverage throughout the year to avoid adverse selection. We propose a single exception for new eligibility for advance payments of the premium tax credit or change in eligibility for cost-sharing reductions. We recognize that limiting enrollees such that they must stay within a specific coverage level during a special enrollment period could pose a challenge for an enrollee in a catastrophic plan that becomes pregnant. We request comment as to whether we should provide an exception for such circumstances.

We clarify that the Exchange will provide information, accept applications, perform eligibility determinations, and accept enrollments and send enrollment information to QHPs for individuals year round to accommodate special enrollment periods, and coverage through Medicaid and CHIP. Although most individuals will likely approach the Exchange during initial and annual open enrollment periods, individuals may approach the Exchange at all times. Further, the special enrollment periods that are required and set forth in § 155.420 are not the only applicable enrollment requirements. To the extent other law applies to require a special enrollment right from issuers, such law continues to apply. The Exchange special enrollment periods are a minimum requirement for the Exchange to permit enrollment outside of the initial and annual open enrollment periods.

e. Termination of Coverage (§ 155.430)

Pursuant to section 1321(a)(1) of the Affordable Care Act, in paragraph (a), we propose that the Exchange must determine the form and manner in which coverage in a QHP may be terminated.

In paragraph (b), we propose a set of events that would cause an enrollee's coverage in a QHP to be terminated. In paragraph (b)(1), we propose that the Exchange must permit an enrollee to terminate his or her coverage in a QHP with appropriate notice to the Exchange or the QHP. We anticipate that these voluntary termination requests will generally occur in situations in which an enrollee in a QHP has obtained other minimum essential coverage. In paragraph (b)(2), we propose that the Exchange may terminate an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage in the following circumstances: (1) The enrollee is no longer eligible for coverage in a QHP through the Exchange; (2) the enrollee becomes covered in other minimum essential coverage; (3) payments of premiums for coverage of the enrollee cease, provided that the grace period for enrollees receiving advance payments of the premium tax credit, as specified in § 156.270(d) of this chapter, has elapsed; (4) the enrollee's coverage is rescinded in accordance with § 147.128 of this chapter; (5) the QHP terminates or is decertified by the Exchange as described in § 155.1080; or (6) the enrollee changes from one QHP to another during the annual open enrollment period, or a special enrollment period in accordance with § 155.410 or § 155.420.

To ensure the Exchange oversees the actions related to termination of coverage undertaken by QHPs, in paragraph (c), we propose that the Exchange must establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS on a monthly basis, establish terms for reasonable accommodations, and retain records in order to facilitate audit functions.

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In paragraph (d), we propose standards for the effective dates for termination of coverage. In paragraph (d)(1), we propose that in the case of a termination requested by an enrollee, the last day of coverage for an enrollee is the termination date specified by the enrollee, if the Exchange and QHP have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage. We also propose that if the Exchange or the QHP do not have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage, the last day of coverage is the first day after such reasonable amount of time has passed.

In paragraph (d)(2), we propose that in the case of a termination by the Exchange or a QHP as a result of an enrollee obtaining new minimum essential coverage, the last day of coverage is the day before the effective date of the new coverage. We solicit comments regarding how Exchanges can work with QHP issuers to implement this proposal, which is intended to ensure that an enrollee is not covered under two forms of minimum essential coverage simultaneously. Among the concerns about double coverage is that it makes an individual ineligible for the premium tax credit in accordance with section 36B(c)(2)(B) of the Code. We also note that as the Exchange establishes procedures for termination of coverage notification to enrollees, it should consider how it will also notify the issuer about effective dates of coverage termination.

In paragraph (d)(3), we propose that in the case of a termination by the Exchange or a QHP as a result of an enrollee changing QHPs, the last day of coverage in the enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP. Lastly, in paragraph (d)(4), we propose that for a termination that is not described in paragraphs (d)(1)-(3), the last day of coverage is the fourteenth day of the month if the notice of termination is sent by the Exchange or termination is initiated by the QHP no later than the fourteenth day of the previous month or, the last day of the month if the notice of termination is sent by the Exchange or termination is initiated by the QHP no later than the last day of the previous month. As an example, if the Exchange notifies an enrollee of his or her termination on September 12, his or her coverage will terminate on October 14.

f. Reserved (§ 155.440)

5. Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)

Section 1311(b)(1)(B) of the Affordable Care Act directs each State that chooses to operate an Exchange to establish insurance options for small businesses through a Small Business Health Options Program (SHOP). This program will enable small employers to offer affordable health plans to their employees. Subpart H of this part contains the proposed standards for Exchanges with respect to a SHOP. States that choose to operate an Exchange may also merge SHOP with the individual market Exchange.

We note that participation in a SHOP is strictly voluntary for small employers. Like the Exchange generally, the SHOP will improve access to information about plan benefits, quality, and premiums. It gives small businesses the types of choices and purchasing power that large businesses typically enjoy. Purchasing employer-sponsored coverage through the SHOP will also qualify certain small employers to receive a small business tax credit for ***41886** up to 50 percent of the employer's premium contributions toward employee coverage pursuant to section 45R of the Code. The requirements for the small business tax credit applicable for calendar years 2014 and beyond are not within the scope of this rule, but will be addressed in separate rulemaking by the Secretary of the Treasury.

a. Standards for the Establishment of a SHOP (§ 155.700)

In § 155.700, we propose that an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart, and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

b. Functions of a SHOP (§ 155.705)

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In § 155.705, we propose the required functions of a SHOP. In paragraph (a), we propose that the SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, H, and K of this part. As some of the requirements contained in those subparts are specific to the individual market, we propose the SHOP exceptions from those requirements in (a)(1) through (a)(5).

In paragraph (a)(1), we propose that the SHOP does not need to meet the requirements related to individual eligibility determinations described in § 155.200(c) and the appeals of such determinations described in § 155.200(d). In paragraph (a)(2) we clarify that the SHOP does not need to comply with the requirements related to enrollment of qualified individuals into QHPs, as described in subpart E. The enrollment requirements specific to SHOP are outlined in § 155.720 of this subpart.

In paragraph (a)(3), we propose that the SHOP does not need to include the calculator described in § 155.205(c) given that individuals eligible for affordable employer sponsored coverage are not eligible for advance payments of the premium tax credit. Because of the employee choice provisions of the Affordable Care Act, we encourage a SHOP to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the full premium amount. Because conveying net premium to the employee for coverage is current market practice and is important to informed employee choice, we encourage SHOPs to use this practice.

In paragraph (a)(4), we clarify that the SHOP does not need to certify exemptions from the individual coverage requirement as described in § 155.200(b), as the Exchange will fulfill this requirement. In paragraph (a)(5), we clarify that requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240 do not apply to the SHOP.

In paragraph (b), we propose unique functions of the SHOP. In paragraph (b)(1), we clarify that a SHOP must adhere to unique enrollment and eligibility requirements that are further described in §§ 155.710, 155.715, 155.720, 155.725, and 155.730. In addition, the SHOP must at a minimum facilitate the special enrollment periods described in § 156.285(b)(2). We note that in the context of a SHOP, a special enrollment period allows a qualified employee to join or change plans in certain circumstances during a period other than the employer's annual open enrollment period. In paragraph § 156.285(b)(2), we propose that all of the special enrollment periods that apply in the Exchange in connection with individual market coverage apply in the SHOP, with two exceptions:

(1) Because non-lawfully present individuals employed by a small business are not eligible for the SHOP, there would be no special enrollment period associated with becoming a new citizen, national, or lawfully present individual for the SHOP;

(2) There would be no special enrollment period in the SHOP to reflect a change in eligibility or new eligibility for advance payments of the premium tax credit or cost-sharing reductions since neither is available to qualified employees in the SHOP.

We recognize that other laws (including, but not limited to HIPAA (Pub.L. 104-191)) may require additional special enrollment periods and this proposed rule in no way eliminates those requirements. We also clarify that the two exceptions described above also apply to qualified employees in a SHOP with merged risk pools. We invite comment on special enrollment periods for the SHOP and how they might differ from those that would apply to the Exchange for the individual market.

In paragraph (b)(2) of this section, we propose to codify section 1312(a)(2) of the Affordable Care Act, which specifically provides that a qualified employer may choose a level of coverage under 1302(b), under which a qualified employee may choose an available plan at that level of coverage. We interpret the statute as requiring a SHOP to offer this specific consumer choice option to qualified employers and qualified employees.

In paragraph (b)(3), we provide flexibility for Exchanges and their SHOPs to choose additional ways for qualified employers to offer one or more plans to their employees. For example, an Exchange may (1) allow employees to choose any QHP offered in the SHOP at any level; (2) allow employers to select specific levels from which an employee may choose a QHP; (3)

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allow employers to select specific QHPs from different levels of coverage from which an employee may choose a QHP; or (4) allow employers to select a single QHP to offer employees. With respect to the fourth potential option, we believe that section 1312(f)(2)(B) of the Affordable Care Act may allow a qualified employer to select only a single QHP to make available to qualified employees. We welcome comments on the statutory interpretation of section 1312(a)(2)(A), which speaks to employer specification of a level of coverage and section 1312(f)(2)(B), which may permit a single QHP selection by an employer.

We note that allowing a qualified employee to purchase any plan across levels raises some potential for risk selection. A portion of any risk selection among plans and issuers due to employee choice of QHPs as defined in § 155.705(b)(2) may be mitigated through the risk adjustment program established pursuant to section 1343 of the Affordable Care Act. We also address this by only proposing a requirement for employee choice within a level of cost sharing, while providing SHOPs the option to offer broader employee choices among plans. We invite comment on this proposed flexibility.

A common practice in the small group market is the issuers' use of minimum participation rules, as defined in 42 U.S.C. 300gg-11(e)(2). The purpose of minimum participation rules is to protect the issuer against adverse selection related to healthy employees either remaining uninsured or obtaining coverage in the individual market. The first concern is mitigated by the coverage expansion provisions in the Affordable Care Act, and the second is mitigated by the market reform provisions of the Act. Nonetheless, there may still be advantages to establishing a minimum participation rule for participation in the SHOP. Methods for calculating the participation rate may vary across States. For example, in some States, carriers may exclude certain non-participating qualified employees from the calculation if they have certain types of coverage, such as Medicare, ***41887** Medicaid, or employer-sponsored health insurance obtained through a spouse. We invite comment about whether QHPs offered in the SHOP should be required to waive application of minimum participation rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation.

In paragraph (b)(4), we propose standards related to premium aggregation by the SHOP. To simplify the administration of health benefits among small employers, we propose that the SHOP allow qualified employers to receive a single monthly bill for all QHPs in which their employees are enrolled and to pay a single monthly amount to the SHOP. If this option were not available, a qualified employer may have to pay multiple bills from different QHP issuers each month. Therefore, we propose in paragraph (b)(4)(i) to require that the SHOP provide a monthly bill to a qualified employer that identifies the total premiums owed. We anticipate that most SHOPs will also include the employer and employee contribution for the QHP selected by each employee as a service to employers. Employers will have selected their contribution at the time of initial enrollment or renewal, and employees will have based their plan choices in part on the net cost of the QHPs they select. In paragraph (b)(4)(ii), we propose that the SHOP collect from employers offering multiple coverage options a single cumulative premium payment for all of a qualified employer's qualified employees enrolled through the employer in the SHOP. We note that the SHOP, itself, may aggregate these premium payments from employers and distribute these payments to the appropriate QHP issuers or contract with a third party to perform this function.

In paragraph (b)(5), we clarify that with respect to QHP certification, QHPs must meet the requirements described in § 156.285. As described further in subpart C of part 156, the minimum Federal certification criteria for health plans participating in the SHOP are nearly identical to the certification criteria for the Exchange. However, QHP certification criteria for the SHOP do not include adherence to requirements related to the administration of advance payments of the premium tax credit and cost-sharing reductions, which are specific to the Exchange for the individual market. Additionally, there are a few certification criteria that are specific to the SHOP, including:

• Health plan rate setting and premium payment standards for the SHOP,

• Enrollment period requirements for the SHOP, and

• Enrollment process requirements for the SHOP.

In paragraph (b)(6), we propose standards for rates and rate changes. In paragraph (b)(6)(i), we propose that the SHOP require all QHPs to make any change to rates at a uniform time that is either quarterly, monthly, or annually. As described in § 155.725, we propose to permit rolling enrollment in a SHOP, which allows qualified employers to purchase coverage in QHPs at any point during the year. Because employers will purchase coverage through the SHOP at different times during the year, employers will be subject to different rates based on the month or quarter during which they purchase coverage. Although QHPs may change rates during the year, those rates only apply to new coverage and to annual renewals. Additionally, such rate changes are still subject to rate increase consideration as described in § 155.1020. Paragraph (b)(6)(ii) proposes to require that the rate for a given employer not change during the employer's plan year. By providing uniform intervals for rate setting, SHOPs will experience less administrative burden and qualified employers and qualified employees will have more useful rate comparison information. We note that if an employee is hired during the plan year or changes coverage during the plan year during a special enrollment period, the rates set at the beginning of the plan year must be the rates quoted to the employee. We invite comment on whether we should allow a more permissive or restrictive timeframe than monthly, quarterly, or annually. We also invite comment on what rates should be used to determine premiums during the plan year.

In paragraph (b)(7), we propose that if a State merges the individual and small group risk pools, the Exchange may only offer employers and employees QHPs that meet the SHOP requirements for QHPs, such as the deductible maximums described in section 1302(c) of the Affordable Care Act and the employer choice requirements described in § 155.705(b)(2) of the Affordable Care Act. QHPs sold in a merged market must still meet the general standards defined in § 156.20. Similarly, employee choices among QHPs within and across levels may be limited or expanded by policies of the Exchange or by choices made by the employer.

In paragraph (b)(8), we propose that if a State does not merge the individual and small group risk pools described in (b)(7), a SHOP may only make small group QHPs available to qualified employees. We note that if risk pools are not merged, allowing those in the SHOP to purchase health plans outside of the small group risk pool could result in adverse selection.

In paragraph (b)(9), we propose to codify section 1312(f)(2)(B) of the Affordable Care Act, which permits States to allow insurers in the large group market to offer health plans inside of the SHOP beginning in 2017. In States that elect this option, large employers could make an employee eligible for the SHOP if it provides all full-time employees with the opportunity to enter the SHOP. Section 2794(b)(2)(B) of the PHS Act requires the State to consider excess premium growth outside of the SHOP when considering whether to allow large employers to purchase coverage inside of the SHOP.

c. Eligibility Standards for SHOP (§ 155.710)

In § 155.710, we propose the eligibility standards for qualified employers and qualified employees seeking to purchase coverage through a SHOP. In paragraph (a), we propose to codify section 1311(d)(2) of the Affordable Care Act, which specifies that the SHOP make QHPs available to qualified employers. Paragraph (b) describes the eligibility criteria for qualified employers. We limit the scope of these standards to maximize the accessibility of the SHOP, streamline the enrollment process, and to minimize the burden on employers and employees.

In paragraph (b)(1), we propose that the SHOP ensure that an entity is a small employer. Specifically, the employer must employ no more than 100 employees, with the exception that a State may elect to limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016.

Section 1304 of the Affordable Care Act defines the calculation of an employer's size based upon the average number of employees employed on business days during the preceding calendar year. The terms “employer,” “small employer,” and “large employer” are defined in § 155.20, and are based on the definitions from the PHS Act. The PHS Act determines employer size by counting all employees, including part-time and seasonal employees, to determine an employer's size. Part-time workers ***41888** would be counted in the same manner as full-time workers, while seasonal employees would be counted proportionately to the number of days they work in a year, as discussed in more detail later in this preamble. The PHS Act is

in turn consistent with the definition of an employee in section 3(6) of ERISA. Because the PHS Act definition of employer and ERISA definition of group health plan refer to at least 1 employee, they exclude sole proprietors, certain owners of S corporations, and certain relatives of each of the above. The definition of "employer" in § 155.20 also requires that all persons treated as a single employer under subsections (b), (c), (m) or (o) of section 414 of the Code must be treated as one employer when determining employer size. We note that States use a variety of methods to determine employer size with regard to eligibility for participation in the small group market, and that these State methods may, in turn, add a level of specificity not described in this method of determining employer size. We solicit comment on this approach.

In paragraph (b)(2), pursuant to section 1312(f)(2)(A) of the Affordable Care Act, we propose to codify the requirement that the SHOP ensure a qualified employer provides an offer of coverage through a SHOP to all full-time employees. In paragraph (b)(3), we propose that the employer can elect to cover all employees through the SHOP serving the employer's principal business address. An employer with worksites in different SHOP service areas can elect to offer each eligible employee coverage through the SHOP serving the employee's primary worksite.

In paragraph (c), we propose to require a SHOP to accept the application of an employer to provide coverage to eligible employees whose worksite is in the SHOP service area, if the employer elects to cover all employees through the SHOPs serving their worksites. This standard provides qualified employers with the flexibility to cover qualified employees in areas in which such employees work, and provides those employees with access to local QHPs that may best meet their needs. If a qualified employer opts to provide coverage through SHOPs in different service areas, SHOPs could establish a participation rule with respect to the number of employees employed by the employer within the service area of the SHOP.

In paragraph (d), we propose to codify section 1304(b)(4)(D) of the Affordable Care Act which allows an employer participating in the SHOP to continue participating in the SHOP if the number of workers employed exceeds the level specified by the definition of a qualified employer after the employer's initial eligibility determination. This provision seeks to minimize potential disruption to qualified employees who work for growing employers. However, this provision would not apply to an employer that otherwise fails to meet the eligibility criteria for participation in the SHOP.

In paragraph (e), we propose eligibility criteria for a qualified employee. Only employees that receive an offer of coverage through the SHOP from a qualified employer may be a qualified employee.

d. Eligibility Determination Process for SHOP (§ 155.715)

In paragraph (a), we propose the eligibility determination process for employers seeking to offer qualified employees health coverage through a SHOP. We propose that a SHOP determine eligibility consistent with the standards described in § 155.710. For both employers and employees, the information proposed to be collected is limited to the minimum information needed to determine eligibility to participate in the SHOP. One way for SHOPs to determine the size of the employer is to allow employers to self-report the size of its workforce and attest to the report's accuracy; however, SHOPs are permitted to require a more stringent determination of employer size and may require other information.

In addition to verifying the size of an employer, we propose that a SHOP must verify that a qualified employer has fulfilled all of the standards specified in § 155.710, including offering all full-time employees access to health coverage through the SHOP, as well as verifying that at least one employee employed by the employer works in the SHOP's service area. We believe that a self-reported address and an attestation by the employer that it is offering coverage should be considered sufficient for verification purposes.

In paragraph (b), we propose that the SHOP use only two application forms: one for qualified employers and one for qualified employees; this is based on our interpretation of section 1413(b)(1)(A), which requires that the Secretary develop and provide to each State a single, streamlined form, and section 1311(c)(1)(F), which provides that an issuer shall use a uniform enrollment form for qualified individuals and employers to enroll in QHPs through the Exchange.

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In paragraph (c), we propose that for the purpose of determining eligibility in the SHOP, the SHOP may use the information attested to by the employer or employee on the applicable application. However, the SHOP must, at a minimum, verify that an individual attempting to enter the SHOP as an employee is listed on the qualified employer's roster of employees to whom coverage is offered. Additionally, the SHOP may deny applications for which, through its verification process, it has reason to doubt the veracity of the information provided by the applicant. A SHOP may establish additional methods to verify information beyond reliance on the single employer application and the single employee application. Methods of additional verification that may lead to instances in which a SHOP may have a reason to doubt information provided by employers or employees include, but are not limited to: (1) Review of quarterly wage reports suggesting the employer does not meet the State's definition of a small employer; and (2) attempts by an employer to enroll a number of employees that is greater than allowed under the State's definition of small employer, contrary to attestations made on the application. Appeals related to this process will be addressed in future rulemaking.

In paragraph (d), we propose that the SHOP have processes to resolve occasions when the SHOP has a reason to doubt the information provided through the employer and employee applications. In such cases, the employer or employee must be notified by the SHOP. Further, the SHOP must make a reasonable effort to identify and address the cause of the doubt; contact the employee or employer to confirm the accuracy of relevant information and provide the employee or employer with a 30-day period to correct the possible error. At the end of this period, the SHOP must notify the employee or employer of its eligibility determination and in the case of the employer, if the employer was enrolled in a plan before the completion of this verification process, discontinue the employer's participation in the SHOP (and the enrollment of any employees of that employer) at the end of the month following the month in which the notice was sent.

In paragraph (e), we propose that the SHOP notify an employer of the SHOP's eligibility determination and the employer's right to appeal. In paragraph (f) we propose that the SHOP notify an employee of the SHOP's eligibility determination and the employee's right to appeal.

In paragraph (g), we propose that if a qualified employer ceases to purchase ***41889** any coverage through the SHOP, the SHOP must ensure that: (1) Each QHP terminates the coverage of the employer's qualified employees enrolled in QHPs through the SHOP; and (2) each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the employer's withdrawal and their termination of coverage prior to such withdrawal and termination. We are considering whether this notice must inform the employee about his or her eligibility for special enrollment periods in the Exchange and about the process of being determined eligible for advance payments of the premium tax credit and cost-sharing reductions, Medicaid and CHIP. We solicit comments regarding this eligibility and notification process.

e. Enrollment of Employees into QHPs Under SHOP (§ 155.720)

In § 155.720 we address enrollment of employees into QHPs under SHOPs. In paragraph (a), we propose a general standard that the SHOP must process applications for enrollment from employees and facilitate enrollment of qualified employees into QHPs.

In paragraph (b), we propose that the SHOP establish a uniform enrollment timeline and process to be followed by all employers and QHPs in the SHOP. Such timeline is for the following activities: (1) Determination of employer eligibility to purchase coverage in the SHOP as described in § 155.715; (2) qualified employer selection of QHPs offered through the SHOP to qualified employees, consistent with § 155.705(b)(2) and (3); (3) provision of a specific timeframe during which qualified employers may select the level of coverage or QHP offering, as appropriate; (4) provision of a specific timeframe for qualified employees to complete the employee application process; (5) determination and verification of employee eligibility for enrollment through the SHOP; (6) enrollment processing of qualified employees into selected QHPs; and (7) establishment of effective dates of qualified employee coverage. We note that, pursuant to the rolling enrollment requirements of § 155.725(b), the timeframe for these activities should be standardized relative to a plan year as opposed to a calendar year; while the enrollment dates qualified for employers will differ depending on when they join, the period they have to complete the steps along this process will be consistent among all employers. Ultimately, we believe that to provide a competitive shopping experience for qualified

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employees, it is important to have similar enrollment processes across QHPs, so qualified employees are not excluded from some QHPs due to inconsistent timing requirements.

In paragraph (c), we propose that the SHOP must process applications in accordance with the timeline described in paragraph (b) and adhere to the requirements specified in § 155.400(b) regarding relevant standards for enrollment and timing of data exchange between the SHOP and QHPs. In paragraph (d), we propose that the SHOP must adhere to standards set forth in § 155.705(b)(4) regarding payment administration.

In paragraph (e), we propose that the SHOP must ensure that qualified employees who select a QHP are notified of the effective date of coverage. The SHOP may require QHPs to officially make such notice, but we propose to make the SHOP responsible for ensuring that such notification occurs.

In paragraphs (f) and (g), we address maintenance of enrollment records and reconciliation of enrollment information with QHPs. We propose that information maintained must include records of qualified employer participation and qualified employee enrollment in the SHOP. Such information must also be reported to HHS, consistent with the standards of § 155.400(d). We propose that reconciliation of enrollment information with QHPs occur at least monthly. We provide SHOPs with discretion to conduct enrollment reconciliation processes on a more frequent basis, depending upon the technical capabilities of the SHOP and participating QHPs. We welcome comments about whether we should establish target dates or guidelines so that multi-State qualified employers are subject to consistent rules.

In paragraph (h), we propose that if a qualified employee voluntarily terminates coverage from a QHP, the SHOP must notify the individual's employer. This ensures that the employer has the proper information for administration of the benefits provided to its employees and the payment for those benefits. Terminations by qualified employees will also be subject to requirements and limitations identified in other laws and the employer's plan; for example, cafeteria plan restrictions on mid-year changes based on the Code will remain applicable.

f. Enrollment Periods Under SHOP (§ 155.725)

In § 155.725, we address enrollment periods under SHOPs consistent with section 1311(c)(6) of the Affordable Care Act. In paragraph (a), we propose that the SHOP: (1) Adhere to the start of the initial open enrollment period for the Exchange; and (2) ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with § 156.260. We propose that the initial open enrollment for the SHOP begins on October 1, 2013 for coverage effective January 1, 2014, which is the same as the Exchange serving the individual market. However, unlike the initial open enrollment period that closes after a certain date, in the SHOP, the initial open enrollment date represents the starting point for which qualified employers may begin participating in the SHOP.

In paragraph (b), we propose a rolling enrollment process in the SHOP whereby qualified employers may begin participating in the SHOP at any time during the year. We are proposing a rolling enrollment process for the SHOP to match the enrollment process for the small group market outside of the SHOP. We believe that qualified employers will only join the SHOP if it is convenient to do so. Further, employers may be less likely to choose coverage through the SHOP if they can only enroll in the SHOP during a single annual open enrollment period.

We clarify that while a qualified employer may enter the SHOP at any time, the qualified employees will only be able to enroll or change plans (to the extent multiple QHPs are available) once a year unless such employees qualify for a special enrollment period. Additionally, we note that, consistent with current market practice, an employer's plan year may not necessarily align with the calendar year. Instead, plan years inside the SHOP must consist of the twelve-month period beginning with the employer's effective date of coverage. This is different from the open enrollment period for the individual market, where a full plan year will always begin on January 1 and terminate on December 31. We invite comments on these provisions.

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In paragraph (c), we propose an annual employer election period in advance of the annual open enrollment period, during which time a qualified employer may, among other things, modify the employer contribution towards the premium cost of coverage and plan offerings. To ensure timely renewal, the qualified employer must work within the confines of the uniform enrollment timeline established by the SHOP and described in § 155.720(b) to make such changes. This requires the employer to make its election before the conclusion of its current plan year and ***41890** before the annual employee enrollment period for the following plan year. Because of rolling enrollment and the non-alignment of plan years and calendar years in the SHOP, this annual election period may be specific to each qualified employer and therefore must occur at a fixed point in the plan year, for example two months before its completion, and not at a fixed point in the calendar year.

In paragraph (d), we propose that the SHOP must notify participating employers that their annual election period is approaching. We are considering whether to require the participating employer receive 30 days advance notice that the election period is approaching. During this time, the participating employer will have the time to compare the options available and can then make any changes during the election period. We solicit comment on this notice requirement.

In paragraph (e), we propose to require the SHOP to establish an annual employee open enrollment period for qualified employees. We note that if the SHOP were to allow a qualified employer to offer only one plan to its employees, a qualified employee will not be able to change plans during the annual open enrollment period, but could still change who is enrolled by adding and dropping dependents. As previously stated, small group markets are unique and we believe that the annual employee open enrollment period should be established by the SHOP in order to accommodate the markets that it serves. Such period must occur prior to the completion of the employer's plan year and after the employer's annual election period. Similar to the annual employer election period, because of rolling enrollment in the SHOP, the annual employee enrollment period should occur at a fixed point in the plan year and not at a fixed point in the calendar year. We solicit comment on this provision.

In paragraph (f), we propose that the SHOP ensure a qualified employee who is hired outside of the initial or annual open enrollment period would have a specified window set by the SHOP to seek coverage in a QHP beginning on the first day of employment. Much like the Federal Employees Health Benefit program (which has a 60-day window), the coverage for such an employee would continue through the qualified employer's plan year. At the time of the annual open enrollment period, the employee would have the option to renew or change coverage on a similar basis as the other employees of that qualified employer covered through the SHOP. We solicit comments on these proposed notices and their interaction with existing law and regulation.

In paragraph (g), we propose that the SHOP establish effective dates of coverage for qualified employees. In paragraph (h), we propose that if an enrollee remains eligible for coverage in a QHP through the SHOP, such individual will remain in the QHP selected during the previous plan year with limited exceptions. Exceptions would include: (1) Employee termination of coverage in accordance with the standards of § 155.430 for the individual market: (2) enrollment in another QHP if such option exists: or, (3) the qualified health plan in which the enrollee was enrolled is no longer available to the enrollee. In all such cases, an individual would be disenrolled from the QHP in which he or she was enrolled at the end of the coverage year.

We welcome comments about our approach in differentiating the individual and small group market enrollment as well as specific comments concerning the proposed structure for initial, rolling, and annual open enrollment through the SHOP.

g. Application Standards for SHOP (§ 155.730)

Section 155.730 outlines the specific application-related standards for participation in the SHOP, consistent with the authority under section 1311(b)(1)(B) of the Affordable Care Act. In paragraph (a), we propose a general requirement that SHOP applications must adhere to the application standards set forth in this section. Many of the standards in this section are quite similar to the standards of § 155.405 and in places we directly reference those standards. However, we do not require that the SHOP use the same, single streamlined application as the Exchange uses in the individual market, as the SHOP is not responsible for determining eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid or CHIP.

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In paragraph (b), we propose that the SHOP use a single employer application to determine employer eligibility and to collect the information necessary for the employer to purchase coverage through the SHOP. We also propose the minimum employer information that SHOPs must collect on the single employer application. This information includes (1) the employer name and address of employer's; (2) number of employees; (3) Employer Identification Number (EIN); and (4) a list of qualified employees and their social security numbers. Such application may be submitted by other individuals or organizations on behalf of the employer. We welcome comments regarding other employer information we should consider requiring a SHOP to collect.

In paragraph (c), we propose that the SHOP must use a single employee application for each employee to collect eligibility and QHP selection and enrollment information from employees seeking to enroll in a QHP. The amount of information that will be collected about employees will be significantly less than that which is collected for applicants to the individual Exchange making the wholesale reuse of the individual application burdensome. However the single, streamlined application completed by an individual seeking to enroll in the individual market may be modified and reduced to meet the needs of an employee in the SHOP. A SHOP applicant applying online should only be asked questions relevant to an employee application. Similarly, an employee applying through the paper application should receive a paper application containing only the portion relevant to eligibility and enrollment of a qualified employee in the SHOP. Using the same application foundation for employees and individuals will further streamline processes of developing applications and information sharing among the individual Exchange, SHOP, QHP issuers, and HHS. Such application may be submitted by other individuals or organizations on behalf of the employee.

In paragraph (d), we specify that SHOPs may use a model single employer application and model single employee application created by HHS. Model applications will be proposed by HHS, after consultation with the NAIC. This process mirrors the standards in the Exchange serving the individual market. In paragraph (e), we permit a SHOP to use an alternative employer application with approval by HHS. Such application should support the information described in paragraph (b) and information relevant to determine eligibility for the programs for which the employer is applying and plan selection, where relevant. The SHOP may also use an alternative employee application, the approval by HHS. Such application requests the information necessary to establish eligibility of the employee as a qualified employee and to complete the enrollment of a qualified employee, such as a plan selection and identification of dependents to be enrolled.

In paragraph (f), we propose that the SHOP must allow employers and employees to submit their eligibility and enrollment information consistent with § 155.405(c).

***41891 6. Subpart K—Exchange Functions: Certification of Qualified Health Plans**

This subpart codifies section 1311(d)(4)(A) of the Affordable Care Act, which requires that Exchanges, at a minimum, implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by HHS. This subpart also distinguishes the Exchanges' responsibility related to the inclusion in the Exchange of certain multi-State plans. Standards for health insurance issuers with respect to QHP certification are contained in subpart C of part 156 of this regulation, and we cross-reference those standards where applicable in this subpart.

When developing this subpart, we considered comments to the RFC recommending that Exchange certification of QHPs be structured in one of two ways: Establish QHP certification standards that would be uniform across Exchanges, or provide each Exchange the discretion to determine certification standards and whether or not a health plan should be certified. While we recognize the importance of setting consistent consumer protections which may ensure equitable treatment across States, we also acknowledge that an Exchange may be best positioned to identify whether a particular health plan should be certified as a QHP based on the needs of consumers within the State and local market conditions. In this subpart, we seek to strike a balance between the approaches suggested by RFC commenters. In some cases, we propose setting specific requirements to ensure QHPs in all Exchanges meet a consistent minimum standard of quality and value, and in other instances, we propose allowing each Exchange the discretion to set standards for QHPs tailored to local market conditions.

a. Certification Standards for QHPs (§ 155.1000)

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In § 155.1000, we describe the overall responsibility and requirements of an Exchange to certify QHPs, and to ensure that only QHPs are offered. In paragraph (a), we define a multi-State plan. Section 1334(a) of the Affordable Care Act establishes multi-State plans; the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-State QHPs through each Exchange in each State. Section 1334(c)(1) of the Affordable Care Act further specifies that multi-State QHP requirements are satisfied if the OPM Director determines the plan offers a benefits package that is uniform in each State and consists of the benefit design standards described in section 1302, meets all requirements for QHPs, and meets Federal rating requirements pursuant to section 2701 of the PHS Act, or a State's more restrictive rating requirements, if applicable.

In paragraph (b), we propose to codify section 1311(d)(2)(B)(i) of the Affordable Care Act, which requires that an Exchange may not make available any health plan that is not a QHP. Offering only QHPs through an Exchange will assure consumers that the coverage options presented through the Exchange meet minimum standards. Also, consistent with the definition of QHP in § 155.20, we propose to codify section 1301(a)(1)(A) of the Affordable Care Act, in which QHPs must have in effect a certification issued or recognized by the Exchange as QHPs. Finally, we propose to codify section 1301(a)(2) of the Affordable Care Act, which requires any reference to QHPs to include the multi-State plans, unless specifically provided for otherwise.

In paragraph (c), we propose to codify the two basic sets of requirements that an Exchange must ensure that a health plan meets to be certified as a QHP issuer by an Exchange pursuant to section 1311(e) of the Affordable Care Act. In paragraph (c)(1), we propose to codify section 1311(c)(1) of the Affordable Care Act, which provides for the minimum QHP certification requirements to be applied by an Exchange; these requirements are outlined in subpart C of part 156. In developing a process to certify QHPs, the Exchange should identify those standards from subpart C of part 156 with which a health insurance issuer should demonstrate compliance as a condition of certification of QHPs, as well as those standards with which a health insurance issuer should agree to comply as an ongoing condition of offering QHPs.

In paragraph (c)(2), we propose to codify section 1311(e)(1)(B) of the Affordable Care Act, which allows an Exchange to certify a health plan if it determines it is in the interest of qualified individuals and qualified employers in the State. We received RFC comments regarding the extent to which Exchanges should implement an “any-willing plan” model, or implement active purchasing approaches, such as selective contracting or price negotiation. Some commenters argued that active purchasing approaches would minimize costs, improve health outcomes, and increase enrollment and coordination with other programs. Of these comments, many recommended that at a minimum, HHS should not require the Exchanges to accept all eligible plans. In contrast, advocates of the any-willing plan approach noted that State insurance departments already review and approve rates and regulate insurer solvency, and that negotiation would result in de facto premium price controls for the entire market, reduce consumer choice and competition, and result in duplicative regulatory structures.

We provide Exchanges with discretion on how to determine whether offering health plans is in the interest of individuals and employers. An Exchange may want to choose among one of several strategies for making this determination. An Exchange may choose to utilize an “any qualified plan” strategy for certifying QHPs in its Exchange. Under this approach, an Exchange would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements in paragraph (c)(1) of this section.

Alternatively, an Exchange could undertake a competitive bidding or selective contracting process, and limit QHP participation to only those plans that ranked highest in terms of certain Exchange criteria. With competitive bidding, an Exchange may be able to achieve additional value and quality objectives by limiting participation and through plan competition. Since many State Medicaid programs employ selective contracting models today and have experience negotiating with health insurance issuers on Medicaid managed care plans, some State Exchanges may want to pursue similar competitive strategies when certifying QHPs.

An Exchange may also choose to negotiate with health insurance issuers on a case-by-case basis. Under this strategy, the Exchange would request a health insurance issuer, upon meeting the minimum certification standards, to amend one or more specific health plan offerings to further the interest of qualified individuals and qualified employers served by the Exchange.

Unlike the previous options, the Exchange would not need to undertake a competitive bidding process to accomplish this negotiation. Rather, it could choose to negotiate with issuers on certain criteria based on the unique market conditions within the State or region served by that same Exchange.

An Exchange may also implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interests of the qualified individuals and employers. Some examples of such selection criteria include: (1) Reasonableness of the estimated costs supporting the ***41892** calculation of the health plan's premium and cost-sharing levels; (2) past performance of the health insurance issuer; (3) quality improvement activities; (4) enhancements of provider networks including the availability of network providers to new patients; (5) service area of the QHPs (the size of a service area and the amount of choice afforded to the consumers within that service area); and (6) premium rate increases from years preceding the Exchange operation and proposed rate increases, consistent with § 155.1020.

Some of these approaches are not mutually exclusive and may be implemented in combination. How an Exchange elects to implement the "interest" determination may vary based upon a number of factors, including the size and risk profile of the Exchange's potential enrollees, concentration of the health insurance market in the area served by the Exchange, and the applicable State insurance rules. Each Exchange will likely need to assess these factors in selecting an approach that will promote value and quality for its enrollees.

In paragraph (c)(2) we propose to codify section 1311(e)(1)(B) of the Affordable Care Act, which outlines the prohibitions on the Exchange when it is making the determination that a health plan is in the interest of qualified individuals and qualified employers. Under this authority, an Exchange is prohibited from excluding a plan: (1) On the basis that the plan is a fee-for-service plan; (2) through the imposition of premium price controls; or (3) on the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

b. Certification Process for QHPs (§ 155.1010)

In § 155.1010, we propose the required process that Exchanges must use when certifying health plans, and identify which health plans are not subject to Exchange certification. Specifically, in paragraph (a) we propose to codify section 1311(d)(4)(A) of the Affordable Care Act, which requires the Exchange to establish procedures for the certification of QHPs. We further propose that the procedures must be consistent with the certification criteria outlined in § 155.1000(c).

In paragraph (b), we propose to codify section 1334(d) of the Affordable Care Act which requires a multi-State plan offered through OPM to be deemed as certified by an Exchange for the purposes of section 1311(d)(4)(A). We note that, pursuant to section 1334(c)(1)(B), multi-State plans will need to meet all the requirements of a QHP, as determined by OPM. We believe that the intent of the statute is that each Exchange must accept multi-State plans as QHPs without applying an additional certification process to such plans. In paragraph (c), we propose that the Exchange complete the certification of QHPs prior to the open enrollment periods established in § 155.410. We believe this is necessary to ensure that consumers will have a robust market from which to select QHPs when the open enrollment period begins.

In paragraph (d), we propose that the Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in § 155.1000(c). If the QHP issuers or their QHPs cease to demonstrate ongoing compliance, the Exchange may be inclined to seek actions against the issuers or try to remedy the situation.

c. QHP Issuer Rate and Benefit Information (§ 155.1020)

Section 1311(e)(2) of the Affordable Care Act establishes standards on Exchanges regarding the transparency of justifications for rate increases submitted by QHP issuers. In accordance with this section, in paragraph (a) of § 155.1020, we propose that Exchanges must receive a QHP issuer's justification for a rate increase prior to the implementation of such an increase, and ensure that the QHP issuer posts the justification on its Web site. We recognize that QHP issuers may already submit rate

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increase justifications as part of the rate review process, and note that an Exchange may receive this information from the State department of insurance (or HHS, if applicable), to satisfy its obligation to receive such a justification.

Section 1311(e)(2) of the Affordable Care Act also requires an Exchange to consider rate increases in determining whether to make a health plan available on the Exchange. Several comments in response to the RFC recommended a range of purposes for the Exchange consideration of rate increases, including adequacy of claims payment, reasonableness for benefits offered based upon actuarial analysis, discriminatory practices, and unsupported excessive rate increases. Other comments noted the interaction between the State rate review process and Exchange review of premiums for QHP certification purposes. Finally, some commenters recommended transparency in review of rate justifications as well as consistent criteria of “reasonableness” of increases inside and outside Exchanges.

In paragraph (b) we propose to codify the statutory requirement that an Exchange must consider the following factors related to health plan rates when determining whether to certify QHPs: (1) The justification of a rate increase prior to the implementation of the increase; (2) the recommendations provided to the Exchange by the State under section 2794(b)(1)(B) of the PHS Act; and (3) any excess rate growth outside the Exchange as compared to the rate of growth inside the Exchange, including information reported by the States. We clarify that the obligation to consider rate increases justifications is an ongoing requirement, beginning with the plan year 2014.

We seek to avoid duplicating the State rate review process in section 2794 of the PHS Act. We recognize that many States already operate an effective rate review program, collect information from issuers in the rate filing process and make a determination if the rate complies with State law. This process, when available, should be leveraged by the Exchange to avoid any duplication. For example, Exchanges may consider the preliminary justification already collected through the rate review process, and use the same format for the rate justification from health plans issuers under § 154.215. Establishing consistency between the rate justification described in § 154.215 and the justification required from QHP issuers by § 156.210 would reduce duplication of effort for issuers and Exchanges and promote greater transparency.

We are considering a standard for the final rule in which there would be a bifurcated process for the rate increase justifications. Where section 2794 of the PHS Act applies (rates are subject to review), the Exchange may rely on the justification submitted pursuant to section 2794 of the PHS Act. Where section 2794 of the PHS Act does not apply, the Exchange could develop a less burdensome rate justification to satisfy section 1311(e)(2) of the Affordable Care Act. We are cognizant of existing State regulatory authorities; thus, we encourage the Exchange and the State department of insurance to collaborate in this process. Collaboration may include determining the form, manner, and timing of the submission of the rate justifications. We solicit comment on how to best align section 2794 of the PHS Act and section 1311(e)(2) of the Affordable Care Act.

Separate and apart from the consideration of a rate increase ***41893** justification, Exchanges will need to receive rate and benefit information from QHP issuers for specific operational purposes. In paragraph (c) of § 155.1020, we propose that the Exchange must at least annually receive the following information from the QHP issuers' for each QHP: Rates, covered benefits and cost-sharing requirements. HHS will provide the form and manner for the submission of this information. We note that the Exchange will need to receive rate information from QHP issuers in order to determine premium amounts for Exchange applicants as well as for the determination of the second lowest cost silver plan benchmark for advance payments of the premium tax credit. Additionally, benefit information is needed to determine whether a QHP complies with the benefit design standards defined in § 156.20 and with the actuarial value requirements for cost-sharing reductions as well as to display plan options on the Exchange Web site. Furthermore, rate information is needed to support HHS' administration of the risk corridor program.

In establishing the required rate and benefit data elements, HHS will seek to align this reporting requirement with information available through the State rate review process or through State rate filings, to the extent possible, so that an Exchange may consider leveraging already available sources.

d. Transparency in Coverage (§ 155.1040)

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In § 155.1040, we propose to codify section 1311(e)(3) of the Affordable Care Act, which establishes that Exchanges must require health plans seeking certification as QHPs to submit transparency information to the Exchange, HHS, and other entities. In paragraph (a), we require Exchanges to collect information from QHP issuers relating to coverage transparency as described in § 156.220(a).

While the transparency reporting requirements in § 156.220 apply specifically to QHPs, we note that these same requirements will also apply to all group health plans and health insurance issuers in the individual and group markets under section 2715A of the PHS Act as amended by the Affordable Care Act. As section 2715A of the PHS Act is implemented, we anticipate working closely with the Department of Labor and the Department of the Treasury in order to ensure that these reporting standards are applied appropriately across the insurance market. In addition, HHS is soliciting comments under this proposed rule as part of the process of planning for the implementation of section 1311(e)(3)(D) of the Affordable Care Act. Any comments received related to section 1311(e)(3)(D) will be shared with the Department of Labor so that it can update and harmonize its rules for group health plan disclosures.

In paragraph (b), we require the Exchange to monitor the use of plain language by QHP issuers when making available QHP transparency data pursuant to § 156.220. Section 1311(e)(3)(B) requires the Secretary of HHS and the Secretary of Labor to jointly develop and issue guidance on best practices of plain language writing. Exchanges will need to ensure that QHP issuers' use of plain language is consistent with the definition provided in § 155.20 and the guidance set forth as required by section 1311(e)(3)(B).

In paragraph (c), we propose to codify section 1311(e)(3)(C) of the Affordable Care Act which specifies that the Exchange require QHP issuers make available cost-sharing information to enrollees. This requirement on QHP issuers is described in § 156.220(c).

We note that the information provided by QHP issuers pursuant to this section may be used by Exchanges during the certification process when determining if the health plan is in the interest of the qualified individuals served by the Exchange. Information reported under this section may inform Exchanges when considering the past performance of the health insurance issuers.

e. Accreditation Timeline (§ 155.1045)

In § 155.1045, we propose to codify the Exchange responsibility, required by section 1311(c)(1)(D)(ii) of the Affordable Care Act, to establish the time period within which any QHP issuer that is not already accredited must become accredited following certification of a QHP. Accreditation acts as a "seal of approval" to indicate to individuals and employers seeking coverage that a health insurance issuer meets minimum standards of quality and consumer protection. We note that, although section 1311(c)(1)(D)(i) of the Affordable Care Act requires a health plan to be accredited to be certified as a QHP, we interpret this to mean that QHP issuers must be accredited, because accrediting entities accredit issuers, not plans. In § 156.275, we propose that all QHP issuers must be accredited with respect to their QHPs.

The Affordable Care Act does not set the deadline by which a health insurance issuer must be accredited to have a health plan certified as a QHP, nor does it establish a time period after certification of a QHP during which a QHP issuer must become accredited if it is not already accredited. A grace period may be necessary since a typical accreditation process for a health insurance issuer may take twelve to eighteen months to complete, and could be even longer for health insurance issuers seeking accreditation for the first time. We encourage the Exchanges to establish a timeline for accreditation that accommodates the length of the accreditation process, particularly for issuers seeking first-time accreditation.

We propose to require the Exchange to establish the length of time following initial certification of a QHP within which a QHP issuer must become accredited. The Exchange must establish a consistent deadline for accreditation with respect to each QHP issuer's initial participation in the Exchange; the deadline, for example, may be two years following certification of a QHP. This proposal is consistent with section 1311(c)(1)(D)(ii) of the Affordable Care Act which specifies that the time period established by the Exchange must be "applicable to all QHPs." We believe this interpretation, as opposed to a single date by which all QHP

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issuers must be accredited in order to participate or continue participating in the Exchange, will allow for inclusion of a wider variety of QHP issuers in the Exchange.

f. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

The Exchanges will make health insurance available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers. Network adequacy requirements will help ensure that QHP enrollees can readily obtain services. Under section 1311(c)(1)(B) of the Affordable Care Act, HHS is required to establish network adequacy requirements for health insurance issuers seeking certification of QHPs.

We recognize that network adequacy standards should be appropriate to States' particular geography, demographics, local patterns of care, and market conditions. Therefore, to ensure that Exchange network adequacy requirements are appropriate for QHP issuers and reflect local patterns of care, we propose in § 155.1050 that each Exchange ensure that enrollees of QHPs have a sufficient choice of providers. This broad standard affords the Exchange significant flexibility to apply this standard to QHPs in a manner appropriate to the State's existing patterns of care, establishing specific standards where necessary and leveraging existing State oversight and ***41894** enforcement mechanisms in this area. We propose at § 156.230 that QHP issuers adhere to standards set by the Exchange, as well as several statutorily required standards that would apply to all QHP issuers.

We solicit comment on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care. When considering our options for establishing network adequacy standards for QHP issuers, we examined typical standards employed in the existing insurance market by State departments of insurance, Medicare Advantage, TRICARE Prime and States that contract with Medicaid managed care organizations. We also examined the NAIC Managed Care Plan Network Adequacy Model Act, from which a number of States have drawn in developing their network adequacy standards for health insurance issuers. We have sought to develop a standard that balances the need for a uniform level of protection with the level of variation across States and local markets.

In particular, we seek comment on a potential additional requirement that the Exchange establish specific standards under which QHP issuers would be required to maintain the following: (1) Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner. These standards are based in part on the NAIC Managed Care Plan Network Adequacy Model Act. This set of standards would create a baseline that each Exchange could interpret and apply in a manner appropriate to local market conditions and patterns of care. Consistent with these basic standards, an Exchange would be able to set quantitative requirements where possible to establish clear expectations of access to care.

We also seek comment on an additional standard that the Exchange ensure that QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas. Such a requirement would protect against a network design that does not serve all enrollees' medical needs.

The standard proposed here would allow an Exchange to set standards appropriate to local patterns of care. We urge the Exchanges to consider the needs of enrollees in isolated geographic areas in particular; for example, an Exchange may want to consider the needs of American Indians and Alaska Natives residing in remote locations, given that they may often have a limited choice of providers from which to select. We also clarify that a QHP issuer's provider network must ensure reasonable access to care for all enrollees enrolled through the Exchange regardless of an enrollee's medical condition.

We recognize that primary care access is a challenge in many communities nationally, and that more consumers may seek routine primary care services in 2014 given improved access to health insurance coverage. Consistent with the goals and policies of the Affordable Care Act in supporting primary care, in establishing provider networks that ensure broad access to care,

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we encourage States, Exchanges and health insurance issuers to consider broadly defining the types of providers that furnish primary care services (e.g., nurse practitioners).

g. Service Area of a QHP (§ 155.1055)

In § 155.1055, we propose that Exchanges have a process to establish or evaluate the service areas of QHPs. Under this proposed rule, an Exchange would maintain discretion to pre-determine service areas for plans to cover, permit plans to propose coverage of certain service areas, or negotiate with issuers over service areas during the certification process. This provision is intended to promote greater choice and competition as consistently as possible across a State, and to guard against discrimination, “cherry picking,” “red-lining,” or other similar efforts to offer health plans only in areas of low risk. We also seek to recognize that the capacity of health insurance issuers varies by region due to some factors that are outside of their control.

In paragraph (a), we propose that an Exchange must ensure that the service area of a QHP covers at least a county, or a group of counties if the Exchange designates such a group, unless the QHP issuer demonstrates that serving a partial county is necessary, nondiscriminatory, and in the interest of qualified individuals and employers. The requirement outlined here parallels the “county integrity rule” established in Medicare Advantage, which also outlines examples for determining whether serving a partial county would fall under the “necessary” or “nondiscriminatory” standards.

In paragraph (b), we propose that an Exchange must ensure that QHP service areas be established without regard to racial, ethnic, language and health status factors outlined in section 2705(a) of the PHS Act. This provision is intended to guard against redlining and other practices that would specifically exclude high-utilizing or high-cost populations.

h. Stand-Alone Dental Plans (§ 155.1065)

In § 155.1065(a), we propose to codify the requirement in section 1311(d)(2)(B)(ii) of the Affordable Care Act that an Exchange allow limited scope stand-alone dental plans to be offered provided that the plan furnishes at least the pediatric essential dental benefit required in section 1302(b)(1)(J) of the Affordable Care Act. We also propose to codify the requirement that the stand-alone dental plan comply with section 9832(c)(2)(A) of the Code and section 2791(c)(2)(A) of the PHS Act.

In paragraph (b), we propose to codify the option for a dental plan to be offered as a stand-alone plan or in conjunction with a QHP. In paragraph (c), we propose to codify section 1302(b)(4)(F) of the Affordable Care Act that allows a health plan be certified as a QHP if it does not offer the pediatric essential dental benefit, provided that a stand-alone dental plan is offered through the Exchange. We also note that dental plan issuers would be considered participating issuers subject to any user fees specified by the Exchange, as established under § 156.50 and § 155.160.

We are considering interpreting this provision such that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that the Exchange determines to be relevant and necessary. Potential QHP issuer standards that might be applied to stand-alone dental plans might include: Quality reporting, transparency measures, summary of coverage information, provider network standard, and standards regarding the consumer's experience in comparing and purchasing dental plans. While we provide significant latitude to Exchanges regarding requirements for stand-alone dental plans, we request comment on whether some of the requirements on QHP issuers should also apply to stand-alone dental plans as a Federal minimum and what limits Exchanges may face on placing ***41895** requirements on dental plans given that they are excepted benefits.

We also request comment on whether we should set specific operational minimum standards. Substantial operational issues exist with allocating advance payments of the premium tax credit and calculating actuarial value (as defined by section 1302(d)(2) of the Affordable Care Act) when stand-alone dental plans segment coverage of the essential health benefits (as defined in 1302(b) of the Affordable Care Act). Also, a QHP issuer will have to know far enough in advance of the QHP certification process whether it needs to include pediatric dental coverage.

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Lastly, some commenters to the RFC requested that we require all dental benefits to be offered and priced separately from medical coverage, even when offered by the same issuer. Such a requirement would preclude QHP issuers from offering a "bundled" QHP that covers all essential health benefits, including the pediatric dental benefit, under one premium. While we recognize that requiring a QHP to price and offer dental benefits separately could promote comparison of dental coverage offerings, we have significant concerns about the administrative burden this could impose on Exchanges and QHP issuers. We request comment on whether either option should be required.

i. Recertification of QHPs (§ 155.1075)

In § 155.1075, we propose to codify section 1311(d)(4)(A) of the Affordable Care Act, which requires the Exchange to implement procedures for the recertification of health plans as QHPs. While the Exchange must continuously ensure that QHPs are in compliance with the certification standards, recertification provides a process for an Exchange to conduct a comprehensive review of its QHPs. This process also allows for QHPs and Exchanges to terminate their relationship if intended. In paragraph (a), we provide that the Exchange must establish a process for recertification of QHPs that includes a review of the general certification criteria outlined in § 155.1000(c). We note that the recertification process for the QHPs should be less intensive than the initial certification process, given that the Exchange will have an established relationship with the QHP issuer. An Exchange may also consider using this process to make modifications to any agreements between the Exchange and its QHP issuers.

We permit the Exchange to determine the frequency for recertifying QHPs. The Affordable Care Act does not require an Exchange to recertify QHPs on an annual basis. Therefore, an Exchange has the discretion to decide to recertify QHPs annually, or on a less frequent basis, such as every other year or every three years. Some Exchanges may choose to develop longer recertification periods to reduce the administrative costs associated with such an evaluation. By operation of § 156.200, each QHP must still adhere to the requirements listed in § 155.1000(c) on an ongoing basis. We invite comment as to whether we should require more specific requirements associated with the term length for recertification.

We note that an Exchange that elects to conduct multi-year recertification will need to review certain information on a more frequent basis. For example, the Exchange will need to consider rate increase information and ensure compliance with benefit design standards annually, since issuers may alter rate and benefit design on an annual basis.

We also propose that, after reviewing all relevant information and determining whether to recertify a QHP, the Exchange notify a QHP issuer of its recertification status. If the Exchange determines that a plan should be denied recertification, the Exchange would then proceed decertifying the plan as described in § 155.1080.

In paragraph (b), we propose that the Exchange must complete the recertification process on or before September 15 of the applicable calendar year. We chose this date so that the recertification process is completed in advance of the annual open enrollment period, which begins on October 15 of each year. By providing a September 15 deadline, we allow the Exchanges discretion to determine a recertification timeframe that is most suitable for its consumers and QHPs. The Exchange may choose to complete its recertification process well in advance of the September 15 deadline. We solicit comments on the appropriateness of this recertification deadline.

j. Decertification of QHPs (§ 155.1080)

In § 155.1080, we propose to codify section 1311(d)(4)(A) of the Affordable Care Act, which requires the Exchange to implement procedures for the decertification of health plans as QHPs. In paragraph (a), we define decertification as the termination by the Exchange of the certification status and offering of a QHP. We note that decertification is an action taken by the Exchange in response to the most severe actions of a QHP, or as a result of a determination not to recertify a plan. In paragraph (b), we propose to codify section 1311(d)(4)(A) of the Affordable Care Act, which requires the Exchange to implement procedures for the decertification of health plans as QHPs.

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In paragraph (c), we propose that the Exchange may at any time decertify a QHP if the Exchange determines that the QHP issuer or the QHP is no longer acting in accordance with the general certification criteria outlined in § 155.1000(c), including that the QHP participation is no longer in the interest of its enrollees. Similar to the certification and recertification processes, the Exchange has the ability to tailor the decertification process, within the confines of the aforementioned standards, to meet the needs of the market it serves.

The Exchange will have discretion in determining how to implement the decertification process. We recommend that Exchanges solicit input from a broad range of stakeholders, including issuers, when determining how to implement the decertification procedures. We request comments on the creation of the decertification process and what other authorities could be extended to the Exchange to make the process more efficient.

In paragraph (d), we propose to require that the Exchange establish an appeals process for health plans that have been decertified by the Exchange. A health plan that has been decertified should have that ability to request a second evaluation if the issuer believes that its health plan has been unjustly decertified. This appeal process could be implemented in conjunction with the State department of insurance, by the Exchange on its own, or through a third party entity.

In paragraph (e), we propose that if a QHP is decertified, the Exchange must provide notice of the decertification to parties who may be affected. The decertification of a QHP will have an impact on the Exchange market, including the QHP issuer, enrollees of the decertified QHP, who must receive information about a special enrollment period as described in § 155.420, HHS, and the State department of insurance.

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

The Exchanges should be an attractive market for health insurance issuers to achieve the goal of providing consumers and employers with access to a competitive choice of affordable, high quality QHPs. Part 156 contains the proposed standards for QHPs and QHP issuers that are intended to promote robust and meaningful consumer ***41896** choice. Many provisions in this part have parallel standards in part 155, because certain standards for States and Exchanges have complementary standards for health insurance issuers seeking to offer, or offering, QHPs through an Exchange. We cross-reference to minimize redundancy and avoid confusion with respect to certain proposed policies. To the extent possible, this approach to drafting is designed to avoid gaps between the minimum standards we propose for Exchanges and QHPs.

1. Subpart A—General Provisions

a. Basis and Scope (§ 156.10)

Proposed § 156.10 of subpart A specifies the general statutory authority for the ensuing proposed regulation and indicates that the scope of part 156 is to establish standards for health plans and health insurance issuers related to the benefit design standards and in regard to offering QHPs through an Exchange. Under § 156.20, we propose definitions for terms used in part 156. Section 156.50 proposes the user fees that participating issuers may pay to contribute to the operations of a State Exchange, and Exchange-related operations.

b. Definitions (§ 156.20)

Many definitions presented in § 156.20 are taken directly from the Affordable Care Act or from existing regulations. The definitions set forth in subpart A reflect general meanings for the terms as they are used in part 156 unless otherwise indicated; the definitions apply strictly for the purposes of part 156. When a term is defined in part 156 other than in subpart A, the definition of the term is limited to a specified purpose in the relevant subpart or section.

Many of the terms defined in this section refer to those defined in § 155.20, including “applicant,” “benefit year,” “cost sharing,” “cost-sharing reductions,” “plan year,” “qualified employer,” “qualified individual,” “qualified health plan or QHP,”

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and "qualified health plan issuer or QHP issuer." We define "benefit design standards" for the purposes of the requirements related to the benefit packages outlined in the Affordable Care Act. The terms "group health plan," "health insurance coverage," and "health insurance issuer" are defined in section § 144.103 of this chapter.

We propose to use the term "benefit design standards" to mean the "essential health benefits package" defined in section 1302(a) of the Affordable Care Act. To avoid confusion with the term "essential health benefits," which refers only to the definition in section 1302(b) of the Affordable Care Act, we instead refer to the set of health plan requirements as benefit design standards for the purposes of clarity within this proposed rule.

c. Financial Support (§ 156.50)

Section 156.50 contains requirements on participating issuers to pay user fees to support ongoing operations of an Exchange, if a State chooses to impose fees. A State-operated Exchange must be self-sustaining by January 1, 2015, under section 1311(d)(5)(A), which also allows State user fee assessments on participating health insurance issuers, or other methods of funding, to support State Exchange operations.

In paragraph (a), we define the term "participating issuer" to mean an issuer offering plans that participate in the specific function that is funded by the user fee. Under this definition, a participating issuer would encompass different segments of issuers of health plans or other benefit plans depending on the Exchange function being funded by the user fee. As this term is used in section 1311(d)(5)(A), it provides an Exchange with the flexibility to collect user fees from issuers that benefit in some way from an Exchange and Exchange-related operations. We note that the term "participating issuer," for the purposes of this section, may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a)), issuers of stand-alone dental plans (as described in § 155.1065), or other issuers identified by an Exchange. In paragraph (b), we propose that participating issuers pay any fees assessed by a State Exchange, consistent with Exchange authority outlined in § 155.160.

2. Subpart C—Qualified Health Plan Minimum Certification Standards

Section 1311(c)(1) authorizes the Secretary, by regulation, to establish criteria for the certification of health plans as QHPs, which are described in this subpart. The statute outlines several minimum QHP standards to be established by the Secretary that will foster direct competition on the basis of price and quality and which will increase access to high quality, affordable health care for individuals and small employers. Each Exchange will be responsible for determining whether a health plan seeking to participate meets these minimum requirements to be a QHP and will have the discretion to set additional standards to ensure that offering the plan through that Exchange is in the best interest of consumers.

We received many comments in response to the RFC on minimum QHP certification requirements, which we describe in the preamble to subpart K of part 155 and which we considered as we developed the proposed rule. We highlight that, unless otherwise noted, the standards for QHPs proposed in this subpart do not supersede existing State laws or regulations applicable to health insurance issuers. While this subpart addresses health plan standards that States traditionally set, either through the process of granting licensure or otherwise, the standards proposed here apply specifically to the certification of QHPs for participation in the Exchange and do not exempt health insurance issuers from any State laws or regulations that generally apply to health insurance issuers in that State. We note that if a State establishes a higher standard for licensure than what we outline here as a minimum Federal requirement for health plan certification, such standard would apply.

a. QHP Issuer Participation Standards (§ 156.200)

Section 156.200 outlines the requirements on QHP issuers as a condition of participation in the Exchange. States may choose to establish additional conditions for participation beyond the minimum requirements established by the Secretary.

In paragraph (a), we propose to codify section 1301(a)(1)(A) of the Affordable Care Act. To participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it

offers in the Exchange is a QHP and that the issuer meets all requirements on QHP issuers. We clarify that some requirements in this proposed rule apply to the design of the specific QHPs offered. Other requirements are placed on the issuers related to the offering of QHPs.

In paragraph (b), we outline the set of standards with which a QHP issuer must comply related to the offering of a QHP. We propose in paragraph (b)(1) that the QHP issuer must comply with the requirements set forth in this subpart on an ongoing basis. We expect the Exchange to take into account compliance with the requirements in this subpart not only when determining whether to initially certify a health plan as a QHP, but also when reviewing QHPs for recertification.

***41897** In paragraph (b)(2), we propose that QHP issuers must comply with any Exchange processes, procedures, and standards set forth under subpart K of part 155 and § 155.705 for the small group market. We include the requirement to adhere to this certification process as a condition of participation so that the Exchange has the ability to conduct certification processes in a way that best meets the needs of the market it serves. This includes the process in which a health insurance issuer seeking initial certification of a QHP must demonstrate that it complies with the standards listed under paragraph § 155.1000(c).

In paragraph (b)(3), we propose to require that a QHP issuer ensures that each QHP it offers complies with the benefit design standards defined in § 156.20. Benefit design standards relate to the requirement in section 1301(a)(1)(B) of the Affordable Care Act that requires that QHPs offer the essential health benefits, adhere to cost-sharing limits, and meet the levels of coverage described in 1302(a) which will be the subject of future rulemaking.

In paragraph (b)(4), we propose to codify the requirement in section 1301(a)(1)(C)(i) that a QHP issuer be licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage. We interpret the term “good standing” to mean that the issuer has no outstanding sanctions imposed by a State's department of insurance. We seek comment on this interpretation. Licensure could also mean a “certificate of authority,” or any other State method of approving a health insurance issuer to offer health insurance coverage in the State.

In paragraph (b)(5), we propose that QHP issuers comply with quality standards established in and pursuant to sections 1311(c)(1), 1311(c)(3), 1311(c)(4), and 1311(g) of the Affordable Care Act. We intend to address specific requirements in future rulemaking, such as requirements for QHP issuers related to quality data reporting, quality improvement strategies, and enrollee satisfaction surveys described in these statutory provisions.

In paragraph (b)(6) and (b)(7), we propose that QHP issuers adhere to additional proposed requirements including user fees described in subpart A of part 156, if applicable, and the risk adjustment participation requirements as described in 45 CFR part 153.

In paragraph (c), we outline the requirements on QHP issuers related to the offering of QHPs. In paragraph (c)(1), we propose to codify section 1301(a)(1)(C)(ii), which requires that each QHP issuer offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level; the levels of coverage are defined in section 1302(d)(1) of the Affordable Care Act. In paragraph (c)(2), we propose to codify section 1302(f) of the Affordable Care Act, which specifies that any QHP issuer offering a non-catastrophic health plan in the Exchange must offer the identical plan as a child-only health plan. Child-only plans are only available to individuals under the age of 21. In paragraph (c)(3), we require the QHP issuer to offer a QHP at the same premium rate consistent with the requirements described in § 156.255(b).

In paragraph (d), we require that QHP issuers adhere to the requirements of this subpart and any additional participation standards that may be applied by the Exchange or the State.

In paragraph (e), pursuant to the authority to set QHP standards in section 1321(a)(1)(B), we propose that QHP issuers must not discriminate based on race, color, national origin, disability, age, sex, gender identity and sexual orientation. Such practices would include, but not be limited to marketing, outreach, and enrollment.

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b. QHP Rate and Benefit Information (§ 156.210)

In § 156.210, we propose the requirements for QHP issuers to submit QHP rate and benefit information to the Exchange, including rate justifications. The Exchange will be responsible for ensuring that issuers adhere to this requirement during initial certification and on an annual basis, as specified in § 155.1020.

In paragraph (a), we propose that a QHP's rates must be applicable for an entire benefit year or, for the SHOP, plan year. We propose this requirement since the Exchange will have an annual open enrollment period during which qualified individuals will be able to change their QHP selection. This requirement would shield consumers from rate increases during the benefit year or, for the SHOP, the plan year. For the SHOP, the timing of the rate changes will vary by employer, since the annual open enrollment periods differ by employer. We discuss this in greater detail in § 156.285.

In paragraph (b), we require the QHP issuer to submit rate and benefit information to the Exchange as described in § 155.1020(c). As noted in § 155.1020(c), to the extent possible, HHS seeks to align the required data elements with information already collected as part of the rate review program and State rate filing processes. This will allow both Exchanges and QHPs to leverage already existing information collections for this purpose.

In paragraph (c), we propose to codify the general requirement that a QHP issuer submit a justification for a rate increase prior to implementation of the rate increase as required by section 1311(e)(2) of the Affordable Care Act. As noted in § 155.1020, Exchanges may leverage the preliminary justification collected as part of the rate review process as described in 45 CFR part 154, and consider the rate justification, as appropriate. We are considering a standard in which the issuers will submit a rate justification in the form and manner determined by the Exchange.

We also propose to codify the rate transparency requirement under section 1311(e)(2) of the Affordable Care Act, which requires that issuers post the rate increase justifications on their Web sites so they can be viewed by consumers, enrollees, and prospective enrollees. To promote consistency in how the rate increase justifications are posted on issuer Web sites, and to assist the consumers in understanding the rate increase justifications, we are considering whether we should develop standards for “prominently posting” rate increase justifications. Again, to avoid duplication of effort, we intend to leverage the rate increase justification provided by QHP issuers as part of the rate review process.

c. Transparency in Coverage (§ 156.220)

In § 156.220(a) and (b), we propose to codify section 1311(e)(3)(A) of the Affordable Care Act, which establishes a transparency standard as a condition for certification of QHPs. To receive and maintain certification, health insurance issuers must make available to the public and submit to the Exchange, the Secretary, and the State insurance commissioner a broad range of information relevant to the plan's quality and cost. The statutorily required disclosures include: (1) Claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under title I of the Affordable Care Act. We clarify that, while the statute refers to “enrollee and participant rights,” we believe our definition of enrollee is inclusive of those who may be considered “participants.” We seek comment on whether issuers should be required to submit this information to ***41898** the Exchange and other entities, or to make such information available to the Exchange and other entities.

Under paragraph (c), we propose to require QHP issuers to provide the information described in paragraph (a) in plain language. Section 1311(e)(3)(B) calls for the Secretary of HHS and the Secretary of Labor to jointly develop and issue guidance on best practices of plain language writing. QHP issuers' use of plain language should be consistent with the definition provided in § 155.20 and the forthcoming guidance.

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In paragraph (d) and pursuant to section 1311(e)(3)(C), we propose that QHP issuers make available to the enrollee information on cost-sharing responsibilities for a specific service by a participating provider under that enrollee's particular plan. The information must be provided upon request from the enrollee in a timely manner through a Web site or through other means for individuals without access to the internet.

d. Marketing of QHPs (§ 156.225)

Section 1311(c)(1)(A) of the Affordable Care Act requires that the Secretary establish marketing requirements for QHP issuers seeking to participate in an Exchange, which we propose in § 156.225.

To ensure that an Exchange's oversight of marketing by QHP issuers is consistent with those standards applied in the non-Exchange market and leverages existing State oversight mechanisms, we propose in paragraph (a) to require QHP issuers to comply with any applicable State laws and regulations regarding marketing by health insurance issuers. Though QHP issuers are not exempt from otherwise applicable State law by participating in the Exchange, we propose to apply compliance with State law as a certification standard to reinforce the coordinated efforts of the Exchange and the State department of insurance and to ensure that the Exchange considers a QHP issuer's marketing practices in determining whether offering a QHP is in the best interest of consumers.

In paragraph (b), we propose to codify section 1311(c)(1)(A), which prohibits QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs. We seek comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs.

We seek comment on also applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents and representatives. Such a requirement would protect consumers from deceptive and misleading marketing practices and allow an Exchange to take action to address such practices if the State's department of insurance or applicable State agency did not have the authority or capacity to do so under applicable law.

We considered setting detailed and uniform Federal standards prohibiting specific marketing practices across all QHP issuers, but were concerned about the interaction with current State marketing rules or unintentionally creating “safe harbors” that might allow issuers to technically comply with specific requirements without meeting the spirit of the broader marketing protections. We permit States and Exchanges to adopt additional requirements for the marketing of health plans that are most appropriate to the unique market dynamics in that State, both inside and outside the Exchange. Any Exchange that chooses to apply additional marketing requirements to QHP issuers should consider working closely with State insurance departments to ensure that all health insurance issuers in the State are subject to the same minimum marketing requirements in order to create a level playing field with equal consumer protections inside and outside the Exchange.

One particular area of concern in regulating marketing practices of health insurance issuers is ensuring that individuals understand the coverage options made available under the Affordable Care Act. For those individuals already covered by Medicare or other third-party coverage, enrollment in a QHP could be duplicative and/or unnecessary. We are particularly concerned that QHPs may be marketed towards certain vulnerable populations, such as Medicare beneficiaries, for whom coverage from a QHP would not be necessary. We seek comment on a standard that QHP issuers do not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP.

e. Network Adequacy Standards (§ 156.230)

In § 156.230, we describe the minimum criteria for network adequacy that health plans must meet to be certified as QHPs, pursuant to section 1311(c)(1)(B) of the Affordable Care Act. We propose in paragraph (a)(1) of this section that QHP issuers must maintain networks for QHPs that include essential community providers in accordance with § 156.235. We propose in paragraph (a)(2) that QHP issuers must maintain networks that comply with any network adequacy standards established by

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the Exchange consistent with § 155.1050. We propose under paragraph (a)(3) that a QHP issuer must ensure that the provider network of its QHPs must be consistent with the provisions of 2702(c) of the PHS Act as amended by the Affordable Care Act, consistent with section 1311(c)(1)(B) of the Affordable Care Act. Section 2702(c) of the PHS Act requires that health insurance issuers furnish coverage to any individual who applies for a group, small group or individual health plan, with exceptions only if the individual resides outside the plan's service area or if the health insurance issuer does not have the capacity to serve the individual because of its existing obligations to enrollees. This allows QHP issuers an exception to the guaranteed issue requirement if their provider network would not be sufficient to serve additional potential enrollees. In such cases, an issuer must apply such an exception uniformly across all employees or individuals without regard to their claims experience or health status. We note that these standards would be applied to all QHP issuers along with any standards established by the Exchange.

As a condition of certification of the QHP, a health insurance issuer must also provide information to potential enrollees on the availability of in-network and out-of-network providers. We propose in paragraph (b) that a QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request. Exchanges will have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange's Web site to the issuer's Web site, or by establishing a consolidated provider directory through which a consumer may search for a provider across QHPs. Under paragraph (b), we also propose that the QHP issuer note providers in the directory that are no longer accepting new patients. We seek comment on standards we might set to ensure that QHP issuers maintain up-to-date provider directories.

f. Essential Community Providers (§ 156.235)

In § 156.235, we propose to codify section 1311(c)(1)(C) of the Affordable Care Act, which requires that a health plan's network include essential community providers who provide care ***41899** to predominantly low-income and medically-underserved populations to be certified as a QHP. As specified in section 1311(c)(1)(C), essential community providers include entities specified under section 340B(a)(4) of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 211 of Public Law 111-8.

We received a number of comments in response to the RFC regarding essential community providers. In general, respondents to the RFC offered recommendations on the types of entities that might be included in the definition of an essential community provider, and essential community provider inclusion in QHP provider networks. We considered these comments in developing the standards related to essential community providers.

In paragraph (a) of this section, we require that QHP issuers include in their provider networks a sufficient number of essential community providers, where available, that serve low-income, medically-underserved individuals. We also propose to codify the provision that nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure. We interpret this to mean that while a QHP issuer must contract with essential community providers, coverage of specific services or procedures performed by an essential community provider is not required.

An important issue with respect to implementing section 1311(c)(1)(C) is establishing a sufficient level of essential community provider participation in QHPs. Although the Affordable Care Act requires inclusion of essential community providers in QHP networks, the Act does not require QHP issuers to contract with or offer contracts to all essential community providers. The statute refers to “those essential community providers, where available,” and “that serve predominantly low-income and medically-underserved,” which suggests a requirement that QHP issuers contract with a subset of essential community providers.

We considered establishing broad contracting requirements where QHP issuers would have to offer a contract to all essential community providers in each QHP's service area, or establishing a requirement for issuers to contract with essential community providers on an any-willing provider basis. Requiring issuers to offer contracts to all essential community providers would allow continuity of service for enrollees with existing relationships especially in communities where the essential community provider has been the only reliable source of care. However, such a requirement may inhibit attempts to use network design

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to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals.

We note that "sufficiency" could be interpreted to mean that the QHP issuer would have to demonstrate to the Exchange that it has a sufficient number and geographic distribution of essential community providers to ensure timely access for low-income, medically underserved individuals in its health plan service area, pursuant to the Exchange's applicable network adequacy and access requirements.

We solicit comment on how to define a sufficient number of essential community providers. We note that States may elect to establish more stringent participation requirements, including adoption of a blanket contracting requirement. Similarly, a potential safe-harbor strategy for QHP issuers would be to offer contracts to all essential community providers or accept any-willing essential community provider in its service area.

We are considering whether to provide separate consideration for integrated delivery network health plans where services are provided solely "in-house." This could include plans where all providers are employees of the plan ("staff model") and plans where the providers are part of an entity that furnishes all of the plan's services on an exclusive basis. We understand that the essential community provider requirements may not be compatible with the operating model of "staff model" plans and exclusive integrated delivery network plans. We seek comment on whether we should create an exemption to the essential community provider requirements for such plans. If such organizations were exempt from the essential community provider requirement, the exemption could be contingent upon the organizations meeting other criteria, such as: evidence of services provided to low-income populations; compliance with national standards for provision of culturally and linguistically appropriate services (CLAS); or implementation of a plan to address health disparities.

In paragraph (b), we specify the types of providers included in the definition of an essential community provider. We include in the definition of essential community providers those providers specifically referenced in statute. In paragraphs (b)(1) and (b)(2) of this section, we define essential community providers to include all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. We continue to look at other types of providers that may be considered essential community providers to ensure that we are not overlooking providers that are critical to the care of the population that is intended to be covered by this provision. We solicit comment on the extent to which the definition should include other similar types of providers that serve predominantly low-income, medically-underserved populations and furnish the same services as the providers referenced in section 340B(a)(4) of the PHS Act.

We acknowledge that two provisions of the Affordable Care Act regarding payment of essential community providers and payment of Federally Qualified Health Centers (FQHCs) may conflict. Section 1311(c)(2) of the Affordable Care Act states that nothing shall be construed to require a QHP to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan. This requirement may conflict with section 1302(g) of the Affordable Care Act, which requires that a QHP issuer reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate. The FQHC Medicaid PPS rates are facility specific rates paid on a per encounter basis, and they may be higher than the rates that a QHP issuer pays to other contracted providers for similar services.

One approach to reconciling these provisions would be to require QHP issuers to pay at least the Medicaid PPS rate to each FQHC that participates in the issuer's QHP network. This approach would enable FQHCs to be paid their Medicaid PPS rates for services provided to QHP enrollees. However, if FQHC Medicaid PPS rates are greater than comparable amounts paid to other providers, and if many of the enrollees in a QHP receive care at FQHCs, the costs of these QHPs may be greater than the costs of QHPs that do not have many enrollees who are seen at the centers. Also, if Medicaid prospective payment rates exceed QHPs' generally applicable payment rates, requiring QHP issuers to pay the full FQHC Medicaid PPS rate could lead insurers to minimally contract with FQHCs.

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We note that there are other practical considerations regarding how issuers would pay the Medicaid PPS rate. For example, it is not clear how QHP issuers would administer the FQHC Medicaid PPS rate, since it is a facility specific rate paid on a per encounter basis for a ***41900** pre-determined set of covered services. Issuers would need to replicate each FQHC's Medicaid PPS rate, which may be complicated since Medicaid covered services vary by State and rates vary by FQHC.

Another potential approach to reconciling these two payment provisions would be to permit issuers to negotiate mutually agreed-upon payment rates with FQHCs, as long as they are at least equal to the issuer's generally applicable payment rates. Such an interpretation may furnish FQHCs with a degree of negotiating leverage with issuers to obtain payment rates higher than the issuer's generally applicable payment rates but not tie issuers to the full Medicaid PPS rate for in-network FQHCs. This approach would decrease the incentive to drive patients away from providers that may be best suited to their needs, while providing FQHCs with leverage to be able to negotiate payments that will allow them to continue providing the comprehensive services that are particularly valuable to the individuals they serve. However, this approach may result in FQHCs receiving less than their Medicaid PPS rates for in-network participation. We invite comment on the issue of FQHC payment and solicit other potential approaches for resolving these potentially conflicting provisions.

We also invite comment on establishing requirements regarding reimbursement of Indian health providers qualifying under 340B(a)(4) of the PHS Act. Section 206 of the Indian Health Care Improvement Act (IHCIA) provides that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. This section also states that no law of any State or provision of any contract shall prevent or hinder this right of recovery. Therefore, this requirement applies whether or not there is a contract between the insurance company and the Indian health provider. We believe that payment requirements under section 206 of IHCIA apply to QHP issuers, as well as to any insurer, employee benefit plan or other third party payer. We invite comment on the payment requirement under section 206 of IHCIA, and how it might be reconciled with the essential community provider payment requirement described in section 1311(c)(2) of the Affordable Care Act.

We also invite comment on other special accommodations that must be made when contracting with Indian health providers. Indian health providers operate under or are governed by numerous federal authorities, including but not limited to the Anti-Deficiency Act, the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, the Federal Tort Claims Act, and the Federal Medical Care Recovery Act. Indian health providers serve a specific population in accordance to these and other federal laws. Some RFC commenters recommended that we consider developing a standard contract addendum containing all conditions that would apply to QHP issuers when contracting with Indian health providers. Such an addendum may be similar to the special Indian Health Addendum currently used in the Medicare Prescription Drug Program, which CMS requires all plans to use when contracting with Indian Health Service, tribal organization, and urban Indian organization (I/T/U) pharmacies and serve as a safe-harbor for all issuers contracting with Indian health providers, which would minimize potential disputes and legal challenges between Indian health providers and issuers. We invite comment on the applicability of these special requirements to QHP issuers, and the potential use of a standardized Indian heath provider contract addendum.

g. Treatment of Direct Primary Care Medical Home (§ 156.245)

In § 156.245, we propose to codify section 1301(a)(3) of the Affordable Care Act, which permits a QHP issuer to provide coverage through a direct primary care medical home that meets the requirements established by HHS, provided that the QHP meets all requirements otherwise applicable. We request comment on what standards HHS should establish under this section.

Commenters to the RFC noted that the direct primary care medical home model in the State of Washington has benefited providers by providing predictable income without added administrative costs, while consumers gain access to an affordable and reliable source of primary services that decreases reliance on emergency rooms as a source of routine care.

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We interpret the phrase “direct primary care medical home plan” to mean an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services, consistent with the program established in Washington. We generally consider primary care services to mean routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury.

We considered allowing an individual to purchase a direct primary care medical home plan and separately acquire wrap-around coverage. However, direct primary care medical homes are providers, not insurance companies, which would require the Exchange to develop an accreditation and certification process that is inherently different from certifying health plans and that would significantly depart from the role of an Exchange. Furthermore, allowing a separate offering would require consumers to make two payments for full medical coverage, adding complexity to the process of acquiring health insurance, ensuring enrollee have access to the full complement of the essential health benefits to which they are entitled, and complicating the allocation of advance payments of the premium tax credit.

h. Health Plan Applications and Notices (§ 156.250)

In § 156.250, we establish basic standards for the format of applications and notices provided by the QHP issuer to the enrollee. QHP issuers will be required to provide enrollees with a variety of applications and notices in accordance with the standards for enrollment and termination of coverage. Since these notices will be provided to all enrollees, it is important to ensure that those enrollees with limited English proficiency (LEP) have access to translated materials and enrollees with disabilities can obtain materials in alternate formats.

We propose that QHP issuers must adhere to the standards established for notices in § 155.230(b). The incorporated standard requires QHP issuers to provide meaningful access to LEP individuals and ensure effective communication for people with disabilities. This may include providing information about the availability and means to obtain oral interpretation services, languages in which written materials are available, and the availability of materials in alternate formats for persons with disabilities.

i. Rating Variation (§ 156.255)

Section 2701(a)(1)(A) of the PHS Act, as revised by section 1201 of the Affordable Care Act, limits the variation in premium rating to four factors: ***41901** Whether the coverage is for an individual or family; rating area; age; and tobacco use. The specific rating rules will be issued through separate regulation, but this section discusses several rate-related provisions for QHPs.

Consistent with the rating rules provision, section 1301(a)(4) of the Affordable Care Act allows QHP issuers to vary premiums by the rating areas established under section 2701(a)(2), which we propose to codify in § 156.255(a). Section 2701(a)(2) of the PHS Act requires that States establish one or more rating areas within a State, subject to the Secretary's approval. Permitting premium variation by geographic rating area enables health insurance issuers to account for regional variation in health care costs. Because section 1302(a)(4) of the Affordable Care Act directly references the rating areas outlined in section 2701(a)(2) of the PHS Act, we interpret that the rating areas will be applied consistently inside and outside of the Exchange.

In paragraph (b), we codify section 1301(a)(1)(C)(iii) of the Affordable Care Act, which specifies that each QHP issuer must offer a QHP at the same premium rate without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent. We interpret this provision to mean that an issuer must charge a premium that uses underlying rating assumptions that account for all expected enrollees of a QHP, including individuals that enroll in the QHP outside of an Exchange, and for all methods of enrollment, including through an Exchange, an agent or broker, or the issuer itself. Thus, the resulting premium for a QHP would vary only by the rating factors listed in 2701(a) of the PHS Act.

We believe that the rating factor related to family size has significant implications for Exchanges. Pursuant to the Secretary's authority to regulate QHPs under section 1311(c)(1), we are considering options on how to structure family rating for QHPs

that are offered in the Exchange. Offering uniform family rating categories will maximize competition between health plans based on price and quality. Our understanding is that issuers currently use multiple rating tiers in the individual market.

In paragraph (c), we propose issuers vary premiums among no more than four different types of family composition that are commonly used among health insurance issuers currently: individual; two adults; adult plus child or children; and a catch-all “family” category for two-adult families with a child or children and other family compositions that do not fit in the other categories. QHP issuers must cover all of these four groups, but in doing so may combine some of the identified categories; for example, a QHP issuer may combine the second and third categories to include both two-adult families and families with one adult plus child or children. We believe that such a rating structure would be beneficial to the market because it would limit premium variation within families of similar types.

We recognize that section 2701(a)(4) of the PHS Act requires that any family premium using age or tobacco rating may only apply those rates to the portion of the premium that is attributable to each family member. As a result, calculating a family premium by determining the age and tobacco rated premium for one member of the family and applying a multiplier to set the rating for the entire family is not permitted. We seek comment on how we might structure family rating categories while adhering to Section 2701(a)(4) of the PHS Act. Additionally, we request comment on how to apply four family categories when performing risk adjustment. We also invite comment on alternatives to four categories for defining family composition. We seek comment on how to balance the number of categories offered by QHP issuers in order to reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market.

We are also considering whether to require QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates. We are considering this approach because of the potential challenge of administering the premium tax credit, particularly for families filing with non-spousal adult dependents. We note that QHP issuers would not be required to cover dependents living outside of the Exchange service area. We recognize that such an approach would add non-spousal adult dependents to the family risk pool, but the impact of this configuration may be offset through risk adjustment. We seek comment on the potential considerations of this approach.

j. Enrollment Periods for Qualified Individuals (§ 156.260)

In § 156.260, we propose that QHP issuers comply with the enrollment periods as a condition of offering a QHP. In paragraph (a), we propose that QHP issuers accept and enroll qualified individuals in QHPs only during the enrollment periods described in § 155.410 and § 155.420.

In paragraph (a)(1), we specify that QHP issuers must accept and enroll qualified individuals during the initial enrollment period, described in § 156.410(b), and during the annual open enrollment period thereafter, described in § 156.410(e). In paragraph (a)(2), we propose that QHP issuers accept and enroll qualified individuals in QHPs if they are granted a special enrollment period described in § 155.420. QHP issuers must also abide by all other State laws that may provide an individual with an enrollment period outside of those described in § 155.410 and § 155.420.

For the initial, annual open, and special enrollment periods, we propose to require QHP issuers to adhere to the effective dates of coverage established in § 155.410(c), § 155.410(f), and § 155.420. We propose that qualified individuals who make QHP selections on or before December 22, 2013 would have a coverage effective date of January 1, 2014 and qualified individuals who make a QHP selection between the twenty-third and last day of the month for any month between December of 2013 and February 2014 would have coverage effective the first day of the month immediately following the next month.

In paragraph (b) we propose to require QHP issuers to provide enrollees with notice of their effective date of coverage, and such notice must correspond with the effective dates established in § 155.410(c), § 155.410(f) and § 155.420(b) as applicable.

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k. Enrollment Process for Qualified Individuals (§ 156.265)

In § 156.265, we propose that QHP issuers must accept and process enrollment of qualified individuals enrolling in a QHPs. In paragraph (a), we propose that QHP issuers must adhere to the Exchange's process for enrollment in QHPs, which includes standards for the collection and transmission of enrollment information. As a general principle, both the Exchange and the QHP issuer must use a common set of enrollment information for an enrollment to be successful.

We propose in paragraph (b)(1) that QHP issuers use the application adopted pursuant to § 155.405 when accepting applications from individuals seeking to enroll in a QHP through the Exchange enrollment process. We interpret section 1413(b)(1)(A), which requires that the Secretary develop and provide to each State a single, streamlined form, together with section 1311(c)(1)(F), which states that an issuer shall use a ***41902** uniform enrollment form for qualified individuals and employers to enroll in QHPs through the Exchange, to require that one single streamlined application developed by HHS with recommendations from the NAIC be used for enrollment in QHPs.

In paragraph (b)(2), we propose that after collecting the uniform enrollment information from an applicant, the QHP issuer must send the information to the Exchange, in accordance with the standards established in § 155.260 and, as applicable, § 155.270. We clarify that the term “applicant” is used here as defined in § 155.20. In paragraph (b)(3), we permit the QHP issuer to enroll the individual in a QHP only after it has received confirmation from the Exchange that the eligibility determination is complete and the applicant is a qualified individual.

We propose in paragraph (c) that QHP issuers receive enrollment information electronically from the Exchange in a format and manner that is consistent with the standards established pursuant to § 155.260 and in § 155.270. We seek comment on the frequency with which plans should receive electronic enrollment information.

In paragraph (d), we propose that QHP issuers abide by the premium payment process established by the Exchange and described in § 155.240.

In paragraph (e), we propose to require QHP issuers provide enrollees in the Exchange with an enrollment packet. We plan to issue standards for the content of the enrollment information package, which may include an enrollment card, information on how to access care, the summary of benefit and coverage document, and information on how to access the provider directory and drug formulary and submit a request for a hard copy. We solicit comment on the appropriateness of these documents and any other documents or information that should be included in an enrollment information package.

In paragraph (f), we propose to require QHP issuers provide the summary of benefits and coverage document to qualified individuals, similar to the requirement in section 2715 of the PHS Act. We note that all health insurance issuers must provide such document on several occasions to potential or current enrollees as required under section 2715 of the PHS Act, for which HHS, the Department of Labor and the Treasury will issue implement regulations in the near future; this requirement is consistent with that PHS Act provision.

In paragraph (g), we propose that QHP issuers reconcile enrollment files with the Exchange no less than once a month, consistent with the proposed standard in § 155.400(d). In paragraph (h), we propose that QHP issuers acknowledge the receipt of enrollment information in accordance with Exchange standards established in § 155.400(b)(2). These provisions will protect consumers from potential gaps in coverage that might occur due to errors in communication.

l. Termination of Coverage for Qualified Individuals (§ 156.270)

A key function of an Exchange, described in § 155.430, will be to verify a QHP issuer's standard operating procedures for the termination of coverage for enrollees enrolled in a QHP through the Exchange. In § 156.270, we propose standards for QHP issuers regarding the termination of coverage of enrollees enrolled in QHPs through the Exchange. We propose in paragraph (a)

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that a QHP issuer may only terminate coverage as permitted by the Exchange in accordance with § 155.430(b), which includes non-payment of premium, fraud and abuse, and relocation outside of the service area, among other situations.

In paragraph (b), we propose that QHP issuers must provide a notice of termination of coverage to the enrollee and the Exchange that is consistent with the standards for effective dates in § 155.430(d). We plan to issue standards for the termination of coverage notice which may include content such as reason for termination and termination effective date. We solicit comment on other information that should be included in the termination notice.

In paragraph (c), we propose that QHP issuers develop a uniform policy as permitted by the Exchange for the termination of coverage due to non-payment of premium in accordance with § 155.430(b)(2)(iii). Section 1412(c)(2)(B)(iv)(II) of the Affordable Care Act requires QHP issuers to provide enrollees receiving advance payments of the premium tax credit with a three-month grace period for non-payment of premium prior to coverage termination, which we propose to codify in paragraph (d). This standard applies only to those enrollees receiving advance payments of the premium tax credit. There is no Federal standard requiring QHP issuers to extend this grace period to enrollees who are not receiving advance payments of the premium tax credit, although the Exchange could choose to require QHP issuers to provide all enrollees with such a grace period, regardless of advance payment status. However, QHP issuers must apply non-payment of premium policies, irrespective of Exchange standards, uniformly to all enrollees in similar circumstances.

In paragraph (d), we propose standards for the application of the three-month grace period for enrollees receiving advance payments of the premium tax credit. We interpret that the three-month grace period only applies to enrollees who have paid at least one month's worth of premiums to establish coverage to ensure that this period applies only when there is a lapse in an enrollee's payment.

During the three-month grace period, we propose that the QHP issuer continue to pay all appropriate claims submitted on behalf of the enrollee. This standard ensures that providers will be reimbursed for care provided to such enrollees during the grace period. In addition, in paragraph (d)(2), we specify how payments received during the grace period would be applied. If an eligible enrollee is more than one month behind on payments, any payment paid to the QHP issuer will be applied to amounts associated with the first billing cycle in which the enrollee was delinquent. The grace period will reset only when the individual has fully paid all outstanding premiums. In paragraph (d)(3), we propose that, during the grace period, the issuer would continue to receive a portion of the premium payment from the advance payments of the premium tax credit from the Department of the Treasury.

In paragraph (e), we propose QHP issuers to provide notice to all enrollees who are delinquent on premium payments. We plan to issue standards for content and timing of the notice. We seek comment on the potential required elements of such a notice, such as the total amount of delinquent payment, possible date of coverage termination and payment options, and the timing and frequency with which such a notice should be provided to enrollees, such as bi-weekly beginning with the first missed payment or more frequently.

In paragraph (f), we propose that if an enrollee receiving advance payments of premium tax credit exhausts the grace period, as provided in paragraph (d), without submitting any premium payment, the QHP issuer may terminate coverage effective at the completion of the three-month period. This termination must be preceded by the appropriate notice as referenced in paragraph (e).

In paragraph (g), we propose to require QHP issuers to maintain records of termination of coverage in accordance with Exchange standards as established in § 155.430(c). In paragraph (h), we propose that QHP issuers abide by the ***41903** effective dates for termination of coverage as described in § 155.430(d).

m. Accreditation of QHP Issuers (§ 156.275)

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In § 156.275, we describe the accreditation standards for QHP issuers. In paragraph (a)(1), we propose to codify the statutory requirement that a QHP issuer be accredited on the basis of local performance in each of the nine categories listed under section 1311(c)(1)(D)(i) of the Affordable Care Act. We clarify that we interpret "local performance" to mean the performance of the QHP issuer in the State in which it is licensed. We note that, although Section 1311(c)(1)(D)(i) of the Affordable Care Act requires a health plan to be accredited in order to be certified as a QHP, we interpret this to mean that QHP issuers must be accredited, since accrediting entities accredit issuers, not plans.

We also further specify that a QHP issuer must be accredited by an entity recognized by HHS. We intend to provide the standards by which HHS will recognize accrediting entities in future rulemaking. Section 1311(c)(1)(D)(i) of the Affordable Care Act requires that QHP issuers be accredited by entities recognized by the Secretary with "transparent and rigorous methodological and scoring criteria." We seek comment on the standards by which HHS should recognize accrediting bodies. We may model this process in part on a similar process used by CMS to identify accrediting organizations for Medicare Advantage plans; this process can be found at 42 CFR 422.157-422.158. We anticipate addressing this issue and identifying recognized accrediting entities as early as possible to give health insurance issuers seeking to participate in the Exchange the time necessary to seek accreditation from appropriate accrediting entities.

In paragraph (a)(2), we propose to require a QHP issuer to authorize the accrediting entity to release certain materials related to the QHP issuer's accreditation (e.g., a copy of its most recent accreditation survey) to the Exchange and to HHS.

In paragraph (b), we propose to codify the requirement that a QHP issuer must obtain its accreditation within a time period established by the Exchange under § 155.1045. Allowing these issuers extra time to meet the standards proposed in this section may encourage a wider variety of health insurance issuers to seek to offer QHPs through the Exchange.

n. Segregation of Funds for Abortion Services (§ 156.280)

Federal funds cannot be used for abortion services (except in the cases of rape or incest, or when the life of the woman would be endangered). The Affordable Care Act is fully consistent with this policy and includes additional provisions to enforce it. Section 156.280 of this proposed rule codifies section 1303 of the Affordable Care Act. This codification includes the non-discrimination clause for providers and facilities, a voluntary choice clause for issuers with respect to abortion services, the standards for the segregation of funds for QHP issuers that elect to cover abortion services for which public funding is prohibited, and the associated communication requirements related to such services. In addition, the Office of Management and Budget and HHS jointly issued "Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act" on September 20, 2010.[FN10] This pre-regulatory guidance furnishes potential standards to meet the segregation requirements of the Affordable Care Act. We are soliciting comment on the model guidelines; we intend that the model guidelines may serve as the basis for the final rule in connection with the provisions included in section 1303 of the Affordable Care Act.

We note that, to maintain consistency with the definitions and terminology used in this part, we have substituted the term "QHP" in the regulation where "plan" is used in the statute and "QHP issuer" in the regulation where "issuer of a qualified health plan" is used in the statute.

o. Additional Standards Specific to the SHOP (§ 156.285)

In § 156.285, we establish requirements for QHP issuers as a condition of participating in the SHOP. In general, QHP issuers must meet the same requirements for the SHOP as the Exchange, along with the additional requirements prescribed in this section.

In paragraph (a), we propose rating and premium payment requirements for QHP issuers in the SHOP. In paragraph (a)(1), we specify that the QHP issuer must accept payment of premiums from the SHOP in accordance with § 155.705(b)(4). We note that this proposed requirement reduces complexity by ensuring the issuer receives all payments from a single source. In paragraph (a)(2), we propose that QHP issuers abide by the rate setting timeline established by the SHOP in § 155.705(b)(5).

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Since the SHOP allows qualified employers to enter the SHOP on a rolling basis, QHP issuers may establish new rates on a quarterly or monthly basis in accordance with SHOP standards. In paragraph (a)(3) we propose that QHP issuers charge the same contract rate for a plan year.

In paragraph (b), we propose requirements for QHP issuers consistent with SHOP enrollment periods. QHP issuers must accept and enroll applicants during the rolling initial enrollment period, the qualified employer's annual employee open enrollment period, and special enrollment periods for a SHOP as established in § 155.725 and in § 155.420 with the exception of (d)(3) and (d)(6). In addition to the enrollment periods, we propose that QHP issuers abide by the effective dates of coverage established in § 155.410(c). We are considering whether to require QHPs in the SHOP to allow employers to offer dependent coverage. We solicit comment on this potential requirement.

In paragraph (c), we propose QHP issuers abide by the SHOP enrollment process requirements and timeline, established pursuant to § 155.720(b). In paragraph (c)(2), we propose that QHP issuers accept electronic transmission of enrollment information frequently from the SHOP in accordance with the requirements pursuant to § 155.260 and § 155.270. In paragraph (c)(3), we propose that QHP issuers provide all new enrollees with the enrollment information package as described in § 156.265(e). In paragraph (c)(4), we proposed to require QHP issuers to provide qualified employers and employees with the summary of cost and coverage document in accordance with the standards described in § 156.265(f).

In paragraph (c)(5), we propose QHP issuers reconcile enrollment files with the SHOP at least monthly. In paragraph (c)(6), we propose that the QHP issuers abide by the SHOP standards for acknowledgement of the receipt of enrollment information. In paragraph (c)(7), we propose that the QHP issuers must issue qualified employees a policy that aligns with the qualified employer's plan year and contract established in paragraph (a)(3). For example, if an employee is hired mid-plan year, the QHP issuer would issue an abbreviated policy for the duration of the employer's plan year so the enrollee will be eligible for an annual open enrollment period at the completion of the qualified employer's plan year.

***41904** In paragraph (d)(1), we propose general standards related to termination of coverage in the SHOP that are largely similar to the standards for the Exchange with respect to their enrollees from the individual market. However, in paragraph (d)(1)(ii), we propose to require the QHP issuer to provide the qualified employers and employees with a notice of termination of coverage of enrollees and QHP non-renewal, as described in § 156.270(a) and § 156.290(b). This will ensure that the qualified employer is aware of the changes in coverage for its employees and the availability of coverage in the SHOP.

In paragraph (d)(2), we propose that a QHP issuer terminate all enrolled qualified employees of the withdrawing employer if the employer chooses to stop participating in the SHOP since the enrollee will no longer be eligible for SHOP coverage.

p. Non-Renewal and Decertification of QHPs (§ 156.290)

In § 156.290(a), we propose requirements on QHP issuers that elect to not seek recertification with the Exchange. In paragraph (a)(1), the QHP issuer must notify the Exchange of its decision prior to the beginning of the recertification process adopted by the Exchange pursuant to § 155.1075. This notification will allow time for the Exchange to determine if it is in the best interest of the qualified individuals and employers to begin modifying the certification process to increase the number of QHPs offered in the Exchange. In paragraph (a)(2), we propose that QHP issuers must continue covering benefits for each enrollee until the completion of the benefit year or plan year for the SHOP. It is critical that enrollees' coverage remain unaffected during the benefit or plan year due to an issuer's decision to withdraw from the Exchange.

In paragraph (a)(3), we propose that a QHP issuer must continue providing the Exchange with reporting information for the benefit or plan year even after withdrawing its QHP from the Exchange. We recognize that a time lag often exists in the collection of data and include this requirement to ensure the Exchange is able to compile a complete set of data records for the QHP.

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In paragraph (a)(4), we propose that a QHP issuer provide notice of the non-renewal to enrollees of the QHP, as described in paragraph (b) of this section. In paragraph (a)(5), we propose that a QHP issuer must terminate coverage for enrollees in accordance with the applicable requirements in § 156.270.

In paragraph (b), we propose to require QHP issuers that elect not to seek recertification to provide a written notice to each enrollee. HHS will issue future guidance on the timing and content of the notice. In developing this notice, we may adopt some of the concepts from the Medicare Advantage non-renewal notice, in which the issuer must provide notice at least 90 days prior to the effective date of non-renewal and include information on the enrollee transition process and alternatives for other coverage through the Exchange. We solicit comment on the potential content of the non-renewal notice and any other information we should consider including.

In paragraph (c), we propose that if an Exchange decertifies a QHP, the QHP issuer must terminate coverage for the QHP enrollees only after the Exchange has notified the QHP's enrollees as described in § 155.1080 and enrollees have had the opportunity to enroll in other coverage. We seek comment on the extent to which enrollees should continue to receive coverage from a decertified plan, even if it is for only a short period of time.

q. Prescription Drug Distribution and Cost Reporting (§ 156.295)

Section 6005 of the Affordable Care Act added section 1150A to the Act, which requires a QHP issuer to provide to HHS information on the distribution of prescription drugs, pharmacy benefit management activities, the collection of rebates and other monies in conducting these activities, and costs incurred to provide those drugs. We propose to codify the requirements contained in section 6005 here in § 156.295.

In paragraph (a), we propose to codify the elements specified in section 1150A(b) of the Act that a QHP issuer must report to HHS in a form and manner to be determined by HHS. Specifically, we propose that the QHP issuer must provide the following information: (1) The percentage of all prescriptions that were provided under the contract through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, that is paid by the QHP issuer or pharmacy benefit manager (PBM) under the contract; (2) the aggregate amount, and the type of rebates, discounts, or price concessions, with certain exceptions, that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed; and (3) the aggregate amount of the difference between the amount the QHP issuer pays the PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed. We anticipate issuing guidance on these reporting requirements. We seek comment on how a QHP issuer whose contracted PBM operates its own mail order pharmacy can meaningfully report on the aggregate difference between what the QHP issuer pays the PBM and the PBM pays the mail order pharmacy.

We clarify that, for the purposes of this section, we interpret "generic drug" to have meaning given to the term in 42 CFR 423.4, which is used in the Medicare Prescription Drug Benefit Program. We seek comment on potential definitions for "rebates," "discounts" and "price concessions"; we are considering using the term "direct and indirect remuneration," a term used in regulations related to the Medicare Prescription Drug Benefit Program, to encompass these various arrangements.

The statute refers to PBMs, entities with which health insurance issuers often contract to perform activities such as prescription drug claims processing, negotiation with prescription drug manufacturers, the development and maintenance of pharmacy networks, or the distribution of prescription drugs on behalf of the health insurance issuer. We interpret the statutory references to PBMs to include any entity that performs such activities on behalf of a QHP issuer; we seek comment on this interpretation and whether we should define PBMs as such in this section. We seek comment on how to minimize the burden of these reporting requirements.

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In paragraph (c) we propose to codify the confidentiality requirements to ensure that this information is not disclosed by either HHS or the QHP issuer except under specific circumstances described in the Affordable Care Act. The exceptions allow HHS to de-identify and aggregate prescription drug pricing, rebate and distribution information to report it to the Comptroller General or the Congressional Budget Office.

Finally, we propose under paragraph (c) to codify the penalties for noncompliance. Specifically, a QHP issuer that does not provide HHS the information required under paragraph (b) or knowingly provides false information would be subject to the provisions of subsection (b)(3)(C) of section 1927 of the Act. Under this subsection, if the information is not ***41905** provided at all, the QHP issuer would be subject to a fine that would increase $10,000 each day that the information is not provided. If the information is not reported within 90 days of the set deadline, the QHP issuer would lose its contract with the Exchange. If the QHP issuer provides false information, it would be subject to a fine not to exceed $100,000 for each piece of false information provided.

III. Collection of Information Requirements

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

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Below is a partial summary of the proposed information collection requirements outlined in this regulation. Any information collection requirements in this regulation which are not outlined below will be subject to a separate notice and comment process under the Paperwork Reduction Act. We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding General Standards Related to the Establishment of an Exchange (§ 155.105 and § 155.110)

Within Part 155, subpart B of this proposed rule, we describe reporting requirements for a State to receive approval of its Exchange Plan by January 1, 2013. For purposes of presenting an estimate of paperwork burden in Part 155, we reflect full participation of all States and the District of Columbia in operating an Exchange. However, we recognize that not all States will elect to operate their own Exchanges, so these estimates should be considered an upper bound of burden estimates. These estimates may be adjusted proportionally in the final rule based upon additional information as States progress in their Exchange development processes.

As discussed in § 155.105, States are required to submit an Exchange plan to HHS. As noted above, we plan to issue a template outlining the required components of the Exchange Plan, subject to the notice and comment process under the Paperwork Reduction Act. We estimate that it will take a State approximately 160 hours (approximately one month) for the time and effort needed to develop the plan and submit to HHS. We estimate minimal burden requirements for developing the Exchange plan as States will be gathering most of the information needed for the plan through the planning grants provided by HHS. States are also required to make the governance principles available to the public. We estimate that it will take States 40 hours for the time

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and effort to develop these principles and disclose this information to the public. This estimate is similar to estimates provided for reporting requirements for Medicare Part D as described in § 423.514.

We estimate that all 50 States and the District of Columbia will establish an Exchange and will be subject to meeting these requirements. Again, this estimate should be considered an upper bound, and we may revise these estimates in the final rule based upon additional information as States progress in their Exchange development processes. We estimate that it will take 200 hours for a State to meet these provisions. The total burden for all States and the District of Columbia is 10,200 hours. For the purposes of this estimate, we assume that meeting these requirements will take a health policy analyst 120 hours (at an average wage rate of $43 an hour) and a senior manager 80 hours (at $77 an hour). The wage rate estimates include a 35% fringe benefit estimate for state employees, which is based on the March 2011 Employer Costs for Employee Compensation report by U.S Bureau of Labor Statistics. This fringe benefit estimate will be used throughout this section for all presumed state personnel. The estimated cost burden for each State is $11,320 with a total estimated burden of $577,320.

As described in § 155.105, States must also notify CMS of any changes to its Exchange proposal. We estimate that 5 States submit changes and that it will take each state 12 hours to develop the notification and submit to CMS for a total burden of 60 hours. We presume that it will take a health policy analyst 12 hours (at $43 an hour) to meet this requirement. The estimated burden cost per State is $516 for a total cost burden estimate of $2,580 for five States.

B. ICRs Regarding General Functions of an Exchange (§ 155.205)

In Part 155, subpart C we describe the information and reporting requirements that Exchanges are required to perform. According to provisions spelled out in this subpart, Exchanges are required to collect and populate the Web site they develop with information on qualified health plans, premium and cost-sharing information, benefits and coverage of qualified health plans, levels of plan coverage, medical loss ratio information, transparency of coverage, and a provider directory.

The burden estimate related to the Web site reflects the time and effort needed to collect the information described above and disclose this information on a Web site; however, we understand that overall administrative burden and costs will be higher for Web site development and testing. These costs are reflected in the impact analysis for Exchanges. Assuming that all States and the District of Columbia establish Exchanges, an upper bound estimate, we estimate that it will take 320 hours (approximately 2 months) for each State to meet this requirement for a total estimate of 16,320 hours. We presume that it will take a health policy analyst 40 hours (at $43 an hour), a financial analyst 90 hours (at $62 an hour), a senior manager 50 hours (at $77 an hour), and various network/computer administrators or programmers 140 hours (at $54 an hour) to meet the reporting requirements for this subpart. We estimate the total cost burden for an Exchange to be $18,710 for a total estimated burden of $954,210 for all 50 States and the District of Columbia.

C. ICRs Regarding Exchange Functions: Enrollment in Qualified Health Plans (§ 155.400-§ 155.430)

Within Part 155 subpart E of this proposed rule, we describe the requirements of Exchanges in the enrollment of qualified individuals and disenrollment. As discussed in § 155.400, Exchanges are required to maintain records of enrollment annually. We estimate that this will take an exchange 52 hours annually to maintain these records. This estimate is similar to Medicare Part D, where is was estimated that it will take 52 hours on an annual basis for plan sponsors to maintain books, records, and documents on accounting procedures and practices as described in § 423.505. Estimates related specifically to the maintenance of records for enrollment were not provided in Medicare Part D.

***41906** Exchanges are also required to submit enrollment information to HHS on a monthly basis, and reconcile enrollment information on at least a monthly basis. We estimate that it will take an Exchange 12 hours submit this information and 12 hours to reconcile this information on a monthly basis. Exchanges are also required submit the number of coverage terminations to HHS. We estimated that it will take 12 hours for an Exchange to submit this information. These estimates are similar to estimates provided in Medicare Part D rule for data submission. For example, Medicare Part D estimated that it would take plan sponsors approximately 10 hours annually for plan sponsors to submit data on aggregated negotiated drug pricing from

pharmaceutical companies described in § 423.104. We provide a slightly higher estimate for the submission of data due to the complexity of the Exchange program.

Exchanges are also required to provide a notice of eligibility to the applicant and a notice of the annual open enrollment period to the applicant. Estimates related to notices in this subpart and throughout the proposed rule for Exchanges take into account the time and effort needed to develop the notice and make it an automated process to be sent out when appropriate. As such, we estimate that it will take approximately 16 hours annually for the time and effort to develop and submit a notice when appropriate. Again, this estimate is slightly higher than the 8 hours estimated for notices discussed in the Medicare Part D rule and reflects the overall complexity of the Exchange program.

States are required to maintain records of termination coverage. Again, we estimate that this will take an exchange 52 hours annually to maintain these records. We estimate that all 50 States and the District of Columbia will establish an Exchange subject to these reporting requirements. This estimate is an upper bound of burden as a result of the reporting requirements in this subpart; we will revise these estimates in the final rule as States progress in their Exchange development. We estimate that it will take 436 hours for an Exchange to meet these reporting requirements for a total of 22,236 hours. We presume that it will take an operations analyst 224 hours (at $55 an hour), a health policy analyst 119 hours (at $43 an hour), and a senior manager 93 hours (at $77 an hour) to meet the reporting requirements for a burden cost estimate of $24,598 for an Exchange and total estimated burden costs of $1,254,498 for all 50 States and the District of Columbia.

D. ICRs Regarding Exchange Functions: Small Business Health Options Program (SHOP) (§ 155.715-§ 155.725)

Part 155, subpart H of this proposed rule describes reporting requirements for SHOP. As described in § 155.715 through § 155.725, the SHOP is required to provide the following notices:

• Notice to employer of reason to doubt information submitted;

• Notice to employer of non-resolution for reason to doubt;

• Notice to individual of inability to substantiate employee status;

• Notice of employer eligibility;

• Notice of employee eligibility;

• Notice of employer withdrawal from SHOP;

• Notification of effective date to employees;

• Notice of employee termination of coverage to employer;

• Notice of annual employer election period; and

• Notice to employee of open enrollment period.

As discussed previously, we estimate that it will take 16 hours annually for a SHOP to provide each notice as described in this subpart. The SHOP is also required to maintain records for SHOP enrollment and reconcile SHOP enrollment files on a monthly basis. Again, we estimate that this will take 52 hours annually for a SHOP to maintain SHOP enrollment records. This estimate is similar to Medicare Part D, where it was estimated that it will take 52 hours on an annual basis for plan sponsors to maintain books, records, and documents on accounting procedures and practices as described in § 423.505. Estimates related

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specifically to the maintenance of records for enrollment were not provided in Medicare Part D. We also estimate that it will take 12 hours for a SHOP to reconcile this information on a monthly basis.

We estimate that that all 50 States and the District of Columbia will establish a SHOP subject to meeting these reporting requirements. This estimate is an upper bound of burden as a result of the reporting requirements in this subpart; we will revise these estimates in the final rule as States progress in their Exchange development. We estimate that it will take each SHOP 356 hours to meet these requirements for a total of 18,156 hours. We presume that it will a health policy analyst 132 hours (at $43 an hour), a senior manager 80 hours (at $77 an hour), and an operations analyst 144 hours (at $55 an hour) to meet these reporting requirements for an estimated cost burden of $19,756 for each Exchange. The total estimated cost burden is $1,007,556 for all 50 States and the District of Columbia.

E. ICRs Regarding Exchange Functions: Certification of Qualified Health Plans (§ 155.1020, § 155.1040, and § 155.1080)

Within Part 155, subpart K, we describe data collection and reporting requirements for Exchanges related to the certification of qualified health plans. As described in § 155.1020, § 155.1040, and § 155.1080, Exchanges are required to collect qualified health plan issuer reports on covered benefits, rates, and cost-sharing requirements. We estimate that it will take 12 hours for an Exchange to collect this information from issuers annually. This estimate is similar to estimates for data collection described in the Medicare Part D rule. Exchanges are also required to collect information on coverage transparency from issuers. Again, we estimate that it will take 12 hours for an Exchange to collect this information. Finally, Exchanges are required to provide a notice of the decertification, if applicable, of a QHP to the QHP issuer, Exchange enrollees, HHS, and the State insurance department. This burden was estimated at 16 hours for an Exchange to provide notice.

For this burden exercise, we estimate that all 50 States and the District of Columbia will establish an Exchange subject to these reporting requirements, an upper bound estimate. We further estimate that it will take 40 hours for an Exchange to meet the provisions discussed, with a total burden estimate of 2,040 hours for all 50 States and the District of Columbia. We presume that it will take an operations analyst 32 hours (at $55 an hour) and a senior manager 8 hours (at $77 an hour) to carry out the requirements in this subpart. HHS estimates that the cost burden for an Exchange to meet the reporting requirements in subpart K to be $2,376 with a total cost burden estimate of $121,176 for all 50 States and the District of Columbia.

F. ICRs Regarding Qualified Health Plan Minimum Certification Standards (§ 156.210-§ 156.290)

Part 156, subpart C describes reporting requirements for issuers. Each qualified health plan issuer is required to report annually to the Exchange information on benefits and rates, justification of rate increases, coverage transparency, and a summary of cost and coverage documents, including notice of coverage of abortion provided by a QHP plan. Issuers are also required to make available enrollee cost sharing information, provide information to applicants and enrollees, provide enrollment packages, collect enrollment information and submit this information ***41907** to the Exchange, reconcile enrollment files on a monthly basis, and maintain records related to termination of coverage. There are also several notices that issuers must provide to enrollees related to the effective date of coverage, non-renewal of coverage, termination of coverage, and payment delinquency; and to the Exchange for non-renewal of recertification.

As described in § 156.285, for the SHOP program, issuers must provide an enrollment package to SHOP enrollees and a summary of benefits and coverage to employers and employees; reconcile enrollment files for SHOP on a monthly basis; and provide notice to SHOP enrollees of termination of coverage. As discussed previously, estimates related the collection and submission of data; maintenance of records, notices are similar to estimates provided in the Medicare Part D rule.

Qualified health plan issuers must also submit to the Exchange and HHS on an annual basis information on drug distribution and costs. We estimate that it will take an issuer 24 hours to submit this data. This estimate is a slight increase from the Medicare Advantage estimate of 15 hours for submitting data for drug claims as described for § 423.329 for Medicare Part D and reflects the complexity of reporting this data for the Exchange program.

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For the purpose of this estimate and whenever we refer to burden requirements for issuers, we utilize estimates of the number of issuers provided by the Healthcare.gov Web site as this site provides the best estimate of possible issuers at this time. Based on preliminary findings there are approximately 1827 issuers in the individual and small group markets. While we recognize that not all issuers will offer QHPs, we use the estimate of 1827 issuers as the upper bound of participation and burden.

We estimate that it will take an issuer 588 hours to meet these reporting requirements for a total burden estimate of 1,074,276 hours for all 1827 issuers. We presume that it will take at least two health policy analysts 80 hours (at an average private industry rate of $50 an hour), a financial analyst 124 hours (at $57 an hour), an operations analyst 352 hours (at $51 an hour), and a senior manager 32 hours (at $72 an hour) to meet these reporting requirements. These wage estimates include a 30% fringe benefit rate for the private sector as reported by the U.S. Bureau of Labor Statistics in the March 2011 Employer Costs for Employee Compensation report. The estimated burden cost for each issuer is $31,324. The total estimated burden cost for all issuers is $57.2 million.

Regulation section(s)	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Labor cost of reporting ($)	Total labor cost of reporting ($)
Part II						
155.105-155.110	51	1	200	10,200	11,320	577,320
155.105	5	1	12	60	516	2,580
155.205	51	1	320	16,320	18,710	954,210
155.400-155.430	51	1	436	22,236	24,598	1,254,498
155.715-155.725	51	1	356	18,156	19,756	1,007,556
		Exception: Monthly for SHOP enrollment reconciliation				
155.1020-155.1080	51	1	40	2,040	2,376	121,176
156.210-156.290	1827	1	588	1,074,276	31,324	57.2 million

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Exception:

monthly for enrollment
and SHOP enrollment
reconciliation

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

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

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, [CMS-9989-P],

Fax: (202) 395-5806; or

E-mail: OIRA—submission@omb.eop.gov.

IV. Summary of Preliminary Regulatory Impact Analysis

The summary analysis of benefits and costs included in this proposed rule is drawn from the detailed Preliminary Regulatory Impact Analysis, available at http://cciio.cms.gov under "Regulations and Guidance." That preliminary impact analysis evaluates the impacts of this proposed rule and a second proposed rule, "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The second proposed rule is published elsewhere in this Federal Register. The following summary focuses on the benefits and costs of this proposed rule.

A. Introduction

HHS has examined the impacts of the proposed rule under Executive Orders 12866 and 13563, the Regulatory Flexibility Act (5 U.S.C. 601-612), and the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4). Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits (both quantitative and qualitative) of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of ***41908** reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an "economically" significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Using the Small Business Administration (SBA) definitions of small entities for agents and brokers, providers, and employers, HHS tentatively concludes that a significant number of firms affected by this proposed rule are not small businesses.

Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before proposing "any rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year." The current threshold after adjustment for inflation is approximately $136 million, using the most current (2011) Implicit Price Deflator for the Gross Domestic Product. HHS does not expect this proposed rule to result in one-year expenditures that would meet or exceed this amount.

B. Need for This Regulation

This proposed rule would implement standards for States related to the Establishment of Exchanges and Qualified Health Plans consistent with the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small business the same purchasing power as large businesses.

C. Summary of Costs and Benefits of the Proposed Requirements

Two proposed regulations are being published simultaneously to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. The detailed PRIA, available at http://cciio.cms.gov under "Regulations and Guidance," evaluates the impacts of both proposed rules, while this summary focuses on the benefits and costs of the proposed requirements in this Exchange NPRM.

Benefits in response to the proposed regulation:

Research has consistently noted that health insurance coverage improves health outcomes. For example, individuals without health insurance are significantly more likely to be at risk of mortality.[FN11] Secondly, lack of health insurance significantly increases financial risk for individuals. Thirdly, increases in health insurance results in a decrease in uncompensated care costs. This proposed regulation is expected to decrease the level of uninsurance and therefore should produce a benefit in the form of improved health outcomes, decreased fiscal risk, and decrease in uncompensated care costs. In addition, we estimate that for individuals and some employers, risk pooling and economies of scale will reduce the administrative cost of health insurance, and competition may increase insurers' incentive to lower payments to health care providers, reducing premiums and potentially national health expenditures.

The Exchanges and policies associated with them, according to CBO, are expected to reduce premiums for the same benefits compared to prior law. It estimated that, in 2016, people purchasing non-group coverage through the Exchanges would pay 7 to 10 percent less due to the healthier risk pool that results from the coverage expansion. An additional 7 to 10 percent in savings would result from gains in economies of scale in purchasing insurance and lower administrative costs from elimination of underwriting, decreased marketing costs, and the Exchanges' simpler system for finding and enrolling individuals in health insurance plans.[FN12]

Costs in Response to the Proposed Regulation

Meeting the proposed requirements will have costs on Exchanges and on issuers of qualified health plans (QHPs). The administrative costs of operating an Exchange will almost certainly vary by the number of enrollees in the Exchange due to economies of scale, variation in the scope of the Exchange's activities, and variation in average premium in the Exchange service area. However, we believe major cost components for Exchanges will include: IT infrastructure, Navigators, notifications, enrollment standards, application process, SHOP, certification of QHPs, and quality reporting. The major costs on issuers of QHPs will include: Accreditation, network adequacy standards, and quality improvement strategy reporting. CBO estimates that the administrative costs to QHP issuers would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, prohibit "riders," and end under-writing.

Methods of Analysis

This preliminary impact analysis references the estimates of the CMS Office of the Actuary (OACT) (CMS, April 22, 2010), but primarily uses the underlying assumptions and analysis done by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation. Their modeling effort accounts for all of the interactions among the interlocking pieces of the Affordable Care Act including its tax policies, and estimates premium effects that are important to assessing the benefits of the NPRM. A description of CBO's methods used to estimate budget and enrollment impacts is available.[FN13] The CBO estimates are not significantly different than the comparable components produced by OACT. Based on our review, we expect that the

requirements in these NPRMs will not substantially alter CBO's estimates of the budget impact of Exchanges or enrollment. The proposed requirements are well within the parameters used in the CBO modeling of the Affordable Care Act and do not diverge from assumptions embedded in the CBO model. Our review and analysis of the proposed requirements indicate that the impacts are within the model's margin of error.

Summary of Costs and Benefits

CBO estimated program payments and receipts for outlays related to grants for Exchange startup. States' initial costs to the creation of Exchanges will be funded by these grants.

Table 1—Estimated Outlays for the Affordable Insurance Exchanges FY 2012-FY 2016

[In billions of dollars]

Year	2012	2013	2014	2015	2016
Grant Authority for Exchange Start up	0.6	0.8	0.4	0.2	0.0

***41909 Regulatory Options Considered**

In addition to a baseline, HHS has identified two regulatory options for this proposed rule as required by Executive Order 12866.

(1) Have a uniform Standard for Operations of an Exchange.

Under this alternative HHS would require a single standard for State operations of Exchanges. The proposed regulation offers States the choice of whether to establish an Exchange, how to structure governance of the Exchange, whether to join with other States to form a regional Exchange, and how much education and outreach to engage in, among other factors. This alternative model would restrict State flexibility to some extent, requiring a more uniform standard that States must enact in order to achieve approval of an Exchange.

(2) Uniform Standard for Health Insurance Coverage.

Under this alternative, there would be a single uniform standard for certifying QHPs. QHPs would need to meet a single standard in terms of benefit packages, network adequacy, premiums, etc. HHS would set these standards in advance of the certification process and QHPs would either meet those standards and thereby be certified or would fail to meet those standards and therefore would not be available to enrollees.

Summary of Costs for Each Option

HHS notes that Option 1, which promotes uniformity, could produce a benefit of reduced Federal oversight cost; however this option would reduce innovation and therefore limit diffusion of successful policies and furthermore interfere with Exchange functions and needs. HHS also notes that while Option 2 could produce administrative burdens on Exchanges, this approach could reduce Exchanges' and QHP issuers' ability to innovate. These costs and benefits are discussed more fully in the detailed PRIA.

D. Accounting Statement

For full documentation and discussion of these estimated costs and benefits, see the detailed PRIA, available at http://cciio.cms.gov under “Regulations and Guidance.”

Category	Primary estimate	Year dollar	Units discount rate	Period covered
Benefits (03)				
Annualized Monetized ($millions/ year)	Not estimated	2011	7%	2012-2016
	Not estimated	2011	3%	2012-2016
Qualitative (03)The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including earlier treatment and improved morbidity, fewer bankruptcies and decreased use of uncompensated care. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience.				
Costs (03)				
Annualized Monetized ($millions/ year)	424	2011	7%	2012-2016
	410	2011	3%	2012-2016
Qualitative (03)These costs include grant outlays to States to establish Exchanges.				

V. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this proposed rule is necessary to implement standards related to the Establishment of Exchanges and Qualified Health Plans as authorized by the Affordable Care Act. For purposes of the Regulatory Flexibility Analysis, we expect the following types of entities to be affected by this proposed rule: (1) QHP issuers; (2) agents and brokers; and (3) employers. We believe that health insurers and agents and brokers would be classified under the North American Industry Classification System (NAICS) Codes 524114 (Direct Health and Medical Insurance Carriers) and 524210 (Insurance Agencies and Brokers). According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities

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for both of these NAICS codes. Health issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $10 million or less.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact ***41910** Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the SBA (currently $7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).[FN1]

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

As discussed earlier in this summary of the PRIA, the Department is seeking comments on the potential impacts of the requirements in this proposed regulation on issuers' administrative costs. The Department is also seeking comments relating to potential impacts on small issuers.

This rule proposes Exchange standards related to offering the QHPs. These standards and the associated certification process will impose costs on issuers, but these costs will vary depending on a number of factors, including the operating model chosen by the Exchange, their current accreditation status, and the variation between the proposed standards and current practice. Some QHP issuers will be more prepared to meet the standards than others and will incur fewer costs. For example, if data reporting functions required for certification already exist at the QHP issuer, there would be no additional cost. Exchanges also have the flexibility in some cases to set requirements. For example, the rule proposes discretion for Exchanges in setting network adequacy standards for participating health insurance issuers. The cost to the issuer will depend on whether the Exchange determines that compliance with relevant State law and licensure requirements is sufficient for a QHP issuer to participate in the Exchange or whether they decide to set additional standards in accordance with current provider market characteristics and consumer needs.

The cost of participating in an Exchange is an investment for QHP issuers, with benefits expected to accrue to QHP issuers. The Exchange will function as an important distribution channel for QHPs. QHP issuers currently fund their own sales and marketing efforts. As a centralized outlet to attract and enroll consumers, the Exchanges will supplement and reduce incremental health plan sales and marketing costs with their consumer assistance, education and outreach functions.

We anticipate that the agent and broker industry, which is comprised of large brokerage organizations, small groups, and independent agents, will play a critical role in enrolling qualified individuals in QHPs. We are proposing to codify Section 1312(e) of the Affordable Care Act, which gives States the option to permit agents or brokers to assist individuals enrolling in QHPs through the Exchange. Agents and brokers must meet any condition imposed by the State and, as a result, could incur costs. In addition, agents and brokers who become Navigators will also agree to comply with associated requirements and are likely to incur some costs. Because the States and the Exchanges will make these determinations, we cannot provide an estimate of the potential number of small entities that will be affected or the costs associated with these decisions.

This rule proposes requirements on employers that choose to participate in a SHOP. As discussed above, the SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would

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meet the SBA Standard for Small entities. We do not believe that the proposed regulation imposes requirements on employers offering health insurance through SHOP that are more restrictive than the current requirements on employers offering employer sponsored health insurance. For this reason, we also believe the processes that we have proposed constitute the minimum amount of requirements necessary to implement statutory mandates and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to lessen the compliance burden. We also expect that for some employers, risk pooling and economies of scale will reduce the administrative cost of offering coverage through the SHOP and that they will, therefore, benefit from participation.

We request comment on whether the small entities affected by this rule have been fully identified. We also request comment and information on potential costs for these entities and on any alternatives that we should consider.

VI. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing proposed rule (and subsequent final rule) that includes any Federal mandate that may result in expenditures in any one year by a State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. Because States are not required to set up an Exchange, and because grants are available for funding of the establishment of an Exchange by a State, we anticipate that this proposed rule would not impose costs above that $136 million UMRA threshold on State, local, or tribal governments.

VII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, pre-empts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to certify an Exchange. For States electing to create an Exchange, much of the initial costs to the creation of Exchanges will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In the Department's view, while this proposed rule does not impose substantial direct requirement costs on State and local governments, this ***41911** proposed regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance coverage (i.e., for QHPs) that is offered in the individual and small group markets. Each State electing to establish an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this proposed rule, or have in effect a State law or regulation that implements these Federal standards. However, the Department anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require States to certify an Exchange; if a State elects not to establish an Exchange or the State's Exchange is not approved, HHS, either directly or through agreement with a non-profit entity, must establish and operate an Exchange in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, the Department has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

Throughout the process of developing this NPRM, the Department has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is the Department's view that we have complied with the requirements of Executive Order 13132.

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Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached proposed regulation in a meaningful and timely manner.

List of Subjects

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR subtitle A, subchapter B, as set forth below:

SUBTITLE A—DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B—REQUIREMENTS RELATING TO HEALTH CARE ACCESS

1. Part 155 is added as follows:

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

Subpart A—General Provisions

Sec.

155.10 Basis and scope.

155.20 Definitions.

Subpart B—General Standards Related to the Establishment of an Exchange by a State

155.100 Establishment of a State Exchange.

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155.110 Entities eligible to carry out Exchange functions.

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155.400 Enrollment of qualified individuals into QHPs.

155.405 Single streamlined application.

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155.430 Termination of coverage.

155.440 [Reserved]

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

155.700 Standards for the establishment of a SHOP.

155.705 Functions of a SHOP.

155.710 Eligibility standards for SHOP.

155.715 Eligibility determination process for SHOP.

155.720 Enrollment of employees into QHPs under SHOP.

155.725 Enrollment periods under SHOP.

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Subpart K—Exchange Functions: Certification of Qualified Health Plans

155.1000 Certification standards for QHPs.

155.1010 Certification process for QHPs.

155.1020 QHP issuer rate and benefit information.

155.1040 Transparency in coverage.

155.1045 Accreditation timeline.

155.1050 Establishment of Exchange network adequacy standards.

155.1055 Service area of a QHP.

155.1065 Stand-alone dental plans.

155.1075 Recertification of QHPs.

155.1080 Decertification of QHPs.
Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1341, 1342, 1343, 1402, 1411, 1412-1413.

Subpart A—General Provisions
45 CFR § 155.10

§ 155.10 Basis and scope.
(a) Basis. This part is based on the following sections of title I of the Affordable Care Act:

1301. Qualified health plan defined.

1302. Essential health benefits requirements

1303. Special rules

1304. Related definitions

1311. Affordable choices of health benefit plans.

1312. Consumer choice.

***41912** 1313. Financial integrity.

1321. State flexibility in operation and enforcement of Exchanges and related requirements.

1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

1334. Multi-State plans.

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1342. Establishment of risk corridors for plans in individual and small group markets.

1343. Risk adjustment.

1402. Reduced cost-sharing for individuals enrolling in QHPs.

1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.
(b) Scope. This part establishes minimum standards for the establishment of an Exchange, minimum Exchange functions, eligibility determinations, enrollment periods, minimum SHOP functions, certification of QHPs, and health plan quality improvement.
45 CFR § 155.20

§ 155.20 Definitions.
The following definitions apply to this part:

Advance payments of the premium tax credit means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual of a QHP through an Exchange pursuant to sections 1402 and 1412 of the Affordable Care Act.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer.

Annual open enrollment period means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange.

Applicant means:

(1) An individual who is seeking eligibility through an application to the Exchange for at least one of the following:

(i) Enrollment in a QHP through the Exchange;

(ii) Advance payments of the premium tax credit and cost-sharing reductions; or

(iii) Medicaid, CHIP, and the BHP, if applicable.

(2) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

Benefit year means a calendar year for which a health plan provides coverage for health benefits.

Code means the Internal Revenue Code of 1986.

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Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian who is enrolled in a QHP in the Exchange.

Eligible employer-sponsored plan means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(1) A governmental plan (within the meaning of section 2791(d)(8) of the PHS Act); or

(2) Any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan offered in the group market.

Employee has the meaning given to the term in section 2791 of the PHS Act.

Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term must include employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code must be treated as one employer.

Employer contributions means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee means a qualified individual or qualified employee enrolled in a QHP.

Exchange means a governmental agency or non-profit entity that meets the applicable requirements of this part and makes QHPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the requirements specified in subpart B of this part.

Grandfathered health plan means coverage provided by a group health plan, or a health insurance issuer as provided in accordance with requirements under § 147.140.

Group health plan has the meaning given to the term in § 144.103.

Health insurance coverage has the meaning given to the term in § 144.103.

Health insurance issuer or issuer has the meaning given to the term in § 144.103.

Health plan means health insurance coverage and a group health plan. It does not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

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Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

Initial enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define large employer by substituting “51 employees” for “101 employees.”

Lawfully present has the meaning given the term in § 152.2 of this subtitle.

Minimum essential coverage has the meaning given in section 5000A(f) of the Code.

Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the requirements described in § 155.210.

Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing.

Plan year means a consecutive 12 month period during which a health plan provides coverage for health ***41913** benefits. A plan year may be a calendar year or otherwise.

Qualified employee means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term “qualified employer” shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered pursuant to the process described in subpart K of part 155.

Qualified health plan issuer or QHP issuer means a health insurance issuer that offers, pursuant to a certification from an Exchange, a QHP.

Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll in a QHP in the individual market offered through the Exchange.

SHOP means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting “50 employees” for “100 employees.”

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Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer (as defined in this section).

Special enrollment period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

State means each of the 50 States and the District of Columbia.

Subpart B—General Standards Related to the Establishment of an Exchange by a State
45 CFR § 155.100

§ 155.100 Establishment of a State Exchange.
(a) General requirements. Each State may elect to establish an Exchange that facilitates the purchase of health insurance coverage in QHPs and provides for the establishment of a SHOP.

(b) Eligible Exchange entities. The Exchange must be a governmental agency or non-profit entity established by a State, consistent with § 155.110.
45 CFR § 155.105

§ 155.105 Approval of a State Exchange.
(a) State Exchange approval requirement. Each State Exchange must be approved by HHS by no later than January 1, 2013 in order to begin offering QHPs on January 1, 2014.

(b) State Exchange approval standards. HHS will approve the operation of an Exchange established by a State provided that it meets the following standards:

(1) The Exchange is able to carry out the required functions of an Exchange consistent with subparts C, E, H, and K of this part;

(2) The Exchange is capable of carrying out the information requirements pursuant to section 36B of the Code;

(3) The State agrees to perform the responsibilities related to the operation of a reinsurance program pursuant to standards set forth in part 153 of this chapter; and

(4) The entire geographic area of the State is covered by one or more State Exchanges.

(c) State Exchange approval process. In order to have its Exchange approved, a State must:

(1) Elect to establish an Exchange by submitting, in a form and manner specified by HHS, an Exchange Plan that sets forth how the Exchange meets the standards outlined in paragraph (b) of this section; and

(2) Demonstrate operational readiness to execute its Exchange Plan through a readiness assessment conducted by HHS.

(d) State Exchange approval. Each Exchange must receive written approval or conditional approval of its Exchange Plan and its performance under the operational readiness assessment consistent with paragraph (c) of this section in order to be considered an approved Exchange.

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(e) Significant changes to Exchange Plan. The State must notify HHS in writing before making a significant change to its Exchange Plan; no significant change to an Exchange Plan may be effective until it is approved by HHS in writing.

(f) HHS operation of an Exchange. If a State is not an electing State under § 155.100(a) or an electing State does not have an approved or conditionally approved Exchange by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State. In the case of a Federally-facilitated Exchange, the requirements in § 155.130 and subparts C, E, H, and K of this part will apply.
45 CFR § 155.106

§ 155.106 Election to operate an Exchange after 2014.
(a) Election to operate an Exchange after 2014. A State electing to seek initial approval of its Exchange later than January 1, 2013 must:

(1) Comply with the State Exchange approval requirements and process set forth in § 155.105;

(2) Have in effect an approved, or conditionally approved, Exchange Plan and operational readiness assessment at least 12 months prior to the Exchange's first effective date of coverage; and

(3) Develop a plan jointly with HHS to facilitate the transition from a Federally-facilitated Exchange to a State Exchange.

(b) Transition process for State Exchanges that cease operations. A State that ceases operations of its Exchange after January 1, 2014 must:

(1) Notify HHS that it will no longer operate an Exchange at least 12 months prior to ceasing operations; and

(2) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.
45 CFR § 155.110

§ 155.110 Entities eligible to carry out Exchange functions.
(a) Eligible contracting entities. The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are:

(1) An entity:

(i) Incorporated under, and subject to the laws of, one or more States;

(ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(iii) Is not a health insurance issuer or treated as a health insurance issuer ***41914** under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(2) The State Medicaid agency.

(b) Responsibility. To the extent that an Exchange establishes such arrangements, the Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met.

(c) Governing board structure. If the Exchange is an independent State agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:

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(1) Is administered under a formal, publicly-adopted operating charter or by-laws;

(2) Holds regular public governing board meetings that are announced in advance;

(3) Represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(d) Governance principles.

(1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

(e) SHOP independent governance.

(1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

(f) HHS review. HHS may periodically review the accountability structure and governance principles of a State Exchange.
45 CFR § 155.120

§ 155.120 Non-interference with Federal law and non-discrimination standards.
(a) Non-interference with Federal law. An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) Non-interference with State law. Nothing in parts 155 or 156 of this subtitle shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.

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

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

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.
45 CFR § 155.130

§ 155.130 Stakeholder consultation.
The Exchange must regularly consult on an ongoing basis with the following stakeholders:

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(a) Educated health care consumers who are enrollees in QHPs;

(b) Individuals and entities with experience in facilitating enrollment in health coverage;

(c) Advocates for enrolling hard to reach populations, which include individuals with a mental health or substance abuse disorder;

(d) Small businesses and self-employed individuals;

(e) State Medicaid and CHIP agencies;

(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange's geographic area;

(g) Public health experts;

(h) Health care providers;

(i) Large employers;

(j) Health insurance issuers; and

(k) Agents and brokers.
45 CFR § 155.140

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.
(a) Regional Exchange. A State may participate in a regional Exchange if:

(1) The Exchange spans two or more States, regardless of whether the States are contiguous; and

(2) The regional Exchange submits a single Exchange Plan and is approved to operate consistent with § 155.105(c).

(b) Subsidiary Exchange. A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) Exchange standards. Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its area in accordance with subpart H of this part; and

(ii) If a State elects to operate its individual market Exchange and SHOP under two governance or administrative structures as described in § 155.110(e), the SHOP must encompass a geographic area that matches the geographic area of the regional or subsidiary Exchange.
45 CFR § 155.150

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§ 155.150 Transition process for existing State health insurance exchanges.
(a) Presumption. Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State Exchange meets the standards under this part if:

(1) The Exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act.

(b) Process for determining non-compliance. Any State described in paragraph (a) must work with HHS to identify areas of non-compliance with the standards under this part.
45 CFR § 155.160

§ 155.160 Financial support for continued operations.
(a) Definition. For purposes of this section, participating issuers has the meaning provided in § 156.50.

(b) Funding for ongoing operations. A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) The State may fund Exchange operations by charging assessments or user fees on participating issuers;

(2) States may otherwise generate funding for Exchange operations;

(3) No Federal funds will be provided for State Exchange operations after January 1, 2015; and

(4) The State Exchange must announce the user fees to participating issuers in advance of the plan year.

***41915 Subpart C—General Functions of an Exchange**
45 CFR § 155.200

§ 155.200 Functions of an Exchange.
(a) General requirements. The Exchange must perform the minimum functions described in this subpart and in subparts E, H, and K of this part.

(b) Certificates of exemption. The Exchange must issue certificates of exemption consistent with section 1311(d)(4)(H) and 1411 of the Affordable Care Act.

(c) Eligibility determinations. The Exchange must perform eligibility determinations.

(d) Appeals of individual eligibility determinations. The Exchange must establish an appeals process for eligibility determinations.

(e) Oversight and financial integrity. The Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.

(f) Quality Activities. The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

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45 CFR § 155.205

§ 155.205 Required consumer assistance tools and programs of an Exchange.
(a) Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance.

(b) Internet Web site. The Exchange must maintain an up-to-date Internet Web site that:

(1) Provides standardized comparative information on each available QHP, including at a minimum:

(i) Premium and cost-sharing information;

(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of enrollee satisfaction survey, described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned pursuant to section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in § 155.1040; and

(viii) The provider directory made available to the Exchange pursuant to § 156.230.

(2) Is accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons with limited English proficiency.

(3) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under (i) and (ii) of this paragraph;

(iv) Administrative costs of such Exchange; and

(v) Monies lost to waste, fraud, and abuse.

(4) Provides applicants with information about Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(5) Allows for an eligibility determination to be made pursuant to § 155.200(c) of this subpart.

(6) Allows for enrollment in coverage in accordance with subpart E of this part.

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(c) Exchange calculator. The Exchange must establish and make available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

(d) Consumer assistance. The Exchange must have a consumer assistance function, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.

(e) Outreach and education. The Exchange must conduct outreach and education activities to educate consumers about the Exchange and to encourage participation.
45 CFR § 155.210

§ 155.210 Navigator program standards.
(a) General Requirements. The Exchange must establish a Navigator program consistent with this section through which it awards grants to eligible public or private entities described in paragraph (b) of this section.

(b) Entities eligible to be a Navigator.

(1) To receive a Navigator grant, an entity must—

(i) Be capable of carrying out at least those duties described in paragraph (d) of this section;

(ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable; and

(iv) Not have a conflict of interest during the term as Navigator.

(2) The Exchange must include entities from at least two of the following categories for receipt of a Navigator grant:

(i) Community and consumer-focused nonprofit groups;

(ii) Trade, industry, and professional associations;

(iii) Commercial fishing industry organizations, ranching and farming organizations;

(iv) Chambers of commerce;

(v) Unions;

(vi) Resource partners of the Small Business Administration;

(vii) Licensed agents and brokers; and

(viii) Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

(c) Prohibition on Navigator conduct. The Exchange must ensure that a Navigator must not—

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(1) Be a health insurance issuer; or

(2) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP.

(d) Duties of a Navigator. An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;

(2) Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs;

(3) Facilitate enrollment in QHPs;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, ***41916** complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(e) Funding for Navigator grants. Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange.
45 CFR § 155.220

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.
(a) General rule. A State may choose to permit agents and brokers to—

(1) Enroll qualified individuals, qualified employers or qualified employees in any QHPs in the individual or small group market as soon as the QHP is offered through an Exchange in the State; and

(2) Assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

(b) Web site disclosure. The Exchange may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange.
45 CFR § 155.230

§ 155.230 General standards for Exchange notices.
(a) General requirement. Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees must be in writing and include:

(1) Contact information for available customer service resources;

(2) An explanation of appeal rights, if applicable; and

(3) A citation to or identification of the specific regulation supporting the action.

(b) Accessibility and readability requirements. All applications, forms, and notices must be written in plain language and provided in a manner that:

(1) Provides meaningful access to limited English proficient individuals; and

(2) Ensures effective communication for people with disabilities.

(c) Re-evaluation of appropriateness and usability. The Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices on an annual basis and in consultation with HHS in instances when changes are made.
45 CFR § 155.240

§ 155.240 Payment of premiums.
(a) Payment by individuals. The Exchange must allow a qualified individual to pay any applicable premium owed by such individual directly to the QHP issuer.

(b) Payment by tribes, tribal organizations, and urban Indian organizations. The Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Exchange.

(c) Payment by qualified employers. The Exchange must accept payment of an aggregate premium by a qualified employer pursuant to § 155.705(b)(4).

(d) Payment facilitation. The Exchange may establish a process to facilitate through electronic means the collection and payment of premiums.

(e) Required standards. In conducting an electronic transaction with a QHP that involves the payment of premiums or an electronic funds transfer, the Exchange must use the standards and operating rules referenced in § 155.260 and § 155.270.
45 CFR § 155.260

§ 155.260 Privacy and security of information.
(a) Definitions. For purposes of this section, the following term has the following meaning:

Personally identifiable information means information that there is a reasonable basis to believe, alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, can be used to distinguish or trace an individual's identity. Specifically, the term applies to information collected, received or used by the Exchange as part of its operations.

(b) Use and disclosure.

(1) The Exchange must not collect, use, or disclose personally identifiable information unless:

(i) The collection, use, or disclosure is specifically required or permitted by this section or by other applicable law; or

(ii) The collection, use, or disclosure is made pursuant to subpart E of this part, while the Exchange is fulfilling its responsibilities in accordance with § 155.200(c) of this subpart, or pursuant to section 1942(b) of the Act as described in paragraph (c) of this section.

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(2) Exchanges must establish and follow security standards for collection, use, disclosure and disposal of personally identifiable information that provide administrative, physical, and technical safeguards for the information that are consistent with the security standards required for covered entities by 45 CFR 164.306, 164.308, 164.310, 164.312 and 164.314.

(3) Exchanges must establish and follow privacy standards consistent with applicable law and that establish acceptable parameters for proper collection, use, disclosure and disposal of personally identifiable information.

(4) Policies and procedures regarding the use, disclosure and disposal of personally identifiable information must, at minimum:

(i) Be in writing, and available to the Secretary of HHS upon request;

(ii) Identify applicable law governing use, disclosure and disposal of personally identifiable information; and

(5) In any contract or agreement with a contractor, require that personally identifiable information provided to, created by, received by, used by, or subsequently disposed of by a contractor of the Exchange or any of its subcontractors, pursuant to an agreement with the Exchange or on behalf of the Exchange, be protected by privacy and security standards that are the same as or more stringent than those described in this section.

(c) Other applicable law. Data matching and sharing arrangements made between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must be consistent with other applicable laws, including section 1942 of the Act.

(d) Compliance with the Code. Tax returns and return information must be kept confidential and disclosed only in accordance with section 6103(l)(21) of the Code.

(e) Improper use and disclosure of information. Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a civil penalty of not more than $25,000 per person or entity, per disclosure, in addition to other penalties that may be prescribed by law.
45 CFR § 155.270

§ 155.270 Use of standards and protocols for electronic transactions.
(a) HIPAA administrative simplification. To the extent that the Exchange performs electronic transactions with a covered entity, the Exchange must use standards, implementation specifications and code sets adopted by the Secretary in 45 CFR parts 160 and 162.

***41917** (b) HIT enrollment standards and protocols. The Exchange must incorporate interoperable and secure standards and protocols developed by the Secretary pursuant to section 3021 of the PHS Act. Such standards and protocols must be incorporated within Exchange information technology systems.

Subpart E—Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans
45 CFR § 155.400

§ 155.400 Enrollment of qualified individuals into QHPs.
(a) General requirements. The Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with the standards established in accordance with § 155.200(c) of this subpart, and must—

(1) Notify the issuer of the applicant's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the applicant.

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(b) Timing of data exchange. The Exchange must:

(1) Send eligibility and enrollment information to QHP issuers on a timely basis; and

(2) Establish a process by which a QHP issuer verifies and acknowledges the receipt of such information.

(c) Records. The Exchange must maintain records of all enrollments in QHPs through the Exchange and submit enrollment information to HHS on a monthly basis.

(d) Reconcile files. The Exchange must reconcile enrollment information with QHP issuers no less than on a monthly basis.
45 CFR § 155.405

§ 155.405 Single streamlined application.
(a) The application. The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for enrollment for—

(1) QHPs;

(2) Advance payments of the premium tax credit;

(3) Cost-sharing reductions; and

(4) Medicaid, CHIP, or the BHP, where applicable.

(b) Alternative application. If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

(c) Filing the single streamlined application. The Exchange must—

(1) Accept the single streamlined application from

(i) An applicant;

(ii) An authorized representative; or,

(iii) Someone acting responsibly for the applicant.

(2) Provide the tools to allow for an applicant to file an application—

(i) Via an Internet portal;

(ii) By telephone through a call center;

(iii) By mail; and

(iv) In person.

(d) [Reserved]

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(e) [Reserved]
45 CFR § 155.410

§ 155.410 Initial and annual open enrollment periods.
(a) General requirements.

(1) The Exchange must provide an initial open enrollment period and annual open enrollment periods consistent with this section, during which qualified individuals may enroll in a QHP or enrollees may change QHPs.

(2) The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period specified in paragraph (b) of this section, the annual open enrollment period specified in paragraph (e) of this section, or a special enrollment period described in § 155.420 of this subpart for which the qualified individual or enrollee has been determined eligible.

(b) Initial open enrollment period. The initial open enrollment period begins October 1, 2013 and extends through February 28, 2014.

(c) Effective coverage dates for initial open enrollment period. For QHP selections received by the Exchange from a qualified individual—

(1) On or before December 22, 2013, the Exchange must ensure a coverage effective date of January 1, 2014; and

(2) Between the first and twenty-second day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; and

(3) Between the twenty-third and last day of the month for any month between December 2013 and February 28, 2014, the Exchange must ensure a coverage effective date of either the first day of the following month or the first day of the second following month.

(d) Notice of annual open enrollment period. Starting in 2014, the Exchange must provide advance written notification to each enrollee about annual open enrollment.

(e) Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.

(f) Effective date for coverage after the annual open enrollment period. The Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

(g) [Reserved]
45 CFR § 155.420

§ 155.420 Special enrollment periods.
(a) General requirements. The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals and enrollees may enroll in QHPs or change enrollment from one QHP to another.

(b) Effective dates. Once a qualified individual is determined eligible for a special enrollment period, the Exchange must ensure that the qualified individual's effective date of coverage is:

(1) On the first day of the following month for all QHP selections made by the 22nd of the previous month,

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(2) On either the first day of the following month or the first day of the second following month for all QHP selections made between the 23rd and last day of a given month, or

(3) In the case of birth, adoption or placement for adoption effective on the date of birth, adoption, or placement for adoption.

(c) Length of special enrollment periods. Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a qualified health plan.

(d) Special enrollment periods. The Exchange must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

(1) A qualified individual or dependent loses minimum essential coverage;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or ***41918** eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the individual;

(6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

(7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

(8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another 1 time per month; and

(9) A qualified individual or enrollee meets other exceptional circumstances as the Exchange or HHS may provide.

(e) Loss of coverage. Loss of coverage does not include termination or loss due to—

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128, Rules Regarding Rescissions.

(f) Limits on special enrollment periods. An enrollee may only move to a different plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, excluding paragraph (d)(6) of this section.
45 CFR § 155.430

§ 155.430 Termination of coverage.

(a) General requirements. The Exchange must determine the form and manner in which coverage in a QHP may be terminated.

(b) Termination events.

(1) The Exchange must permit an enrollee to terminate his or her coverage in a QHP with appropriate notice to the Exchange or the QHP.

(2) The Exchange may terminate an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage, in the following circumstances:

(i) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(ii) The enrollee becomes covered in other minimum essential coverage;

(iii) Payments of premiums for coverage of the enrollee cease, provided that the grace period required by § 156.270 of this subtitle has expired;

(iv) The enrollee's coverage is rescinded in accordance with § 147.128 of this subtitle;

(v) The QHP terminates or is decertified as described in § 155.1080; or

(vi) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with § 155.410 or § 155.420.

(c) Termination of coverage tracking and approval. The Exchange must—

(1) Establish mandatory procedures for issuers of QHPs to maintain records of termination of coverage;

(2) Track number of coverage terminations and submit that information to HHS on a monthly basis;

(3) Establish standards for termination of coverage that require issuers of QHPs to provide reasonable accommodations to individuals with mental or cognitive conditions, including mental and substance use disorders, Alzheimer's disease, and developmental disabilities before terminating coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage.

(1) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is the termination date specified by the enrollee, if the Exchange and QHP have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage. If the Exchange or the QHP do not have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage, the last day of coverage is the first day after such reasonable amount of time has passed.

(2) In the case of a termination in accordance with paragraph (b)(2)(ii) of this section, the last day of coverage is the day before the effective date of an enrollee's coverage for new minimum essential coverage.

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(3) In the case of a termination in accordance with paragraph (b)(2)(vi) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

(4) In cases other than those described in paragraphs (d)(1)-(3) of this section, the last day of coverage is:

(i) The fourteenth day of the month if the notice of termination is sent by the Exchange or termination is initiated by the QHP no later than the fourteenth day of the previous month; or

(ii) The last day of the month if the notice of termination is sent by the Exchange or termination is initiated by the QHP no later than the last day of the previous month.
45 CFR § 155.440

§ 155.440 [Reserved]

Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)
45 CFR § 155.700

§ 155.700 Standards for the establishment of a SHOP.
General requirement. An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.
45 CFR § 155.705

§ 155.705 Functions of a SHOP.
(a) Exchange functions that apply to SHOP. The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, H, and K of this part, except:

(1) Requirements related to individual eligibility determinations in § 155.200(c) and appeals of such determinations in § 155.200(d).

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to create a premium tax credit calculator pursuant to § 155.205(c);

(4) The requirement to certify exemptions from the individual coverage requirement pursuant to § 155.200(b);

(5) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) Unique functions of a SHOP. The SHOP must also provide the following unique functions:

(1) Enrollment and eligibility functions. The SHOP must adhere to the requirements outlined in §§ 155.710, 155.715, 155.720, 155.725, and 155.730. In addition, the SHOP must at a minimum facilitate the special enrollment periods described in § 156.285(b)(2) of this subtitle.

(2) Employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP must allow a qualified ***41919** employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

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(3) SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(4) Premium aggregation. The SHOP must perform the following functions related to premium payment administration:

(i) Provide each qualified employer with a bill on a monthly basis that identifies the total amount that is due to the QHP issuers from the qualified employer; and

(ii) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all qualified enrollees.

(5) QHP Certification. With respect to certification of QHPs in the small group market, the SHOP must ensure QHPs meet the requirements specified in § 156.285 of this subtitle.

(6) Rates and rate changes. The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually; and

(ii) Not vary rates for a qualified employer during its plan year.

(7) QHP availability in merged markets. If a State merges the individual market and the small group market risk pools pursuant to section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting the following requirements of the small group market:

(i) Deductible maximums described in section 1302(c) of the Affordable Care Act; and

(ii) Levels of coverage described in § 155.705(b)(2).

(8) QHP availability in unmerged markets. If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) SHOP expansion to large group market. If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017, provided that a large employer meets the qualified employer requirements by electing to make all full-time employees of such employer eligible for one or more QHPs offered in the large group market through a SHOP.
45 CFR § 155.710

§ 155.710 Eligibility standards for SHOP.
(a) General requirement. The SHOP must permit qualified employers to purchase coverage for qualified employees through the SHOP.

(b) Employer eligibility requirements. An employer is a qualified employer eligible to purchase coverage through a SHOP if such employer—

(1) Is a small employer;

(2) Elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and

(3) Either—

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(i) Has its principal business address in the Exchange service area and offers coverage to all its employees through that SHOP; or

(ii) Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

(c) Participating in multiple SHOPs. If an employer meets the criteria in (b) above and makes the election described in paragraph (b)(3)(ii) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

(d) Continuing eligibility. The SHOP must treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees of such employer as a qualified employer until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

(e) Employee eligibility requirements. An employee is a qualified employee eligible to enroll in coverage through a SHOP if such employee receives an offer of coverage from a qualified employer.
45 CFR § 155.715

§ 155.715 Eligibility determination process for SHOP.
(a) General requirement. Before permitting the purchase of coverage in a QHP, the SHOP must determine that the employer or individual who requests coverage is eligible in accordance with the requirements of § 155.710.

(b) Applications. The SHOP must accept a SHOP single employer application form from employers and the SHOP single employee application form from employees wishing to elect coverage through the SHOP in accordance with the relevant standards of § 155.730.

(c) Verification of application. For the purpose of verifying information within the employer and employee applications, the SHOP—

(1) Must verify that an individual applicant is identified by the employer as an employee to whom the qualified employer has offered coverage and must otherwise accept the information attested to within the application unless the SHOP has a reason to doubt the information's veracity; and

(2) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the applicable application.

(d) Eligibility adjustment period.

(1) For an employer requesting to purchase coverage through the SHOP for which the SHOP has a reason to doubt the information on the application submitted by the employer, the SHOP must—

(i) Make a reasonable effort to identify and address the causes of such reason to doubt, including through typographical or other clerical errors;

(ii) Notify the employer of the reason;

(iii) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (d)(1)(i) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(1)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must—

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(A) Notify the employer of its denial of eligibility pursuant to paragraph (e) of this section; and

(B) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the notice is sent.

(2) For an individual requesting eligibility to enroll in a QHP through the SHOP for whom the SHOP has a reason to doubt the information on the application submitted by the individual, the SHOP must—

(i) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(ii) Notify the individual of the inability to substantiate his or her employee status;

(iii) Provide the employee with a period of 30 days from the date on which the notice described in paragraph (d)(2)(ii) of this section is sent to the employee to either present satisfactory documentary evidence to support the ***41920** employee's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(2)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must notify the employee of its denial of eligibility pursuant to paragraph (f) of this section.

(e) Notification of employer eligibility. The SHOP must provide an employer requesting eligibility to purchase coverage with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination.

(f) Notification of employee eligibility. The SHOP must notify an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the individual is eligible in accordance with § 155.710 and the employee's right to appeal such determination.

(g) Notification of employer withdrawal from SHOP. If a qualified employer ceases to purchase coverage through the SHOP, the SHOP must ensure that—

(1) Each QHP terminates the coverage of the employer's qualified employees enrolled in the QHP through the SHOP; and

(2) Each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the termination of their coverage prior to such termination.
45 CFR § 155.720

§ 155.720 Enrollment of employees into QHPs under SHOP.
(a) General requirements. The SHOP must process the SHOP single employee applications of qualified employees to the applicable QHP issuers and facilitate the enrollment of qualified employees in QHPs. All references to QHPs in this section refer to QHPs offered through the SHOP.

(b) Enrollment timeline and process. The SHOP must establish a uniform enrollment timeline and process that all QHP issuers and qualified employers comply with for the following activities to occur before the effective date of coverage for qualified employees:

(1) Determination of employer eligibility for purchase of coverage in the SHOP as described in § 155.715;

(2) Qualified employer selection of QHPs offered through the SHOP to qualified employees, consistent with § 155.705(b)(2) and (3);

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(3) Provision of a specific timeframe during which the qualified employer can select the level of coverage or QHP offering, as appropriate;

(4) Provision of a specific timeframe for qualified employees to provide relevant information to complete the application process;

(5) Determination and verification of employee eligibility for enrollment through the SHOP;

(6) Processing enrollment of qualified employees into selected QHPs; and

(7) Establishment of effective dates of employee coverage.

(c) Transfer of enrollment information. In order to enroll qualified employees of a qualified employer participating in the SHOP, the SHOP must—

(1) Transmit enrollment information on behalf of qualified employees to QHP issuers in accordance with the timeline described in paragraph (b) of this section; and

(2) Follow requirements set forth in § 155.400(c) of this part.

(d) Payment. The SHOP must—

(1) Adhere to requirements set forth in § 155.705(b)(4); and

(2) Terminate qualified employers that do not comply with the process established in § 155.705(b)(4).

(e) Notification of effective date. The SHOP must ensure that a qualified employee enrolled in a QHP is notified of the effective date of coverage consistent with § 156.260(b) of this subtitle.

(f) Records. The SHOP must receive and maintain records of enrollment in QHPs, including identification of—

(1) Qualified employers participating in the SHOP, and

(2) Qualified employees enrolled in QHPs.

(g) Reconcile files. The SHOP must reconcile enrollment information and employer participation information with QHPs on no less than a monthly basis in accordance with standards established in § 155.400(d).

(h) Employee termination of coverage from a QHP. If any employee terminates coverage from a QHP, the SHOP must notify the individual's employer.
45 CFR § 155.725

§ 155.725 Enrollment periods under SHOP.
(a) General requirements. The SHOP must—

(1) Adhere to the start of the initial open enrollment period set forth in § 155.410; and

(2) Ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with § 156.260 of this subtitle.

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(b) Rolling enrollment in the SHOP. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

(c) Annual employer election period. The SHOP must provide qualified employers with a period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(1) The method by which qualified employer makes QHPs available to qualified employees pursuant § 155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in § 155.705(b)(2) and (3); or

(4) The QHP or plans offered to qualified employees pursuant to § 155.705.

(d) Annual employer election period notice. The SHOP must provide notification to a qualified employer of the annual election period in advance of such period.

(e) Annual employee open enrollment period. The SHOP must establish an annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(f) Employees hired outside of the initial or annual open enrollment period. The SHOP must provide an employee hired outside of the initial or annual open enrollment period a specified period to seek coverage in a QHP beginning on the first day of employment.

(g) Effective dates. The SHOP must establish effective dates of coverage for qualified employees consistent with the effective dates of coverage described in § 155.720.

(h) Renewal of coverage. If a qualified employee enrolled in a QHP through the SHOP remains eligible for coverage, such individual will remain in the plan selected the previous year unless—

(1) He or she disenrolls from such plan in accordance with standards identified in § 155.430;

(2) He or she enrolls in another QHP if such option exists; or

(3) The QHP is no longer available to the qualified employee.
45 CFR § 155.730

§ 155.730 Application standards for SHOP.
(a) General requirements. Application forms used by the SHOP must meet the requirements set forth in this section.

(b) Single employer application. The SHOP must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following—

***41921** (1) Employer name and address of employer's locations;

(2) Number of employees;

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(3) Employer Identification Number (EIN); and

(4) A list of qualified employees and their social security numbers.

(c) Single employee application. The SHOP must use a single application for eligibility determination, QHP selection and enrollment for qualified employees.

(d) Model application. The SHOP may use the model single employer application and the model single employee application provided by HHS.

(e) Alternative employer application. The SHOP may use an alternative application if such application is approved by HHS and collects the following—

(1) In the case of the employer application, the information described in paragraph (b) of this section; and

(2) In the case of the employee application, the information necessary to establish eligibility of the employee as a qualified employee and to complete the enrollment of a qualified employee, such as plan selection and identification of dependents to be enrolled.

(f) Filing. The SHOP must allow an employer to file the SHOP single employer application and employees to file the single employee application in the form and manner described in § 155.405(c).

Subpart K—Exchange Functions: Certification of Qualified Health Plans
45 CFR § 155.1000

§ 155.1000 Certification standards for QHPs.
(a) Definition. The following definition applies in this subpart:

Multi-State plan is a health plan offered by a health insurance issuer under contract with the U.S. Office of Personnel Management (OPM) to offer a multi-State QHP through the Exchange. The plan must offer a benefits package that is uniform in each State and consists of the benefit design standards described in section 1302 of the Affordable Care Act; meets all requirements for QHPs; and meets Federal rating requirements pursuant to section 2701 of the PHS Act, or a State's more restrictive rating requirements, if applicable.

(b) General requirement. The Exchange must offer only QHPs which have in effect a certification issued or recognized by the Exchange as QHPs. Any reference to QHPs must be deemed to include multi-State plans, unless specifically provided for otherwise.

(c) General certification criteria. The Exchange may certify a health plan as a QHP in the Exchange if—

(1) The health insurance issuer provides evidence during the certification process in § 155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156 of this subtitle, as applicable; and

(2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan—

(i) On the basis that such plan is a fee-for-service plan;

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(ii) Through the imposition of premium price controls; or

(iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.
45 CFR § 155.1010

§ 155.1010 Certification process for QHPs.
(a) Certification procedures. The Exchange must establish procedures for the certification of QHPs consistent with § 155.1000(c).

(b) Exemption from certification process. Notwithstanding paragraph (a) of this section, a multi-State plan is exempt from the certification process established by the Exchange and deemed as meeting the certification requirements for QHPs.

(c) Completion date. The Exchange must complete the certification of the QHPs prior to the open enrollment period as outlined in § 155.410.

(d) Ongoing compliance. The Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in § 155.1000(c).
45 CFR § 155.1020

§ 155.1020 QHP issuer rate and benefit information.
(a) Receipt and posting of rate increase justification. The Exchange must receive a justification for a rate increase for a QHP prior to the implementation of such an increase. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site as required under § 156.210 of this subtitle.

(b) Rate increase consideration. The Exchange must consider rate increases in accordance with section 1311(e)(2) of the Affordable Care Act, which includes consideration of the following:

(1) A justification for a rate increase prior to the implementation of the increase;

(2) Recommendations provided to the Exchange by the State pursuant to section 2794(b)(1)(B) of the PHS Act; and

(3) Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

(c) Benefit and rate information. The Exchange must receive the following information, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS:

(1) Rates;

(2) Covered benefits; and

(3) Cost-sharing requirements.
45 CFR § 155.1040

§ 155.1040 Transparency in coverage.
(a) General requirement. The Exchange must collect information relating to coverage transparency as described in § 156.220(a) of this subtitle from QHP issuers.

(b) Use of plain language. The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

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(c) Transparency of cost-sharing information. The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle.
45 CFR § 155.1045

§ 155.1045 Accreditation timeline.
The Exchange must establish a uniform period following certification of the QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle.
45 CFR § 155.1050

§ 155.1050 Establishment of Exchange network adequacy standards.
An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.
45 CFR § 155.1055

§ 155.1055 Service area of a QHP.
The Exchange must have a process to establish or evaluate the service areas of QHPs to determine whether the following minimum criteria are met:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of 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.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.
45 CFR § 155.1065

§ 155.1065 Stand-alone dental plans.
***41922** (a) General requirements. The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act.

(b) Offering options. The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) Certification standards. If a plan described in paragraph (a) is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.
45 CFR § 155.1075

§ 155.1075 Recertification of QHPs.
(a) Recertification process. The Exchange must establish a process for recertification of QHPs that includes a review of the general certification criteria as outlined in § 155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.

(b) Timing. The Exchange must complete the QHP recertification process on or before September 15 of the applicable calendar year.
45 CFR § 155.1080

§ 155.1080 Decertification of QHPs.
(a) Definition. The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) Decertification process. The Exchange must establish a process for the decertification of QHPs which, at a minimum, meet the requirements in this section.

(c) Decertification by the Exchange. The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c).

(d) Appeal of decertification. The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) Notice of decertification. Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in § 155.420;

(3) HHS; and

(4) The State department of insurance.

3. Part 156 is added as follows:

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

Subpart A—General Provisions

Sec.

156.10 Basis and scope.

156.20 Definitions.

156.50 Financial support.

Subpart B—[Reserved]

Subpart C—Qualified Health Plan Minimum Certification Standards

156.200 QHP issuer participation standards.

156.210 QHP rate and benefit information.

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156.220 Transparency in coverage.

156.225 Marketing of QHPs.

156.230 Network adequacy standards.

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156.245 Treatment of direct primary care medical homes.

156.250 Health plan applications and notices.

156.255 Rating variation.

156.260 Enrollment periods for qualified individuals.

156.265 Enrollment process for qualified individuals.

156.270 Termination of coverage for qualified individuals.

156.275 Accreditation of QHP issuers.

156.280 Segregation of funds for abortion services.

156.285 Additional standards specific to the SHOP.

156.290 Non-renewal and decertification of QHPs.

156.295 Prescription drug distribution and cost reporting.
Authority: Title I of the Affordable Care Act, sections 1301-1304, 1311-1312, 1321, 1322, 1324, 1334, 1342-1343, and 1401-1402.

Subpart A—General Provisions
45 CFR § 156.10

§ 156.10 Basis and scope.
(a) Basis.

(1) This part is based on the following sections of title I of the Affordable Care Act:

1301. QHP defined.

1302. Essential health benefits requirements.

1303. Special rules.

1304. Related definitions.

1311. Affordable choices of health benefit plans.

1312. Consumer choice.

1313. Financial integrity.

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1321. State flexibility in operation and enforcement of Exchanges and related requirements.

1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

1334. Multi-State plans.

1402. Reduced cost-sharing for individuals enrolling in QHPs.

1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.
(2) This part is based on the following sections of title I of the Act:

§ 1150A. Pharmacy Benefit Managers Transparency Requirements
(b) Scope. This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.
45 CFR § 156.20

§ 156.20 Definitions.
The following definitions apply to this part, unless the context indicates otherwise:

Applicant has the meaning given to the term in § 155.20 of this subtitle.

Benefit design standards means coverage that provides for all of the following:

(1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in § 155.20 of this subtitle.

Group health plan has the meaning given to the term in § 144.103 of this subtitle.

Health insurance coverage has the meaning given to the term in § 144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in § 144.103 of this subtitle.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(2) of the Affordable Care Act of plan coverage.

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***41923** Plan year has the meaning given to the term in § 155.20 of this subtitle.

Qualified employer has the meaning given to the term in § 155.20 of this subtitle.

Qualified health plan has the meaning given to the term in § 155.20 of this subtitle.

Qualified health plan issuer has the meaning given to the term in § 155.20 of this subtitle.

Qualified individual has the meaning given to the term in § 155.20 of this subtitle.
45 CFR § 156.50

§ 156.50 Financial support.
(a) Definitions. The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering plans that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subtitle), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.

(b) Requirement for State Exchanges. A participating issuer must remit user fee payments assessed by an Exchange under § 155.160 of this subtitle.

Subpart B—[Reserved]

Subpart C—Qualified Health Plan Minimum Certification Standards
45 CFR § 156.200

§ 156.200 QHP issuer participation standards.
(a) General requirement. In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) QHP issuer requirement. A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth pursuant to subpart K of part 155 and, in the small group market, § 155.705 of this subtitle;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act; and

(6) Pay any applicable user fees assessed under § 156.50; and

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(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.

(c) Offering requirements. A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act;

(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21; and

(3) A QHP at the same premium rate consistent with § 156.255(b).

(d) State requirements. A QHP issuer participating in the Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation with respect to each of its QHPs.

(e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.
45 CFR § 156.210

§ 156.210 QHP rate and benefit information.
(a) General rate requirement. A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

(b) Rate and benefit submission. A QHP issuer must submit rate and benefit information to the Exchange pursuant to § 155.1020.

(c) Rate justification. A QHP issuer must submit a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.
45 CFR § 156.220

§ 156.220 Transparency in coverage.
(a) Required information. A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.

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(b) Reporting requirement. A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) Use of plain language. A QHP issuer must make sure that the information submitted under paragraph (b) of this section is provided in plain language as defined under § 155.20 of this subtitle.

(d) Enrollee cost-sharing transparency. A QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.
45 CFR § 156.225

§ 156.225 Marketing of QHPs.
A QHP issuer and its officials, employees, agents and representatives must—

(a) State law applies. Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) Non-discrimination. Not employ marketing practices that discourage the enrollment of individuals with significant health needs in QHPs.
45 CFR § 156.230

§ 156.230 Network adequacy standards.
(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—

(1) Includes essential community providers in accordance with § 156.235;

(2) Complies with any network adequacy standards established by the Exchange consistent with § 155.1050 of this section; and

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Notice to applicants and enrollees. A QHP issuer must make its provider ***41924** directory for a QHP available to the Exchange for publication online pursuant to guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.
45 CFR § 156.235

§ 156.235 Essential community providers.
(a) General requirement. A QHP issuer must include within the provider network of the QHP a sufficient number of essential community providers, where available, that serve predominantly low-income, medically-underserved individuals. Nothing in this requirement shall be construed to require any health plan to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Inclusion. Essential community providers under paragraph (a) of this section include:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8.
45 CFR § 156.245

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§ 156.245 Treatment of direct primary care medical homes.
A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.
45 CFR § 156.250

§ 156.250 Health plan applications and notices.
QHP issuers must provide all applications and notices to enrollees in accordance with the standards described in § 155.230(b) of this subtitle.
45 CFR § 156.255

§ 156.255 Rating variations.
(a) Rating areas. A QHP issuer, including an issuer of a multi-State QHP, may vary premiums for a QHP or a multi-State QHP by the geographic rating area established under section 2701(a)(2) of the PHS Act.

(b) Same premium rates. A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.

(c) Rating categories. A QHP issuer must cover all of the following groups using some combination of the following categories:

(1) Individuals;

(2) Two-adult families;

(3) One-adult families with a child or children; and

(4) All other families.
45 CFR § 156.260

§ 156.260 Enrollment periods for qualified individuals.
(a) Individual market requirement. A QHP issuer must:

(1) Enroll a qualified individual during the initial and annual open enrollment periods described in § 155.410(b) and § 155.410(e) of this subtitle, and abide by the effective dates of coverage established by the Exchange pursuant to the requirements described in § 155.410(c) and § 155.410(f) of this subtitle; and

(2) Make available, at a minimum, special enrollment periods described in § 155.420(d), for QHPs and abide by the effective dates of coverage established by the Exchange pursuant to the requirements described in § 155.420(b) of this subtitle.

(b) Notification of effective date. A QHP issuer must notify the qualified individual of his or her effective date of coverage in coordination with the standards established in § 155.410(c), § 155.410(f) and § 155.420(b) of this subtitle.
45 CFR § 156.265

§ 156.265 Enrollment process for qualified individuals.
(a) General requirement. A QHP issuer must adhere to the following requirements for individuals seeking enrollment in a QHP.

(b) Enrollment information collection and transmission. If an applicant initiates enrollment directly with the issuer for enrollment in a QHP, the QHP issuer must—

(1) Collect enrollment information using the application adopted pursuant to § 155.405 of this subtitle;

(2) Transmit the enrollment information to the Exchange consistent with the standards described in § 155.260 and § 155.270 of this subtitle to facilitate the eligibility determination process; and

(3) Enroll an individual only after receiving confirmation that the eligibility process is complete and the applicant has been determined eligible for enrollment in a QHP, in accordance with the standards established in § 155.200(c) of this subtitle.

(c) Acceptance of enrollment information. A QHP issuer must accept enrollment information in an electronic format from the Exchange that is consistent with the requirements of § 155.260 and § 155.270 of this subtitle.

(d) Premium payment. A QHP issuer must follow the premium payment process established by the Exchange pursuant to § 155.240 of this subtitle.

(e) Enrollment information package. A QHP issuer must provide new enrollees an enrollment information package.

(f) Summary of benefits and coverage document. A QHP issuer must provide the summary of benefits and coverage document to enrollees as specified in 2715 of the PHS Act and prior to the start of the open enrollment period.

(g) Enrollment reconciliation. A QHP issuer must reconcile enrollment files with the Exchange no less than once a month in accordance with § 155.400(d) of this subtitle.

(h) Enrollment acknowledgement. A QHP issuer must acknowledge receipt of enrollment information in accordance with Exchange standards established in § 155.400(b)(2) of this subtitle.
45 CFR § 156.270

§ 156.270 Termination of coverage for qualified individuals.

(a) General requirement. A QHP issuer may only terminate coverage as permitted by the Exchange pursuant to § 155.430(b) of this subtitle.

(b) Termination of coverage notice requirement. If an enrollee's coverage with a QHP is terminated for any reason, the QHP issuer must provide the Exchange and the enrollee with a notice of termination of coverage which is consistent with the effective date established by the Exchange pursuant to § 155.430(d) of this subtitle.

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

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

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

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

(1) Pay all appropriate claims submitted on behalf of the enrollee;

(2) Apply all payments received during such period to the first billing cycle in which payment was delinquent; and

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

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

***41925** (f) Exhaustion of grace period. If an enrollee receiving advance payments of the premium tax credit exhausts the grace period in paragraph (d) of this section without submitting any premium payment, the QHP issuer may terminate the enrollee's coverage effective at the end of the payment grace period.

(g) Records of termination of coverage. QHP issuers must maintain records in accordance with Exchange standards established pursuant to § 155.430(c) of this subtitle.

(h) Effective date of termination of coverage. QHP issuers must abide by the termination of coverage effective dates described in § 155.430(d) of this subtitle.
45 CFR § 156.275

§ 156.275 Accreditation of QHP issuers.
(a) General requirement. A QHP issuer must:

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

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

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

(iii) Consumer access;

(iv) Utilization management;

(v) Quality assurance;

(vi) Provider credentialing;

(vii) Complaints and appeals;

(viii) Network adequacy and access; and

(ix) Patient information programs, and

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

(b) Time frame for accreditation. A QHP issuer must be accredited within the timeframe established by the Exchange pursuant to § 155.1045 of this subtitle. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.
45 CFR § 156.280

§ 156.280 Segregation of funds for abortion services.

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(a) State opt-out of abortion coverage. QHP issuers must comply with State law, if such State enacts a law that prohibits abortion coverage in QHPs.

(b) Termination of opt out. A QHP issuer may provide coverage of abortion services through the Exchange in a State described in paragraph (a) of this section if the State repeals such law.

(c) Voluntary choice of coverage of abortion services. Notwithstanding any other provision of title I of the Affordable Care Act (or any other amendment made under that title):

(1) Nothing in title I of the Affordable Care Act (or any amendments by that title) shall be construed to require a QHP issuer to provide coverage of services described in paragraph (d) of this section as part of its essential health benefits, as described in 1302(b) of the Affordable Care Act, for any plan year.

(2) Subject to paragraphs (a) and (b) of this section, the QHP issuer must determine whether or not the QHP provides coverage of services described in paragraph (d) of this section as part of such benefits for the plan year.

(d) Abortion services.

(1) Abortions for which public funding is prohibited—The services described in this paragraph (d)(1) are abortion services for which the expenditure of Federal funds appropriated for HHS is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(2) Abortions for which public funding is allowed—The services described in this paragraph (d)(2) are abortion services for which the expenditure of Federal funds appropriated for HHS is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(e) Prohibition on the use of Federal funds.

(1) If a QHP provides coverage of services described in paragraph (d)(1) of this section, the QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

(i) The credit under section 36B of the Code and the amount (if any) of the advance payment of the credit under section 1412 of the Affordable Care Act;

(ii) Any cost-sharing reduction under section 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under section 1412 of the Affordable Care Act.

(2) Establishment of allocation accounts. In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:

(i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in paragraph (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

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(ii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(3) Segregation of funds.

(i) The QHP issuer to which paragraph (e)(1) of this section applies must establish allocation accounts described in paragraph (e)(3)(ii) for enrollees receiving the amounts described in paragraph (e)(1) of this section.

(ii) Allocation accounts. The QHP issuer to which paragraph (e)(1) of this section applies must deposit:

(A) All payments described in paragraph (e)(2)(i)(A) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services other than the services described in paragraph (d)(1);

(B) All payments described in paragraph (e)(2)(i)(B) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (d)(1) of this section.

(4) Actuarial value. The QHP issuer must estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the QHP of services described in paragraph (d)(1) of this section. In making such an estimate, the QHP issuer:

(i) May take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) Must estimate such costs as if such coverage were included for the entire population covered; and

(iii) May not estimate such a cost at less than one dollar per enrollee, per month.

(5) Ensuring compliance with segregation requirements.

(i) Subject to paragraph (e)(5)(ii) of this section, the QHP issuer must comply with the efforts or direction of the State health insurance commissioner to ensure compliance with this section through the segregation of QHP funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of ***41926** Management and Budget and guidance on accounting of the Government Accountability Office.

(ii) Nothing in this clause shall prohibit the right of an individual or QHP issuer to appeal such action in courts of competent jurisdiction.

(f) Rules relating to notice.

(1) Notice. A QHP that provides for coverage of services in paragraph (d)(1) of this section, must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

(2) Rules relating to payments. The notice described in paragraph (f)(1) of this section, any advertising used by the QHP issuer with respect to the QHP, any information provided by the Exchange, and any other information specified by HHS must provide information only with respect to the total amount of the combined payments for services described in paragraph (d)(1) of this section and other services covered by the QHP.

(g) No discrimination on basis of provision of abortion. No QHP offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(h) Application of State and Federal laws regarding abortions.

(1) No preemption of State laws regarding abortion. Nothing in the Affordable Care Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) No effect on Federal laws regarding abortion. Nothing in the Affordable Care Act shall be construed to have any effect on Federal laws regarding:

(i) Conscience protection;

(ii) Willingness or refusal to provide abortion; and

(iii) Discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) No effect on Federal civil rights law. Nothing in section 1303(c) of the Affordable Care Act shall alter the rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964.

(i) Application of emergency services laws. Nothing in the Affordable Care Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Act (popularly known as "EMTALA").
45 CFR § 156.285

§ 156.285 Additional standards specific to the SHOP.
(a) SHOP rating and premium payment requirements. QHP issuers offering QHPs through a SHOP must:

(1) Accept payment from the SHOP on behalf of a qualified employer or an enrollee in accordance with § 155.705(b)(4) of this subtitle;

(2) Adhere to the SHOP timeline for rate setting as established in § 155.705(b)(5) of this subtitle; and

(3) Charge the same contract rate for a plan year.

(b) Enrollment periods for the SHOP. QHP issuers must:

(1) Enroll a qualified employee in accordance with the qualified employer's annual employee open enrollment period described in § 155.725 of this subtitle;

(2) QHP issuers must provide special enrollment periods described in § 155.420 of this subtitle excluding paragraphs (d)(3) and (d)(6).

(3) Establish an effective date of coverage in accordance with § 155.410(c) of this subtitle.

(c) Enrollment process for the SHOP. A QHP issuer offering a QHP in the SHOP must:

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(1) Adhere to the enrollment process timeline for SHOP Exchanges as described in § 155.720(b) of this subtitle;

(2) Receive enrollment information in an electronic format, in accordance with the requirements in § 155.260 and § 155.270, from the SHOP frequently as described in § 155.720(c) of this subtitle;

(3) Provide new enrollees with the enrollment information package as described in § 156.265(f) of this subtitle;

(4) Provide the summary of benefits and coverage document to qualified employers and qualified employees as described in § 156.265(g) of this subtitle;

(4) Reconcile enrollment files with the Exchange at least monthly;

(5) Acknowledge receipt of enrollment information in accordance with Exchange standards; and

(6) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(d) Termination of coverage in the SHOP. QHP issuers must:

(1) Abide by the following requirements with respect to coverage termination of enrollees in the SHOP:

(i) General requirements regarding termination of coverage established in § 156.270(a);

(ii) Requirements for notices to be provided to enrollees and qualified employers in § 156.270(b) and § 156.290(b).

(iii) Requirements regarding termination of coverage effective dates as set forth in § 156.270(g).

(2) If a qualified employer chooses to withdraw from participation in the SHOP, the QHP issuer must terminate coverage for all enrollees of the withdrawing qualified employer.
45 CFR § 156.290

§ 156.290 Non-renewal and decertification of QHPs.
(a) Non-renewal of recertification. If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must—

(1) Notify the Exchange of its decision prior to the beginning of the recertification process and procedures adopted by the Exchange pursuant to § 155.1075 of this subtitle;

(2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year;

(3) Fulfill data reporting obligations from the last plan or benefit year;

(4) Provide notice to enrollees as described in paragraph (b) of this section; and

(5) Terminate coverage for enrollees in the QHP in accordance with § 156.270, as applicable.

(b) Notice of QHP non-renewal. If a QHP issuer elects not to seek recertification with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.

(c) Decertification. If a QHP is decertified by the Exchange, the QHP issuer must terminate coverage for enrollees only after:

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(1) The Exchange has made notification as described in § 155.1080 of this subtitle; and

(2) Enrollees have an opportunity to enroll in other coverage.
45 CFR § 156.295

§ 156.295 Prescription drug distribution and cost reporting.
(a) General requirement. In a form and manner specified by HHS, a QHP issuer must provide to HHS the following information:

(1) The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the QHP issuer or the QHP issuer's contracted PBM;

***41927** (2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the QHP issuer or its contracted PBM negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed.

(3) The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(b) Confidentiality. Information disclosed by a QHP issuer or a PBM under this section is confidential and shall not be disclosed by HHS or by a QHP receiving the information, except that HHS may disclose the information in a form which does not disclose the identity of a specific PBM, QHP, or prices charged for drugs, for the following purposes:

(1) As HHS determines to be necessary to carry out section 1150A or part D of title XVIII of the Act;

(2) To permit the Comptroller General to review the information provided;

(3) To permit the Director of the Congressional Budget Office to review the information provided; or

(4) To States to carry out section 1311 of the Affordable Care Act.

(c) Penalties. A QHP issuer that fails to report the information described in paragraph (a) of this section to HHS or knowingly provides false information will be subject to the provisions of subsection (b)(3)(C) of section 1927 of the Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)
Dated: June 29, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 7, 2011.

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Kathleen Sebelius,

Secretary.

[FR Doc. 2011-17610 Filed 7-11-11; 11:15 am]

BILLING CODE 4120-01-P

Footnotes

1 CMS Office of the Actuary, April 22, 2010: https://www.cms.gov/ActuarialStudies/Downloads/PPACA—2010-04-22.pdf (page 24); Congressional Budget Office, March 18, 2011: http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf (excluding unauthorized immigrants).

2 The proposal here to post the summary of benefits and coverage (SBC) on the Exchange Web site is in addition to, and not in lieu of, any requirements regarding the manner, timing, and format for the delivery of an SBC to individuals under PHS Act section 2715. The Departments of HHS, Labor, and the Treasury are developing proposed regulations to be issued in the near future that are expected to address section 2715.

3 http://cciio.cms.gov/resources/files/joint—cms—ociio—guidance.pdf.

FN4 http://www.access-board.gov/sec508/guide/index.htm.

5 Standards accessible at: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

6 In 1973, the Department of Health, Education, and Welfare (HEW) released its report, Records, Computers, and the Rights of Citizens, which outlined a Code of Fair Information Practices that would create “safeguard requirements” for certain “automated personal data systems” maintained by the Federal Government. This Code of Fair Information Practices is now commonly referred to as fair information practice principles (FIPPs) and established the framework on which much privacy policy would be built. There are many versions of the FIPPs; the principles described here are discussed in more detail in The Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information, December 15, 2008. http://healthit.hhs.gov/portal/server.pt/community/healthit—hhs—gov——privacy———security—framework/1173.

FN7 Pritts, J.L., Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rule (Spring 2002), 2 Yale J. Health Pol'y L. & Ethics 325.

FN8 See Department of Commerce, Internet Policy Task Force, Commercial Data Privacy, and Innovation in the Internet Economy: A Dynamic Policy Framework, (Washington, D.C.: 2010).

9 http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

10 OMB and HHS Pre-Regulatory Guidance: http://www.whitehouse.gov/sites/default/files/omb/assets/financial—pdf/segregation—2010-09-20.pdf.

Salaries and fringe benefit estimates were taken from the Bureau of Labor Statistics Web site: (http://www.bls.gov/oco/ooh—index.htm).

11 Franks, Peter et al. “Health Insurance and Mortality.” Journal of American Medical Associates. 6(737-741) 1993.

12 Congressional Budget Office, “Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act.” (Washington2009).

13 CBO, “CBO's Health Insurance Simulation Model: A Technical Description.” (2007, October).

Source: CBO.

1 “Table of Size Standards Matched to North American Industry Classification System Codes,” effective November 5, 2010, U.S. Small Business Administration, available at http://www.sba.gov.

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End of Document

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77 FR 18310-01, 2012 WL 991807(F.R.)
RULES and REGULATIONS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 155, 156, and 157
[CMS-9989-F]
RIN 0938-AQ67

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers

Tuesday, March 27, 2012

AGENCY: Department of Health and Human Services.

***18310** ACTION: Final rule, Interim final rule.

SUMMARY: This final rule will implement the new Affordable Insurance Exchanges ("Exchanges"), consistent with title I of the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.
DATES: Effective Date: These regulations are effective on May 29, 2012.
Comment Date: Certain provisions of this final rule are being issued as interim final. We will consider comments from the public on the following provisions: §§ 155.220(a)(3); 155.300(b); 155.302; 155.305(g); 155.310(e); 155.315(g); 155.340(d); 155.345(a); and, 155.345(g). To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on May 11, 2012.

ADDRESSES: In commenting, please refer to file code CMS-9989-F. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):
1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9989-F, P.O. Box 8010, Baltimore, MD 21244-8010.

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

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9989-F, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

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

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

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

FOR FURTHER INFORMATION CONTACT:
Alissa DeBoy at (301) 492-4428 for general information and matters related to part 155.

Michelle Strollo at (301) 492-4429 for matters related to part 155 subparts D and E.

Pete Nakahata at (202) 680-9049 for matters related to part 156.

Rex Cowdry at (301) 492-4387 for matters related to part 155 subpart H and part 157.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://regulations.gov. Follow the search instructions on that Web site to view public comments.
Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

This final rule incorporates provisions originally published as two proposed rules, the July 15, 2011 rule titled Establishment of Exchanges and Qualified Health Plans (“Exchange establishment proposed rule”), and the August 17, 2011 rule titled Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers (“Exchange eligibility proposed rule”). These proposed rules are referred to collectively as the Exchange establishment and eligibility proposed rules. While originally published as separate rulemaking, the provisions contained in these proposed rules are integrally linked, and together encompass the key functions of Exchanges related to eligibility, enrollment, and plan participation and management. In addition, several sections in this final rule are being issued as interim final rules and we are soliciting comment on those sections. Given the highly connected nature of these provisions, we are combining both proposed rules and the interim final rule into a single final rule for reader ease and consistency with the note that, even though the final rule is shorter than the sum of the two proposed rules, it is longer than each individually.

An updated Regulatory Impact Analysis associated with this final rule is available at http://cciio.cms.gov under “Regulations and Guidance.” A summary of the aforementioned analysis is included as part of this final rule.

Abbreviations

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Affordable Care Act—The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152))

BHP Basic Health Program

CAHPS Consumer Assessment of Healthcare Providers and Systems

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

***18311** DOL U.S. Department of Labor

ERISA Employee Retirement Income Security Act (29 U.S.C. section 1001, et seq.)
FEHBP Federal Employees Health Benefits Program (5 U.S.C. 8901, et seq.)

HEDIS Healthcare Effectiveness Data and Information Set

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)

HMO Health Maintenance Organization

IHS Indian Health Service

IRS Internal Revenue Service

LEP Limited English Proficient

MAGI Modified Adjusted Gross Income

MEWA Multiple Employer Welfare Arrangement

NAIC National Association of Insurance Commissioners

OMB Office of Management and Budget

OPM U.S. Office of Personnel Management

PBM Pharmacy Benefit Manager

PHS Act Public Health Service Act

PRA Paperwork Reduction Act of 1985

QHP Qualified Health Plan

SHOP Small Business Health Options Program

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SSA Social Security Administration

SSN Social Security Number

The Act Social Security Act

The Code Internal Revenue Code of 1986

TIN Taxpayer Identification Number

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Executive Summary: Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges." Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs, and Exchanges will give individuals and small businesses the same purchasing clout as big businesses.

This final rule: (1) Sets forth the minimum Federal standards that States must meet if they elect to establish and operate an Exchange, including the standards related to individual and employer eligibility for and enrollment in the Exchange and insurance affordability programs; (2) outlines minimum standards that health insurance issuers must meet to participate in an Exchange and offer qualified health plans (QHPs); and (3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP). The intent of this final rule is to afford States substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons. Consistent with the scope of the Exchange establishment and eligibility proposed rules, this final rule does not address all of the Exchange provisions in the Affordable Care Act; rather, more details will be provided in forthcoming guidance and future rulemaking, where appropriate.

A portion of this rule is issued on an interim final basis. As such, we will consider comments from the public on the following provisions:

• § 155.220(a)(3)—Related to the ability of a State 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)—Related to Medicaid and CHIP regulations;

• § 155.302—Related to options for conducting eligibility determinations;

• § 155.305(g)—Related to eligibility standards for cost-sharing reductions;

• § 155.310(e)—Related to timeliness standards for Exchange eligibility determinations;

• § 155.315(g)—Related to verification for applicants with special circumstances;

• § 155.340(d)—Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions; and

• § 155.345(a) and § 155.345(g)—Related to agreements between agencies administering insurance affordability programs.

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I. Background

A. Legislative Overview

1. Legislative Requirements for Establishing Exchanges

Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange(s) that: (1) Facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act.

Section 1321 of the Affordable Care Act discusses State flexibility in the operation and enforcement of Exchanges and related policies. Section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321(c)(1) directs the Secretary to establish and operate such Exchange within States that either: (1) Do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 establishes provisions to reduce the cost-sharing obligation of certain ***18312** eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining Indians eligible for certain categories of cost-sharing reductions.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the individual responsibility provision.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

Unless otherwise specified, the provisions in this final rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act.

2. Legislative Requirements for Related Provisions

Subtitle K of title II of the Affordable Care Act, Protections for American Indians and Alaska Natives, section 2901, extends special benefits and protections to Indians including limits on cost sharing and payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and urban Indian organizations. We are finalizing special Exchange enrollment periods and the reductions in cost sharing for Indians authorized, respectively, by sections 1311(c)(6) and 1402(d) of the Affordable Care Act under this authority in subparts D and E of part 155, and we expect to address others in future rulemaking.

Section 6005 of the Affordable Care Act creates new section 1150A of the Act, which directs QHP issuers, and sponsors of certain plans offered under part D of title XVIII of the Act to provide data on the cost and distribution of prescription drugs covered by the plan. We are codifying these standards under this authority in subpart C of part 156.

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B. Structure of the Final Rule

The regulations outlined in this final rule are codified in the new 45 CFR parts 155, 156, and 157. Part 155 outlines the standards relative to the establishment, operation, and minimum functionality of Exchanges, including eligibility standards for insurance affordability programs. Part 156 outlines the standards for health insurance issuers with respect to participation in an Exchange, including the minimum certification standards for QHPs. Many provisions in part 155 have parallel provisions under part 156 because the Affordable Care Act creates complementary responsibilities for Exchanges and QHP issuers. Where possible, there are cross-references between parts 155 and 156 to avoid redundancy. Part 157 establishes the participation standards for employers in the Small Business Health Options Program (SHOP).

Subjects included in the Affordable Care Act to be addressed in separate rulemaking include but are not limited to: (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.

We note that the health plan standards set forth under this final rule are, for the most part, strictly related to QHPs certified to be offered through the Exchange and not the entire individual and small group market. Such policies for the entire individual and small and large group markets have been, and will continue to be, addressed in separate rulemaking issued by HHS, and the Departments of Labor and the Treasury.

C. Alignment With Related Rules and Published Information

The Exchange eligibility proposed rule was published in conjunction with “Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010—CMS-2349-P,” which will be referred to throughout this final rule as the “Medicaid proposed rule” and the proposed rule published by the Department of the Treasury, “Health Insurance Premium Tax Credits—REG 131491-10,” which will be referred to throughout this final rule as the “Treasury proposed rule”. This regulation includes numerous cross-references to the Medicaid final rule, which is expected to be finalized shortly after this final rule. The Treasury final rule is expected to be published soon after this Exchanges final rule.

HHS published a document titled “State Exchange Implementation Question and Answers” on November 29, 2011. [FN1] We reference this document throughout the preamble where the information complements policies in this final rule.

II. Provisions of the Proposed Regulation and Analysis and Responses to Public Comments

The Exchange establishment and eligibility proposed rules were published in the Federal Register on July 15, 2011 and August 17, 2011, respectively, with comment periods ending October 31, 2011. In total, we received approximately 24,781 comments on both proposed rules. Of the comments received, about 23,000 were a collection of letter campaigns related to women's services, or general public comments on the Affordable Care Act and the government's role in healthcare, but not specific to the proposed rules. We also received a number of comments on essential health benefits and preventive services. We have not addressed such comments, and others that are not directly related to the proposed rule, because they are outside the scope of this final rule.

Before the proposed rules, HHS also published a Request for Comment (the RFC) on August 3, 2010 (75 FR 45584) inviting the public to provide input regarding the rules that will govern the Exchanges. In this final rule, we have responded to comments submitted in response to the Exchange establishment and eligibility proposed rules and the RFC, where relevant. These comments are not separately identified, but instead are incorporated into each substantive section of the final rule as appropriate. For the most part, we address issues according to the numerical order of the regulation sections.

Comments represented a wide variety of stakeholders, including but not limited to States, tribes, tribal organizations, health plans, consumer groups, healthcare providers, industry experts, and members of the public. In addition, we held consultation

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sessions on August 22, 2011, September 7, 2011, and September 15, 2011 to provide an overview of the proposed rule where Tribal governments were afforded an opportunity to ask questions and make comments. The public was reminded to submit written comments before the close of the public comment period that was announced in the proposed rule and we extended the comment period by 30 days to ensure ample opportunity for comments.

***18313** Many commenters addressed the balance between flexibility for States and Exchanges and standardization and predictability for consumers nationwide. Commenters also expressed concerns about differences between Exchange and Medicaid policies and about various aspects of the eligibility verification and redetermination process.

While we recognize that consumers may benefit from national standards, we continue to believe that States are best equipped to adapt the minimum Exchange functions to their local markets and the unique needs of their residents. Further, States already have significant experience performing many key functions, including oversight and enforcement of health plans, and determining eligibility for health benefit programs. Therefore, where possible we finalized provisions of the proposed rule that provided significant discretion for States to go beyond the minimum standards in implementing and designing an Exchange. We believe this approach leverages local expertise and experience to provide a positive experience for consumers. Since functions within an Exchange will be handled consistently, consumers comparing plans within an Exchange will benefit from standardization. In addition, based on comments received, we provide States with additional options for determining eligibility under a State-based and Federally-facilitated Exchange in this final rule.

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

1. Subpart A—General Provisions

a. Basis and Scope (§ 155.10)

Proposed § 155.10 of subpart A specified the general statutory authority for and scope of standards proposed in part 155, which establish minimum standards for the State option to establish an Exchange; minimum Exchange functions; eligibility and enrollment of qualified individuals, including for advance payments of the premium tax credit and cost-sharing reductions; enrollment periods; minimum SHOP functions; eligibility and enrollment of qualified employers and employees in a SHOP; and certification of QHPs. We did not receive specific comments on this section and are finalizing the provision as proposed.

b. Definitions (§ 155.20)

Under § 155.20, we set forth definitions for terms that are used throughout part 155. For the most part, the definitions presented in § 155.20 were taken directly from the Affordable Care Act or from existing regulations, though some new definitions were created when necessary.

We proposed definitions or interpretations for “Exchange,” “advance payments of the premium tax credit,” “annual open enrollment period,” “applicant,” “cost-sharing reductions,” “initial enrollment period,” and “special enrollment period.” In addition, in the Exchange Eligibility proposed rule, we included a definition for “application filer.”

Comment: A few commenters suggested that the term “applicant” only apply to individuals seeking coverage for themselves. Another commenter sought clarification as to whether the term applies only to modified adjusted gross income (MAGI)-based Medicaid applicants or to all Medicaid applicants.

Response: We have revised the definition of the term “applicant” to apply only to individuals who are seeking eligibility for coverage for themselves or their family. The proposed definition included an individual who is seeking eligibility for advance payments of the premium tax credit and cost-sharing reductions who might not be seeking coverage for himself or herself (for example, in a situation in which a parent is seeking coverage only for his or her children); we have removed these programs

from the definition of applicant as part of this clarification. Revising this definition is important to clarify that certain provisions of subpart D (for example, verification of citizenship and lawful presence) only apply to individuals who are seeking coverage.

We also note that this term applies regardless of the results of an individual's eligibility determination. Consequently, if an individual is seeking coverage and he or she is ultimately determined eligible for Medicaid in a non-MAGI category, he or she was still an "applicant." We further clarify that the term "applicant" applies regardless of whether an application was submitted directly to the Exchange, or if an application was submitted to an agency administering an insurance affordability program (for example, the State Medicaid or CHIP agency) and then transmitted to the Exchange.

Comment: We received comments suggesting that the definition of "application filer," described in § 155.300(a), incorporate language included in Medicaid proposed regulations at 42 CFR 435.907, allowing that applications be completed by "the applicant, an authorized representative, or someone acting responsibly for the applicant."

Response: In the final rule, we amend the definition of "application filer" in proposed § 155.300 to align with the description of individuals who may submit an application according to § 155.405(c) of this final rule as well as the Medicaid final rule, and to include: applicants; an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Code; authorized representatives; or, if the applicant is a minor or incapacitated, someone acting responsibly on behalf of the applicant.

Comment: A few commenters suggested that defining "benefit year" as a calendar year may be confusing to some industries where such term is not used in the same way. Others asked how this definition impacts the calculation of deductibles and out-of-pocket limits.

Response: The term "benefit year" is defined only for the purposes of this regulation and does not change the industry's use of the term. In this final rule, as in the proposed rule, we use "benefit year" to refer to the calendar year of coverage provided through the Exchange. The calculation of deductibles and cost-sharing limits described in section 1302(c) of the Affordable Care Act will be addressed in future regulations.

Comment: One commenter recommended we should define "consumer" to include enrollees, qualified employers, qualified individuals and qualified employers. One commenter requested that "person" be more clearly defined to be limited to individuals acting as brokers or agents, because in some States the word "person" is defined to include entities such as a company, insurer, association, or an organization.

Response: In response to the comments, we have tried to limit the use of the terms "consumer" and "person" to reduce ambiguity and any confusion. When possible, we say "individual" when the terms "applicant, qualified individual, or enrollee" are not suitable. The definition of agent or broker is inclusive of individuals, companies, insurers, associations, organizations, and any other entity that holds a license as an agent, broker, or insurance producer. This final rule does not define "person."

Comment: Some commenters suggested that we codify the definition of "educated health care consumer in section 1304(e) of the Affordable Care Act.

Response: We have added this definition to § 155.20.

***18314** Comment: Two commenters sought clarification on whether the term "Exchange" includes both the individual market and SHOP components of an Exchange.

Response: The definition of "Exchange" includes the phrase "makes QHPs available to qualified individuals and qualified employers" and thus incorporates the Exchange functions that serve both the individual and small group markets. Governance of an independent SHOP is addressed in § 155.110(e) and unique standards for the SHOP are outlined in subpart H of this final rule.

Comment: One commenter suggested that we define what it means for an Exchange to "make available" QHPs.

Response: We believe that this regulation in its entirety defines what it means to "make available" QHPs in terms of certifying QHPs, displaying comparative QHP information, determining eligibility for enrollment, facilitating enrollment, and providing consumer assistance.

Comment: One commenter requested that we define the term "entities eligible to carry out Exchange functions."

Response: We define what entities are eligible to carry out Exchange functions in § 155.110(a) of this final rule, and believe that a definition in § 155.20 would be duplicative.

Comment: Several commenters recommended that the final rule include a definition of "family" and that it be based on definitions used by Office of Personnel Management or the Department of Labor, or as defined under the Family and Medical Leave Act. Commenters urged the definition to capture the diversity and variety of family structures. Several commenters noted that a definition will promote clarity and consistency in the implementation of proposed § 156.255.

Response: For purposes of the administration of advance payments of the premium tax credit and cost-sharing reductions, this final rule cross-references and incorporates from section 36B of the Code the definition of "household income." That definition relies on an identification of members of the "family" that is based on section 36B of the Code, which will be finalized as part of the Treasury rule. We intend this final rule to align with the Code as implemented by the Secretary of the Treasury's final rules. This final rule, at § 155.320(c)(2)(i), provides that an application filer must provide an attestation to the Exchange regarding the individuals that comprise his or her household for purposes of Medicaid and CHIP eligibility (within the meaning of 42 CFR 435.603(f)). Please refer to part 155 subpart D for a more detailed discussion of this topic. We note that we are not finalizing the provisions of § 156.255(c).

Comment: Several commenters stated that the definition of "qualified employer" should include a multi-employer plan as defined in ERISA Section 3(37), and that "qualified employee" should include individuals who are participants in a multi-employer plan, not just individuals who are employed by a qualified employer.

Response: We do not think that the law supports accepting the commenters' suggested changes in the definitions of "qualified employer" and "qualified employee." Accordingly, we have not changed the definitions in the final rule. We intend to address commenters' concerns surround multi-employer and church plans in future guidance.

Comment: We received numerous comments regarding the types of plans that should be considered health plans eligible for certification as QHPs. A few commenters suggested that multiple employer welfare arrangements (MEWAs) be allowed to offer plans through the Exchange, be allowed to offer plans only in the SHOP and not the individual market, and be allowed to restrict enrollment to specific industry members or associations. A small number of commenters also suggested that Taft-Hartley plans and church plans be available through the Exchange. Other commenters urged HHS to ensure that all QHPs offered through the Exchange meet the same standards to ensure a level playing field and questioned the ability of self-insured employer groups to comply.

Response: We finalize the definition of a health plan as codified from section 1301(b)(1) of the Affordable Care Act, and the standards set forth for participation in an Exchange are equally applicable to any health insurance issuer seeking certification of health plans as QHPs. We intend to address issues related to multi-employer and church plans in future guidance.

Comment: Many commenters recommended HHS adopt an expansive definition of "lawfully present" that includes all prospective qualified individuals. A few commenters suggested that our definition be based on the current definition in section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA, Pub. L. 111-3) or definitions proposed by

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the National Immigration Law Center and Asian and Pacific Islander American Health Foundation. Several commenters recommended that States have flexibility to continue using existing standards for lawfully present, as long as the rules are no more restrictive than Federal law. Many commenters recommended that we clarify that any list of "lawfully present" immigration categories is not exhaustive, as statuses and documents are constantly evolving.

Many commenters also suggested a range of additional categories to be included in the lawfully present definitions, including individuals whose immigration status makes them eligible to apply for an Employment Authorization Document regardless of whether they have secured a work permit under 8 CFR 274a.12; certain victims of trafficking who have been granted "continued presence"; individuals granted a stay of removal/deportation by administrative or court order, statute, or regulations; individuals who are lawfully present in the Commonwealth of the Mariana Islands and American Samoa; individuals Permanently Residing in the U.S. under Color of Law; and asylum applicants (including pending applicants for asylum under section 208(a) of the Immigration and Nationality Act (INA), or for withholding of removal under section 241(b)(3) of the INA or Convention Against Torture).

Response: We maintain the definition of "lawfully present" as used in the Pre-Existing Condition Insurance Plan, which is consistent with the definition of "lawfully present" used in section 214 of CHIPRA, and included in the proposed rule. HHS will consider commenters' recommendations in developing future rulemaking on this definition as it relates to Medicaid, CHIP, and the Exchanges.

Comment: Several commenters recommended we adopt the broad, U.S. Census data definition for "limited English proficient" which is "an individual whose primary language is not English and who speaks English less than very well."

Response: In the final rule, we do not adopt a definition for the phrase "limited English proficient." We anticipate issuing future guidance that will interpret this term and will provide best practices and advice related to meaningful access standards for limited English proficient individuals.

Comment: One commenter recommended that the definition for "minimum essential coverage" include both defined contribution and defined benefit plans, allowing individuals to use any health care funds to maximize their purchasing power. Another commenter suggested that the Federal definition of "eligible employer sponsored plan" be such that in ***18315** circumstances that an employer is not able to provide a threshold of quality coverage, a defined contribution combined with premium tax credits should be provided in the individual market Exchange.

Response: The definitions of "minimum essential coverage" and "eligible employer sponsored plan" are provided in section 5000A(f) of the Code and will be interpreted in Treasury guidance. The provisions of the Affordable Care Act that we implement through this final rule rely on those definitions from the Code.

Comment: One commenter believes that Navigators should not be an individual person, but rather a regulated entity/institution, noting that awarding Navigator grants to individuals will increase the potential for fraud and consumer protection violations.

Response: We maintain the definition for "Navigator" from the proposed rule. However, we have added Navigator standards in § 155.210(b) that are intended to reduce the potential for fraud and increase consumer protection.

Comment: Regarding the definition of "plain language," one commenter recommended that all communications be provided in the individual's primary language. Several commenters recommended that we align with the National Institutes of Health's definition of "plain language," including standards that communications be written between a fourth and sixth grade reading level, include non-written visuals, and reflect the likelihood that a proportion of individuals accessing the Exchange will not be familiar with utilizing online technologies.

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Response: We maintain the definition of “plain language” as codified from section 1311(e)(3)(B) of the Affordable Care Act, which directs HHS and the Department of Labor to jointly develop and issue guidance on best practices of plain language writing.

Comment: One comment voiced concern that the definition of “qualified health plan” might potentially undermine a State that wanted to implement a standard that QHP issuers offer their QHPs outside of an Exchange.

Response: We note that, consistent with the Affordable Care Act provisions that address how issuers of QHPs may offer their products, nothing in this final rule precludes a QHP issuer from offering a QHP outside of an Exchange, which we believe leaves flexibility for States to establish the offering of QHPs outside of the Exchange as a condition of certification.

Comment: We received comments throughout to add the phrase “and stand-alone dental plans providing the pediatric dental essential health benefit” when referring to QHPs. One commenter requested that we define “stand-alone dental plan.”

Response: In general, with some exceptions as noted in new § 155.1065(a)(3) of this final rule, we consider stand-alone dental plans to be a type of “qualified health plan,” and therefore believe that the addition of the suggested text is unnecessary. We believe that § 155.1065 sufficiently defines “stand-alone dental plan” for the purposes of participation in an Exchange, and a definition in § 155.20 would be duplicative.

Comment: We received several comments about the applicability of Medicare Secondary Payer (MSP) rules regarding coverage of End Stage Renal Disease (ESRD) and their applicability to QHPs as group health plans. These comments were received within the context of several sections, including: § 155.20, which defines the terms “health plan” and “qualified health plan”; § 155.705 (Functions of a SHOP); § 155.1000 (Certification Standards for QHPs); and § 156.200 (QHP Participation Standards). Commenters recommended that MSP rules regarding coverage of ESRD apply to QHPs as group health plans.

Response: We clarify that QHPs offered in the small group market fall under the definition of a group health plan subject to MSP provisions codified in section 1862(b)(1) of the Social Security Act. This would result in parity between the SHOP and non-Exchange small group market regarding the applicability of MSP rules that pertain to ESRD coverage.

Comment: A few commenters suggested that the definition of “State” include the Territories.

Response: The definition of State is based on section 1304 of the Affordable Care Act, which does not include Territories. Section 1323 of the Affordable Care Act addresses Territories in the context of Exchanges and is not within the scope of this regulation.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.20, with the addition of the term “educated healthcare consumer,” which references the statutory definition for such term. As discussed in later sections, we also add a definition for “application filer” and “Exchange Blueprint” to provide more detail for the purposes of eligibility and enrollment and approval of State-based Exchanges. We also clarified the definition of “applicant.” Finally, we have replaced the text of definitions copied from the Affordable Care Act with a direct reference instead, including: “eligible-employer sponsored plan,” “grandfathered health plan,” “health plan,” “individual market,” “plain language,” and “small group market.”

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

The Affordable Care Act sets forth general standards related to the establishment of an Exchange and identifies a number of areas where States that choose to operate an Exchange may exercise operational discretion. This subpart sets forth approval standards for State-based Exchanges, as well as the process by which HHS will determine whether a State-based Exchange meets those standards.

a. Establishment of a State Exchange (§ 155.100)

We proposed to codify the option for States to elect to establish an Exchange to serve qualified individuals and qualified employers, provided that the Exchange is a governmental agency or non-profit entity established by the State and that the governance structure of the Exchange is consistent with § 155.110. Furthermore, we introduced the concept of a State Partnership model that would allow States to leverage work done by other States and the Federal Government.

Comment: Many commenters supported the general approach of State flexibility in the Exchange establishment proposed rule, while some urged additional flexibility and others requested more uniformity to decrease administrative complexity. Some topics where more uniformity was suggested include: minimum numbers of board meetings, conflict of interest standards, stakeholder consultation, call centers outside of normal hours, types of consumer outreach, notices, and access for limited English proficient individuals. Several commenters urged HHS to establish a menu of systems, functions, standard operating procedures, educational materials, reporting formats, and other tools that States could adopt for their Exchanges. One commenter suggested that States that use the HHS templates should receive an accelerated review process.

Response: Decreasing administrative complexity will assist States in Exchange establishment. States are encouraged to make use of materials available to them from other States and on HHS's Collaborative Application Lifecycle Tool (CALT). HHS is also ***18316** developing a Web portal that will allow continued sharing of information, business process flows, and templates to aid States in the establishment of their Exchange.

Comment: One commenter requested clarification on proposed § 155.100(a) regarding whether a State could only establish a SHOP, and not an Exchange to serve the individual market. Other commenters urged HHS not to allow administrative separation of the small group and individual markets between a State-based and Federally-facilitated Exchange.

Response: HHS will approve a State-based Exchange upon determining that all minimum functions of an Exchange are met, which includes providing access to QHPs to qualified individuals and to qualified employers through a SHOP.

Comment: In relation to proposed § 155.100(b), several commenters voiced support of the option for Exchanges to be operated through a non-profit or governmental entity. One commenter requested clarification on what is encompassed in "governmental." Some commenters were concerned about accountability of non-profit entities and encouraged States to establish governmental or quasi-governmental entities. Several commenters requested clarification that stakeholders would still need to be consulted regardless of the governance entity.

Response: The discretion afforded States outlined in section 1311(d)(1) of the Affordable Care Act is critical. We do not provide additional clarification regarding what would be considered "governmental" in deference to existing State classifications. We note that § 155.130 of this final rule applies to all Exchanges.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.100 of the proposed rule without modification.

b. Approval of a State Exchange (§ 155.105)

In § 155.105, we proposed that the Secretary must determine by January 1, 2013 whether a State's Exchange will be fully operational by January 1, 2014 and outlined the proposed standards based upon which HHS will approve a State Exchange. Please refer to the preamble of the Exchange establishment proposed rule, at 76 FR 41870-41871, for a detailed discussion of these standards.

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Specifically, we outlined the process through which HHS will approve a State-based Exchange. We proposed that to initiate the State Exchange approval process, a State must submit an Exchange Plan to HHS. We noted that we planned to issue a template outlining the components of the Exchange Plan, subject to the notice and comment process under the Paperwork Reduction Act. We proposed that each State receive written approval or conditional approval of its Exchange Plan in order to operate and to constitute an agreement between HHS and the Exchange to adhere to the contents of the Exchange Plan. We also proposed that a State must notify HHS and receive written approval from HHS before significant changes are made to the Exchange Plan. We sought comment on whether the State Plan Amendment process offered an appropriate model for change submission and approval.

Finally, we proposed to codify the provision in the Affordable Care Act that if a State elects not to establish an Exchange—or if the State's Exchange is not approved—HHS must establish an Exchange in that State, and we proposed standards of the proposed rule that would apply to a Federally-facilitated Exchange.

Comment: Many commenters were concerned that the approval date of January 1, 2013 for State-based Exchanges, as described in proposed § 155.100(a), will be difficult for many States to meet and suggested that HHS allow more flexibility or issue waivers for States that cannot meet the timeframes. One commenter suggested that HHS approve an Exchange if a State has passed enabling legislation, or has the necessary regulatory process for Exchange creation underway by January 1, 2013, and can provide HHS with a detailed plan and timeline for Exchange development. In contrast, several commenters supported the January 1, 2013 approval deadline and requested that HHS closely monitor and enforce the implementation timeline.

Several commenters also supported conditional approval and noted that it could help States meet the timelines for Exchange development. One commenter requested additional information on conditional approval, including the latest date when HHS could revoke conditional approval and interim deadlines and benchmarks. Another commenter did not support conditional approval and felt it diluted Federal scrutiny, while others expressed concern that conditional approval would result in States beginning open enrollment late, in a diminished capacity, or in a way that impairs HHS's ability to implement a Federally-facilitated Exchange.

Response: We believe that in order to meet the October 1, 2013 open enrollment date, a State-based Exchange must be approved or conditionally approved by January 1, 2013, as called for in section 1321(c)(1)(B) of the Affordable Care Act. HHS may conditionally approve a State-based Exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013, which provides States with flexibility in meeting Exchange development timelines. HHS will provide additional details in future guidance.

Comment: One commenter suggested that proposed § 155.105(b) include additional confidentiality standards, including that an Exchange comply with section 1411(g) of the Affordable Care Act and the Privacy Act (5 U.S.C. 552a).

Response: HHS is committed to ensuring that security and privacy standards are in place in an Exchange. Security and privacy standards are addressed in § 155.260 and § 155.270 of this final rule. We believe it is duplicative to include these standards in § 155.105(b).

Comment: Several commenters requested that the rule regarding the geographic area described in proposed § 155.105(b)(4) be modified to clearly indicate that where there are multiple Exchanges, with each Exchange serving a distinct geographic area, that consumers could only use one Exchange. Several commenters suggested that HHS establish that the distinct geographic areas be consistent with premium rating areas in the State as determined under section 2701(a)(2) of the PHS Act.

Response: In the preamble to the Exchange establishment proposed rule for § 155.105, we clarified that only one Exchange may operate in each geographically distinct area and that a subsidiary Exchange must be at least as large as a rating area. We maintain this position in the final rule, which we believe provides States with discretion to ensure that subsidiary Exchange service areas are consistent with rating areas.

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Comment: Several commenters requested that the proposed Exchange Plan described in proposed § 155.105(c)(1) be subject to a public comment period before HHS approval. One commenter asked that HHS post documents related to the proposed Exchange Plan and operational readiness on the HHS Web site.

Response: We believe that accelerating timeframes to accommodate a period for public comment on what we now refer to as "Exchange Blueprints" would put unreasonable pressure on what is already perceived as a tight timeline. Therefore, in order to maintain flexibility and because of ***18317** timeframe concerns, the final rule does not call for a State's Exchange Blueprint to be made public and open to comment prior to approval by HHS.

Comment: One commenter supported the proposal that the operational readiness assessment conducted by HHS, as described in proposed § 155.105(c)(2), be coordinated with the monitoring process of the State Establishment Grants provided under section 1311 of the Affordable Care Act.

Response: We believe that the operational readiness assessment should be coordinated with the grants monitoring process and are currently developing guidance for the evaluation process.

Comment: In relation to proposed § 155.105(d) and (e), several commenters supported using a process modeled from the Medicaid and CHIP State Plan review process for the approval of the initial Exchange and subsequent changes, including the 90-day review timeframe and posting of changes on the Internet, and because they believe that the process ensures sufficient Federal oversight and transparency. In contrast, many other commenters urged HHS to use a review plan other than the Medicaid and CHIP model, contending that the State Plan review process would delay State implementation while waiting for an HHS review that could potentially take up to 180 days. The commenters suggested that the proposed approach would be unwieldy, especially where HHS requests for additional information from States would restart the 90-day period, and would inhibit States from being able to effectively establish an Exchange and respond to changing circumstances over time.

Response: We believe that initial approval of an Exchange and approval of subsequent changes should not cause unnecessary delay in Exchange implementation or future operations. Therefore, HHS will not model the review of the initial proposed Exchange Plan or future changes after the Medicaid and CHIP State Plan process. Additionally, we have changed reference of the "Exchange Plan" to "Exchange Blueprint" to avoid confusion with the Medicaid and CHIP review process. Finally, we amended § 155.105(e) to provide that when a State makes a written request for approval of a significant change to 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. For good cause, HHS may extend the review period an additional 30 days to a total of 90 days. We note that during the review period, HHS may deny the significant change to the Exchange Blueprint.

Comment: Several commenters sought more information and provided suggestions on the establishment and operation of the Federally-facilitated Exchange described in proposed § 155.100(f), including: the overall structure, governance, oversight, and standards; how it would differ from State to State; the approach to certification of QHPs ("active purchaser" versus "any willing plan"); and, what the relationship would be between a Federally-facilitated Exchange and Partnership model. One commenter expressed concern about consumer advocates' ability to engage in the governance and oversight of a Federally-facilitated Exchange, while other commenters requested that the Federally-facilitated Exchange's planning documents and updates should be subject to public notice and comment.

Response: Information regarding the Federally-facilitated Exchange will be provided in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.105 of the proposed rule, with the following modifications: in paragraph (a), we added clarifying language regarding the timeframe for Exchange approval, and clarified that HHS may consult with other relevant Federal agencies to approve a State-based Exchange. Throughout § 155.105, we changed "Exchange Plan" to

“Exchange Blueprint.” We included subpart D in the list of Exchange functions in paragraph (b)(2) because we are finalizing the Exchange establishment and eligibility rules together, and removed the policy that States agree to perform responsibilities related to the reinsurance program because we are not finalizing the operation of the reinsurance program in connection with Exchange establishment. We amended paragraph (e) to provide timeframes for the approval of significant changes to the Exchange Blueprint.

c. Election To Operate an Exchange After 2014 (§ 155.106)

We proposed to give States the opportunity to seek approval to operate an Exchange after the statutory date of January 1, 2013. Specifically, we proposed that a State electing to operate an Exchange after 2014 must have in effect an approved or conditionally approved Exchange Plan at least 12 months prior to the first effective date of coverage, or January 1 of the prior year. Further, a State must work with HHS to develop a plan to transition from a Federally-facilitated Exchange (including a Partnership) to a State-based Exchange.

We also proposed a process to allow a State-based Exchange to cease its operations after January 1, 2014 and to elect to have the Federal government establish and operate an Exchange within the State, provided that the State notifies HHS of this determination 12 months prior to ceasing its operations and collaborates with HHS on the development and execution of a transition plan.

Comment: One commenter stated that the deadlines set by the Affordable Care Act for setting up a State-based Exchange are not realistic and that HHS should extend them.

Response: We understand the concerns regarding the deadlines for setting up a State-based Exchange. While we do not believe authority exists in section 1321(c) of the Affordable Care Act to alter the January 1, 2014 Exchange implementation date, we proposed § 155.106 to alleviate some of the timing pressure. We maintain that approach in this final rule.

Comment: Numerous commenters supported the flexibility for a State to elect to operate an Exchange after 2014, and several requested more detail on the transition plans in proposed § 155.106(a)(3). Suggestions for the transition plan included: demonstration of consumer input and tribal consultation; process for educating consumers about potential changes; process for ensuring QHP issuers have sufficient time to comply with new standards (such as a one-year grace period); and, a plan to protect enrollees from lapses of coverage. A number of commenters recommended a State-based Exchange starting after 2014 must have similar or better levels of insured rates, affordability, covered benefits, and administrative simplicity or quality of services.

Response: We believe that it is important to develop a seamless transition plan for consumers and issuers alike, and will provide future guidance on transition plans.

Comment: Several commenters requested clarification on the process for transitioning to a Federally-facilitated Exchange in proposed § 155.106(b) when a State terminates Exchange operations with less than twelve months notice to HHS. One commenter urged HHS to establish an alternative process for providing interim coverage to consumers if a State does not provide sufficient notice.

Response: We understand concerns regarding the transition timeframes. ***18318** HHS will develop an approach to transitioning Exchanges in various circumstances when it becomes clearer what such circumstances would entail.

Comment: One commenter requested information as to the availability of funding options for States electing to operate an Exchange after 2014.

Response: As described in the State Exchange Implementation Questions and Answers released by HHS on November 29, 2011, establishment grants may be awarded through the end of 2014 for approved and permissible establishment activities. The process of “establishing” an Exchange may extend beyond the first date of operation and may include improvements and

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enhancements to key functions over a limited period of time. Generally, grants can be used to establish Exchange functions and operating systems and to test and improve systems and processes. We have determined that a State that does not have a fully approved State Exchange on January 1, 2013 may continue to qualify for and receive a grant award, subject to the Funding Opportunity Announcement (FOA) eligibility criteria.

Summary of Regulatory Changes

We are finalizing the provisions in § 155.106 of the proposed rule, with a conforming, technical change that replaced "Exchange Plan" with "Exchange Blueprint" in paragraph (a)(2) and removed the word initial from paragraph (a) to make the provision more broad.

d. Entities eligible to carry out Exchange functions (§ 155.110)

In § 155.110, we proposed to codify an Exchange's authority to contract with eligible entities, and requested comment on conflict of interest standards. We noted that the Exchange remains responsible for meeting all Federal rules related to contracted functions.

If the Exchange is an independent State agency or not-for-profit entity established by the State, we proposed that its governing board meet the standards outlined in § 155.110(c)(1) through § 155.110(c)(4) of the proposed rule, which included: the Exchange accountability structure must be administered under a formal, publicly-adopted operating charter or by-laws; the Exchange board must hold regular public meetings; representatives of health insurance issuers, agents, brokers, or other individuals licensed to sell health insurance may not constitute a majority of the governing board; and, all members of the governing board must meet conflict of interest and qualifications standards. We invited comment on several topics related to conflict of interest and Exchange governance.

We also proposed that the Exchange governing body ensure that a majority of members have relevant experience in a number of areas and invited comment on the types of representatives that could best ensure successful Exchange operations. We solicited comment on ethics and disclosure standards.

Additionally, we proposed to allow a State to operate its individual market Exchange and SHOP under separate governance or administrative structures, provided that the State coordinates and shares relevant information between the two Exchange bodies and that it ensures adequate resources to assist both individuals and small employers.

Finally, we proposed that HHS retain the option to review the accountability structure and governance principles of an Exchange and requested comment on the appropriate frequency for these reviews.

Comment: A number of commenters requested clarification on whether State departments of insurance would be considered eligible contracting entities under proposed § 155.110(a), citing the importance of such expertise in the operation of an Exchange.

Response: We clarify in § 155.110(a)(2) of this final rule that, in addition to State Medicaid agencies, other State agencies that meet the qualifications in (a)(1) would be considered eligible contracting entities. For purposes of this final rule and Exchange operations, we interpret the term "incorporated" in (a)(1)(i) to include State agencies, such as departments of insurance, that have been established under and are subject to State law.

Comment: Several commenters urged HHS to apply conflict of interest standards to eligible contracting entities.

Response: We generally defer to States to establish conflict of interest standards for eligible contracting entities beyond the prohibition of health insurance issuers being eligible contracting entities, as established in section 1311(f)(3) of the Affordable Care Act and codified in § 155.110(a)(1)(iii). We believe that many States have existing conflict of interest laws, have appropriate expertise in this area, and can support Exchanges in the development of conflict of interest standards for such entities.

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Comment: Several commenters agreed with the governance provisions in proposed § 155.110(c) and requested further guidance on governance, while others recommended that HHS defer to States on governance citing concerns of burden. Another commenter suggested that all Exchanges, including an Exchange that is a State agency, needed a governing board. One commenter requested that all Exchanges post their policies and procedures on the Internet.

Response: We have afforded States substantial discretion regarding governance and do not believe that the governance standards are burdensome from an operational or systems standpoint. Additionally, to lessen the burden on States, an Exchange may use the State's conflict of interest standards, regulations, or laws for governance of the Exchange. An existing State agency would already have an accountability structure, unlike an independent agency or nonprofit entity. Therefore, we believe that a governing board is not necessary for an existing State agency, although we note that a State may choose to establish one anyway. Section 155.110(d) of this final rule directs Exchanges to make publicly available a set of guiding governance principles, which it may do through the Internet. We also create minimum standards for consumer representation on Exchange Boards to protect consumers and the interests of the Exchange without adding burden on States or Exchanges.

Comment: With respect to proposed § 155.110(c)(3), a few commenters requested HHS define "represents consumer interests" and "conflict of interest." Many commenters recommended that all Exchange boards must have at least one consumer representative or advocate and a formal consumer advisory committee. A few commenters recommended increasing the threshold for voting members that do not have a conflict of interest to something higher than a simple majority.

Response: We accept the suggestion that at least one voting member be a consumer advocate, and have amended in § 155.110(c)(3)(i) of this final rule accordingly. We do not believe this change will conflict with any current Exchange boards. We have also maintained the minimum standard that a simple majority of board members not have a conflict of interest, but a State can choose to establish an Exchange with a higher threshold of non-conflicted board members.

Comment: Commenters suggested broadening the list of groups identified as having a conflict of interest in proposed § 155.110(c)(3)(ii) to include: health care providers; anyone with a financial interest; anyone with a spouse or immediate family with a conflict of interest; major vendors, subcontractors, or other financial partners of conflicted parties; members of health trade ***18319** associations and providers; and, health information technology companies. Commenters recommended that such groups be limited or prohibited from participation in an Exchange. Other commenters recommended that individuals with ties to the insurance industry participate through technical panel or advisory group instead of through board membership.

Response: As proposed, § 155.110(c)(3)(ii) ensures as a minimum standard that the groups with the most direct conflict of interest cannot form a majority of voting members on a governing board. We believe that further definition of conflict of interest may create inconsistencies with State law and other existing State standards, but note that Exchanges may expand the list or further define conflict of interest. For example, a State may elect to prohibit any conflicted members from serving on the board.

Comment: Several commenters suggested areas in addition to those listed in proposed § 155.110(c)(4) in which governing board members should have experience, including: minority health; mental health; pediatric health; consumer education or outreach; public coverage programs; health disparities; or represent or be American Indian and Alaska Natives. A few commenters suggested that the Exchange board include members that reflected the cultural, ethnic and geographical diversity of the State.

Response: Each of the suggested groups could add value to an Exchange governance board. However, we believe that a State can determine the expertise it believes would be most beneficial for the needs of its community. We note that the list in § 155.110(c)(4) is a minimum; thus, States may establish governing boards standards that include expertise in other areas, or may set up advisory committees to achieve another mechanism for specialized input.

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Comment: Regarding proposed § 155.110(f), some commenters suggested that HHS limit review of an Exchange's governance to every three or four years, while several commenters voiced concerns about the administrative burden of an annual review. One commenter recommended an annual review but only for the first few years of Exchange operation.

Response: We have maintained language in the final rule but clarify that any changes to the accountability structure and governing principles of the Exchange will likely be reviewed under § 155.105(e) of this final rule or at the discretion of HHS through a process that may not occur annually under § 155.110(f).

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.110, with the following modifications: in paragraph (a)(1)(iii)(2), we clarified that any State entity that meets the qualifications of paragraph (a)(1) is an eligible contracting entity to include State departments of insurance. We established in new paragraph (c)(3)(i) that at least one member of the Exchange's board must include one voting member who is a consumer representative, and renumbered proposed paragraph (c)(3)(i) as (c)(3)(ii).

e. Non-interference with Federal Law and Non-Discrimination Standards (§ 155.120)

In § 155.120, we proposed that an Exchange may not establish rules that conflict with or prevent the application of Exchange regulations promulgated by HHS. We also proposed to codify that nothing in title I may be construed to preempt any State law that does not prevent the application of the provisions set forth under title I of the Affordable Care Act. In addition, we proposed that a State must comply with any applicable non-discrimination statutes, specifically that a State must not operate an Exchange in such a way as to discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Comment: One commenter suggested that HHS ensure that contractors comply with the non-discrimination provisions of proposed § 155.120. One commenter recommended HHS amend § 155.120(c) to explicitly name specific activities of the Exchange, including marketing, outreach, and enrollment in the Exchange.

Response: We clarify that § 155.120 applies to Exchange contractors and believe this notion is conveyed in § 155.110(b) for contractors. We believe that § 155.120 already applies to all activities of the Exchange, and thus do not explicitly list marketing, outreach, and enrollment.

Comment: Several commenters recommended that HHS specify that proposed § 155.120(b) functions as a floor for protection against discrimination. The commenters stated that in the event a State law provides additional consumer protections in an Exchange, the final rule should make clear that such a State law will prevail over the minimum protections codified in Federal law.

Response: We believe the proposed approach of codifying section 1321(d) of the Affordable Care Act does not preclude the application of stronger protections in the Exchange provided by State law. Therefore, we do not make any further changes in the regulations to make this clarification.

Comment: A number of commenters requested that HHS provide clarification on proposed § 155.120(c)(1) and specify which statutes would be considered “applicable non-discrimination statutes,” with suggestions including the Americans with Disabilities Act, section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, provider non-discrimination in accordance with section 2706 of the PHS Act. One commenter recommended that HHS ensure that States and Exchanges comply with existing State provider non-discrimination laws and another recommended that we amend the § 155.120(c)(1) to include consumer protection laws.

Response: We clarify that by “applicable non-discrimination statutes,” we mean any statute that would apply to Exchange activities by its clear language or as consistent with any rulemaking that has been established in accordance with such statutes.

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We acknowledge that the some non-discrimination statutes apply to specific activities and situations, and an Exchange must comply with such statutes to the extent its activities or circumstances would be subject to these standards.

Comment: We received a comment on the preamble to the proposed § 155.120(c)(2). The commenter recommended that HHS delete the phrase “operating in such a way as to discriminate” or revise the nondiscrimination standard to prohibit discrimination based “solely” on the listed grounds.

Response: To clarify, we believe that Exchanges should not discriminate in any way on the basis of groups listed in § 155.120(c)(2). We believe that the regulatory text conveys that intent.

Comment: A number of commenters recommended HHS amend proposed § 155.120(c)(2) to add categories to the proposed list, including Indians or individuals in the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, individuals with limited English proficiency, and people with disabilities.

Response: We recognize the commenters' concerns but we are maintaining the categories specified in § 155.120(c) because we believe that categories not listed in § 155.120(c)(2) are already protected by existing laws that apply to Exchanges.

Comment: A number of commenters requested that HHS provide clarification ***18320** on the oversight and enforcement of the non-discrimination standards, including recommendations for strong oversight, the establishment of a clear complaints process, and mandatory public dissemination of an acknowledgement by QHP issuers that they comply with the non-discrimination standards in section 1557 of the Affordable Care Act.

Response: We acknowledge the commenters' concerns regarding the monitoring and enforcement of the non-discrimination policies. We plan to issue future guidance on the oversight and enforcement of the non-discrimination standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.120 of the proposed rule, with a technical change to include part 157 in paragraph (b).

f. Stakeholder Consultation (§ 155.130)

Consistent with the Affordable Care Act, we proposed that Exchanges consult with certain groups of stakeholders on an ongoing basis. The list of stakeholders identified were the following: educated health care consumers who are enrollees in QHP; individuals and entities with experience in facilitating enrollment in health care coverage; advocates for enrolling hard to reach populations; small businesses and self employed individuals; State Medicaid and CHIP agencies; Federally-recognized Tribes; public health experts; health care providers, large employers; health insurance issuers; and agents and brokers. For a more complete list of stakeholders and for a discussion of how Exchanges may interact with tribes, please refer to page 41873 of the Exchange establishment proposed rule.

Comment: Some commenters requested clarification on what it means to “regularly consult on an ongoing basis,” as described in proposed § 155.130, and suggested that we clarify that an Exchange must consult with stakeholders beyond establishment of the Exchange, outlining specific processes for consultation (including public meetings and input sessions), and specifying that Exchange activities must be topics of consultation (including the call center, Web site, consumer assistance functions and Navigators).

Response: We recognize that it is important to utilize various methods of consultation to ensure the Exchange meets the diverse needs of the State's population and seeks input on a broad set of issues. However, we believe that States are in the best position to determine what will be the most efficient and effective methods of stakeholder consultation for meeting the State's unique needs and, therefore, we do not establish additional standards in the final rule.

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Comment: Many commenters recommended that HHS add additional categories of stakeholder groups to proposed § 155.130, including: a nonprofit community organization; unions; representatives of individuals with disabilities; minorities; advocates for individuals with limited English proficiency; essential community providers; employees of small businesses; stand-alone dental plans; health care consumer advocates; experts in low income tax policy; experts in privacy policy; and professional organizations representing specific health care providers. Several commenters requested clarification on what types of health insurance issuers and providers fall under the categories for consultation. A few commenters suggested that we narrow the list of stakeholders.

Response: We recognize that Exchange consultation with the above groups would help the Exchange ensure it can meet the needs of the population it serves. However, we believe that the categories proposed in § 155.130 are broad enough to encapsulate a wide variety of stakeholders, and encourage Exchanges to consult with any other stakeholders that will add perspective to the development of an Exchange. Similarly, we did not accept suggestions to make the stakeholder categories narrower and believe the minimum list proposed will stimulate stakeholder participation. Exchanges have the flexibility to determine what types of stakeholders would fall under each of the categories.

Comment: Regarding proposed § 155.130(a), one commenter was concerned that including "educated health care consumer" as a stakeholder unfairly excludes people of a certain education level. Another commenter recommended that HHS delete the word "educated" from "educated health care consumer" to avoid multiple interpretations. Numerous commenters recommended that HHS replace "educated health care consumer" with "health care consumer experienced with the system." One commenter suggested that the definition of "educated health care consumers" take into account the diversity in the age, background, and health status of consumer stakeholders. A few commenters suggested that HHS expand the stakeholder group to include consumers who are eligible or likely to enroll in a QHP in addition to those consumers enrolled in QHPs.

Response: We note that the term "educated health care consumer" is defined in section 1304(e) of the Affordable Care Act to mean an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters; we have codified this definition in § 155.20 of this final rule. An Exchange can interpret and apply the term in the way that is most appropriate for its environment consistent with this definition.

Comment: Regarding proposed § 155.130(f), commenters recommended that the final rule prohibit States from delegating consultation with Federally-Recognized Tribes to the governing bodies operating the Exchange. Commenters noted that establishing Exchanges as independent public entities would make stakeholder consultation difficult to monitor consultation with Tribes. Several commenters suggested that a tribal consultation policy be developed and approved by the State, the Exchange, and tribal governments prior to the submission of approval of an Exchange Blueprint. Some commenters also recommended that States must utilize a process for seeking advice from the Indian Health Service, tribal organizations, and urban Indian organizations as outlined in section 5006(e) of the American Recovery and Reinvestment Act. Also, one commenter requested HHS to expand the tribal consultation standard to include any tribal organization or inter-tribal consortium as defined in the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act.

Response: Section 1311(d)(6) of the Affordable Care Act directs the Exchange to carry out consultation with stakeholders, and § 155.130(f) codifies this provision with respect to Federally-recognized Tribes. We note that Exchange tribal consultation reflects a government-to-government relationship, as Exchanges would conduct consultation on behalf of States. Future guidance will be provided to States regarding key milestones, including tribal consultation, for approval of a State-based Exchange. Because of the government-to-government nature of tribal consultation, we did not include a provision similar to section 5006(e) of the American Recovery and Reinvestment Act in the proposed rule or in this final rule, and did not expand the tribal consultation standard to include tribal organizations, programs, or commissions. In the final rule, ***18321** Exchanges must consult with Federally-recognized Tribes; however, this does not preclude Exchanges from engaging in discussions or consulting with tribal and Urban Indian organizations. It should be noted that when a tribal or Urban Indian organization is a stakeholder as defined in

§ 155.130—for example, the tribal or Urban Indian organization is a health care provider—then consultation may be necessary. We therefore encourage States to consult with tribal and Urban Indian organizations.

Comment: Some commenters recommend that as a component to the ongoing tribal consultation standard in proposed § 155.130(f), the Exchange should establish an "Indian desk" with the lead person identified and contact information provided, and extend the authority of CMS Native American Contacts to include facilitating and interacting with the State Exchange governing bodies.

Response: We did not accept the suggestion that all Exchanges must establish an "Indian Desk." States have discretion to determine appropriate approaches and mechanisms for interacting with the Tribes, providing information to Indian Country and for meeting the needs of American Indians/Alaska Natives, which can be determined during the tribal consultation process. We also did not accept the suggestion related to the CMS Native American Contacts. While we recognize that the Native American Contacts have a critical role in working with States and Tribes, structuring the responsibilities of CMS staff positions is not within the scope of this final rule.

Comment: A few commenters suggested that the final rule enforce tribal consultation by Exchanges in the planning, implementation and operation of State-based Exchanges, and ensure adequate funding for the technical assistance provided by tribal entities to States and Exchanges. One commenter expressed a concern that Exchanges may not be able to process eligibility and enrollment information regarding American Indians/Alaska Natives unless they are included in policy and regulation development. Some commenters strongly urge CMS to work with Tribes to undertake a thorough education of State insurance commissioners on issues related to Indian law, the structure of the Indian health care delivery system, and protocols for consulting with Tribes, since many Tribes do not have experience working with insurance commissioners.

Response: We did not accept the suggestion for Exchanges to obligate State grant funding for technical assistance provided by tribal entities to States and Exchanges. We believe that the concern regarding Exchange inclusion of American Indians and Alaska Natives in policy development is addressed in the final rule and the Exchange Establishment Grant, which directs Exchanges to consult with Federally-recognized Tribes. We note that education of State health insurance commissioners on Indian law will be addressed at the operational level of CMS.

Comment: We received a number of comments stating that HHS should limit the number of consultations with health insurance issuers, agents, and brokers described in proposed § 155.130(j) and (k) to minimize any potential conflicts of interest. One commenter recommended that consultation with a health insurance issuer be made fully transparent, while several other commenters recommended that the consultation only include agents and brokers that enroll qualified individuals, employers, or employees.

Response: We understand the concerns of commenters, but also acknowledge that health insurance issuers and agents and brokers are likely to play a significant role in the Exchange. We encourage Exchanges to be transparent in the consultation process. Furthermore, in States where the Exchange is not housed in the department of insurance, we expect there to be regular consultation between the Exchange and the department of insurance, given the need for coordination between the two entities.

Comment: One commenter recommended that stakeholder input should contribute to both State-based Exchanges and Federally-facilitated Exchanges.

Response: As indicated in § 155.105(f), the stakeholder standards of § 155.130 apply to both Federally-facilitated Exchanges and State-based Exchanges.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.130 of the proposed rule without modification.

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g. Establishment of a Regional Exchange or Subsidiary Exchange (§ 155.140)

In § 155.140, we outlined several proposed features of regional Exchanges, including that a regional Exchange would encompass two or more States and could submit a single Exchange Blueprint, and the criteria that the Secretary will use to approve such an Exchange.

Specifically, we proposed that a State may establish one or more subsidiary Exchanges if each such Exchange serves a geographically distinct area that is at least as large as a rating area described in section 2701(a) of the PHS Act. We invited comment on operational or policy concerns related to subsidiary Exchanges that cross State lines. We also requested comment on the extent to which we should allow more flexibility in the structure of a subsidiary Exchange.

Finally, we proposed basic standards for a regional or subsidiary Exchange. For a complete discussion of the proposed standards, please see pages 41873-41874 and 41914 of the Exchange establishment proposed rule.

Comment: Regarding proposed § 155.140(a), several commenters supported the flexibility to establish regional Exchanges so that States could share Exchange infrastructure and systems. However, other commenters had concerns regarding the applicability of State standards across a regional Exchange. Some were concerned about coordinating the regulation of QHP issuers in a regional Exchange to ensure each State's insurance standards were met, especially regarding licensure and solvency, and others raised concerns about coordination between the Medicaid agencies of multiple States regarding consistency of eligibility determinations and provider payments. Other commenters were concerned that consumer protections, including State non-discrimination laws, minimum benefit standards, network adequacy, complaints processes, and tribal consultation, would be potentially undermined by a regional Exchange (particularly one that crosses non-contiguous States). Some commenters suggested that States must provide a compelling reason to establish a regional Exchange to help preserve consumer protections.

Response: We acknowledge the commenters' concerns regarding coordination across States. We note that in § 155.140(c)(1), we establish that a regional or subsidiary Exchange must meet all Exchange standards, which would include, for example, the standard in § 156.200(b)(4) that a QHP issuer be licensed and in good standing in each State in which it offers coverage. We believe that this and other provisions in the final rule provide some clarity on coordination. We recognize the concerns regarding consumer protection, and HHS will take those into account on a case-by-case basis during review of a regional Exchange Blueprint.

***18322** Comment: With regard to proposed § 155.140(a), one commenter requested clarification on whether a regional Exchange would need to cover the entirety of each State, and another requested clarification on whether two States could share administrative resources without sharing governance.

Response: We note that in § 155.140(c)(1), a regional Exchange would have to comply with all Exchange standards, including § 155.105(b)(3), which directs a State to ensure that the entire geographic area of a State is covered by an Exchange. A State has flexibility in the way it meets this standard. We believe that States are able to share administrative and operational resources to the extent practicable, and would not be considered a regional Exchange unless they also shared governance, consumer assistance, enrollment and eligibility processes, QHP certification authority, and the SHOP.

Comment: Regarding proposed § 155.140(b), a number of commenters did not support the proposed rules regarding subsidiary Exchanges out of concern for consumer protections, consumer confusion, administrative complexity, the effect of smaller risk pools, and the ability for subsidiary Exchanges to exacerbate adverse selection. Commenters suggested that a State must demonstrate a compelling justification as to how a subsidiary Exchange would be in the best interest of consumers. Some commenters suggested that subsidiary Exchanges should remain under centralized State governance and policy decisions to provide some consistency across the State. A number of commenters supported the provision in proposed § 155.140(b)(2) that ensures a subsidiary Exchange is as large as a rating area because they believe it would prevent risk selection. Several commenters urged HHS not to allow subsidiary Exchanges to cross State lines while others supported the concept.

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Response: We recognize the concerns of commenters related to the consumer experience under subsidiary Exchanges, but we believe that such Exchanges may be valuable and appropriate in some marketplaces. In reviewing a State's Exchange Blueprint, HHS will consider how best to protect the consumer experience.

Comment: A few commenters requested clarification on whether an Exchange can be statewide for the individual market with several SHOPs operated through subsidiary Exchanges. Several commenters supported the alignment of SHOP and individual market Exchange service areas to ensure consistency for consumers and insurers, and for a more robust insurance market.

Response: In this final rule, we maintain the standard in § 155.140(c)(2)(ii) that the service areas of a SHOP and individual market Exchange must match.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.140 of the proposed rule without modification.

h. Transition Process for Existing State Health Insurance Exchanges (§ 155.150)

In § 155.150, we proposed that, unless determined to be non-compliant, a State operating a pre-Affordable Care Act exchange is presumed to be in compliance with the standards set forth in this part if: (1) The exchange was operating before January 1, 2010; and (2) the State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act. We invited comment on which proposed threshold should be used and on alternative data sources. We also proposed that any State that is currently operating a health insurance exchange that meets these criteria must work with HHS to identify areas of non-compliance with the standards of this part.

Comment: A small number of commenters had suggestions for proposed § 155.150(a). A few commenters suggested that we use the Congressional Budget Office estimates for projected coverage in 2016 and others recommended the Census Bureau's American Community Survey or the Current Population Survey estimates of State coverage on January 1, 2010. A number of commenters suggested using a source that included Urban Indian-specific data, while another commenter suggested the coverage numbers be based on non-elderly State residents only. One commenter raised concerns that coverage numbers are calculated inaccurately at the State level.

Response: We have amended proposed § 155.150(a)(2) to reference the Congressional Budget Office projected coverage numbers published on March 30, 2011. HHS will work with any State that believes it would fall into this category to determine if its State coverage numbers were equal to or above that threshold in January of 2010.

Comment: Several commenters suggested that proposed § 155.150(b) should provide additional information, provide for an expedited review process, make corrective action plans publicly available, establish that determining compliance will occur by fall 2012, and otherwise remain consistent with the January 1, 2013 timeframe for Exchange approval.

Response: We believe that any State that qualifies under § 155.150(a) would continue to generally meet all standards for Exchange approval as established elsewhere in the final rule, including the process for review and timeframes, so we do not believe it necessary to outline standards in this section.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.150 of the proposed rule, with the exception of specifying the database for the projected coverage numbers upon implementation.

i. Financial support for continued operations (§ 155.160)

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In § 155.160, we proposed to codify the statutory provision that a State ensure its Exchange has sufficient funding to support ongoing operations beginning January 1, 2015 and develop a plan for ensuring funds will be available. Specifically, we proposed to allow a State Exchange to fund its ongoing operations by charging user fees or assessments on participating issuers or by generating other forms of funding, provided that any such assessments are announced in advance of the plan year. We invited comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be assessed on an annual basis.

Comment: In response to proposed § 155.160, several commenters stated that an Exchange must not be approved by HHS unless a clear plan to achieve financial sustainability has been articulated. Further, commenters recommended that an Exchange also address the implications of its selected fee structure with respect to adverse selection and identify strategies to mitigate this risk.

Response: A clearly defined plan for financial sustainability is essential to Exchange success and in § 155.160(b), we codify section 1311(d)(5)(A) of the Affordable Care Act, which establishes that a State ensure that its Exchange has sufficient funding to support its operations beginning January 1, 2015. As noted in the preamble to the proposed rule, a funding plan is necessary for Exchange approval. States should conduct an analysis of various user fee structures as well as other financial support options before making a decision. This analysis could include, among other factors, the potential impact on risk selection, issuer ***18323** participation, consumer experience, and provider contracting. We maintain the codification in this final rule.

Comment: With respect to proposed § 155.160(b), many commenters offered specific recommendations on how Exchanges should generate revenue, including methods for calculating assessments, such as percent of premium with or without a cap; per-policy fees; or establishing fees at a specified amount. Commenters also recommended uniform notice standards, such as 10 or 12 months in advance of the relevant plan or benefit year, or in March of each year. A few commenters recommended specific frequencies of collection, such as monthly.

Response: The Affordable Care Act directs Exchanges to be self-sustaining and provides flexibility for Exchanges to generate support for continued operation in a variety of ways, such as through user fees. Accordingly, we do not limit Exchanges' options in the final rule by prescribing or prohibiting certain approaches. We believe that user fees parameters, as well as the need for other revenue-generating strategies, may vary by State depending upon several factors such as the number of potential enrollees and the Exchange's operational costs. Consistent with this flexibility, we have not finalized the proposal that the Exchange announce user fees in advance of the applicable plan year, and instead look to Exchanges that opt to charge user fees to establish a deadline and vehicle for such announcement, as well as the frequency with which the Exchange will collect such fees.

Comment: Some commenters expressed support for the flexibility provided with respect to funding for ongoing operations as specified in proposed § 155.160(b). Others recommended a centralized approach to assessments or raised concerns about specific approaches for generating revenue, such as a provider or general tax. A few commenters requested that HHS provide technical assistance to States in developing assessment structures.

Response: Exchange flexibility in funding ongoing operations is critical, as we believe that the ability to pursue specific funding strategies may vary by State. We encourage Exchanges to consider the implications of various fee structures on all stakeholders before making a selection, but note that the Exchange has discretion to set parameters related to assessments. As we have noted previously, HHS is committed to working with States on a variety of Exchange features, including but not limited to financial sustainability.

Comment: In response to the reference to the definition of “participating issuer” in proposed § 156.50, many commenters made recommendations regarding the types of issuers that should be subject to any assessments established by the Exchange. The majority of commenters advocated for a broad-based approach in which all issuers would be subject to the assessment. Fewer commenters recommended a narrower approach or that certain plans, such as excepted benefit plans, be excluded. Finally, several commenters requested that the final rule clarify that Exchanges will identify the issuers subject to any assessment.

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Response: The Exchange should identify the issuers that are subject to any user fees or other assessments, if applicable. This could include all participating issuers, as defined in § 156.50 of this final rule, or a subset of issuers identified by the Exchange. Similarly, an Exchange could exempt certain issuers from assessments. We believe that Exchange discretion is important with respect to issuer participation so that Exchanges can consider a broad range of user fee and assessment alternatives. We anticipate that Exchanges will consider a variety of factors, such as the projected operating costs of the Exchange, and the number of issuers and consumers who are expected to participate, if and when establishing a fee structure.

Comment: A few commenters expressed concern that user fees or assessments charged in accordance with proposed § 155.160 will be shifted to consumers and providers. These commenters variously recommended that any user fees passed on to the consumer be treated as rate increases, that user fees be reported separately on consumer bills, and that the final rule prohibit direct assessments on consumers. Conversely, several commenters recommended that the Exchange must report on user fees and other assessments; specifically, the amount collected and how the fees were used.

Response: Any user fees or other assessments collected by the Exchange would be reflected in issuers' premiums, consistent with current industry practice, and would thus be considered as part of any rate review conducted by the State. We believe that having issuers report separately any user fees is unnecessary, as we expect that the Exchange will announce user fees in advance of each plan year. With respect to having Exchanges report on user fees, we recognize that transparency is important, but defer to State flexibility to establish a process to notify issuers and report on the assessment of user fees, if this is the approach taken to supporting continued operations. We encourage States to be transparent in this process.

Comment: A handful of commenters on proposed § 155.160 recommended that Exchanges establish uniform user fees for issuers in the individual Exchange and SHOP.

Response: We believe that the decision about whether to charge uniform user fees for issuers in the individual and small group markets is best made by the Exchange, within the context of the local market and the Exchange operational structure. Therefore, we are not limiting Exchange flexibility in this area.

Comment: A few commenters on proposed § 155.160(b) requested that HHS clarify the statement in the proposed rule that no Federal funds will be available to Exchanges after 2014. A few other commenters suggested that Exchanges secure funding from State Medicaid and CHIP agencies to support functions performed on behalf of individuals eligible for Medicaid and CHIP (for example, eligibility screenings and referrals).

Response: The Affordable Care Act specifies that the State ensure that its Exchange is self-sustaining by January 1, 2015. Further, as noted in the Department's State Exchange Implementation Questions and Answers released on November 29, 2011, section 1311 grant funding to establish an Exchange will only be awarded through 2014. This funding is available to States pursuing State-based Exchanges, or preparing to partner with HHS on specific functions, and can be used to fund State activities to establish Exchange functions and operating systems and to test and improve systems and processes over time. In addition, we note that nothing in this final rule prohibits an Exchange from executing agreements with other State agencies to provide funding for certain functions that also assist or support those other State agencies. As noted in the November 29, 2011 Q&A document, HHS has provided additional help to States to build and maintain a shared eligibility service that allows for the Exchange, the Medicaid agency, and the CHIP agency to share common components, technologies, and processes to evaluate applications for insurance affordability programs. This includes enhanced funding under Medicaid and opportunities for other State programs to reuse the information ***18324** technology infrastructure without having to contribute funding for development costs related to shared services.

Comment: Several commenters on proposed § 155.160 made recommendations with respect to how user fees or other assessments collected by the Exchange should be incorporated into issuers' medical loss ratios. Some commenters suggested that user fees should be treated as administrative costs, while others recommended that user fees be excluded from the calculation.

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Response: We clarify that all calculations and reporting of user fees must be consistent with HHS's medical loss ratio rule, published at 45 CFR 158.

Summary of Regulatory Changes

We are finalizing the provisions in proposed § 155.160, with limited exceptions: first, in revised paragraph (b)(1), we consolidated the description of how Exchange revenue may be generated to simplify the regulatory language. We deleted proposed paragraph (b)(3) and instead clarified in revised paragraph (b)(2) that no Federal grant funding to establish an Exchange will be awarded after January 1, 2015. Finally, we removed the proposal that an Exchange announce user fees in advance of the plan year and instead defer to State notification processes for assessing user fees, if applicable.

3. Subpart C—General Functions of an Exchange

Subpart C outlines the minimum functions of an Exchange, with cross-references in some cases to more detailed standards that are described in subsequent subparts (specifically, subparts D, E, H and K). The minimum functions are designed to provide State flexibility. Uniform standards are established where specified by the statute or where there were compelling practical, efficiency or consumer protection reasons. This subpart also outlines standards for consumer tools and assistance, including the Internet Web site to facilitate consumer comparison of QHPs, the Navigator program, notices, the involvement of agents and brokers, premium payment, and privacy and security.

a. Functions of an Exchange (§ 155.200)

We proposed that an Exchange must perform the minimum functions outlined in subparts E, H, and K related to enrollment, SHOP, and QHP certification, respectively. We also proposed that the Exchange grant certifications of exemptions from the individual responsibility requirement. The proposed rule established that each Exchange would perform eligibility determinations; establish a process for appeals of eligibility determinations; perform functions related to oversight and financial integrity; evaluate quality improvement strategies; and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting. We invited comments regarding these and other functions that should be performed by an Exchange.

Comment: Several commenters suggested that HHS establish objective and public performance measures to determine how well an Exchange is executing the minimum functions. Examples provided by commenters include monitoring the percent of consumers enrolled in a QHP in a timely fashion, or monitoring the change in premiums over time in relation to health plans offered outside of an Exchange. Other commenters suggested that performance should be measured against benchmarks that change over time. The commenters further suggested that HHS employ remedies to address any State-based Exchange that is not performing the minimum functions adequately, particularly the processing of applications for advance payments of the premium tax credit and cost-sharing reductions.

Response: Ongoing compliance with regulatory standards is critical to the effective operation of Exchanges and HHS is currently exploring mechanisms for performance measures and oversight tools available under section 1313 of the Affordable Care Act. We also note that the Government Accountability Office is also directed by section 1313(b) of the Affordable Care Act to conduct a study of Exchanges, including a comparison of premiums inside and outside of an Exchange.

Comment: Several commenters urged HHS to clarify that the minimum functions in proposed § 155.200 are a floor and not a ceiling. Similarly, some commenters suggested other minimum functions, including but not limited to: coordinating with public programs and entities; monitoring and addressing adverse selection; creating an ombudsman office to handle complaints and appeals related to Exchange functions; and minimizing wrongful denials of eligibility.

Response: The minimum functions presented in § 155.200 represent a floor that can be exceeded by an Exchange, but we do not believe we need to revise our proposed regulation text for that clarification. In response to the specific functions suggested

by commenters, we believe that many of the suggested additional minimum functions are already encompassed in the final rule. For example, subpart D addresses coordination with other public programs and entities as well as the accuracy of eligibility determinations. We also note that subpart K of this part equips the Exchange with the ability to establish certification standards that mitigate adverse selection, while other sections of this subpart outlines various forms of consumer support.

Comment: A number of commenters suggested that the final rule include the standard to fulfill the United States' Trust Responsibility to provide health care for American Indian/Alaska Native individuals regardless of where they reside.

Response: We believe Congress has acknowledged the Federal government's historical and unique legal relationship with Indian tribes by providing additional benefits for American Indians and Alaska Natives to increase access to health care coverage in rural and urban areas. Those benefits include the waiver of cost-sharing amounts and the special enrollment period. We believe that the provisions in this final rule implementing these benefits will supplement the services and benefits that are provided by the Indian Health Service.

Comment: Numerous commenters recommended standards related to the certificates of exemption described in § 155.200(b) of the proposed rule.

Response: As noted in the preamble to the proposed rule, we intend to address certificates of exemption and implement section 1311(d)(4)(H) and 1411 of the Affordable Care Act through future rulemaking.

Comment: Many commenters urged HHS to provide more details on the eligibility appeals minimum function in § 155.200(d) of the proposed rule, and several specifically commented on the need for appeals processes to accommodate limited English proficient individuals.

Response: As noted in the preamble to the proposed rule, we intend to address the content and manner of appeals of individual eligibility determinations in future rulemaking. We have removed this from the list of minimum functions at this time. We note, however, that § 155.355 provides that Exchange eligibility notices include notice of the right to an appeal. In addition, Exchange notices must meet certain minimum standards in § 155.230. Both of these provisions are discussed in more detail in response to comments on those specific sections.

***18325** Comment: Many commenters urged HHS to provide more details on the standards for oversight and financial integrity of an Exchange in § 155.200(e) of the proposed rule.

Response: Section 1313 of the Affordable Care Act describes the steps the Secretary may take to oversee Exchanges and ensure their financial integrity, including conducting investigations and annual audits and partially rescinding Federal financial support from a State in which the Exchange has engaged in serious misconduct. We may publish regulations or other guidance in the future describing specific parameters of this oversight.

Comment: Several commenters submitted comments in response to our proposals in § 155.200(f) supporting the use of national quality standards, State flexibility in implementation, reporting quality information to consumers and the evaluation of Exchanges as well as QHPs.

Response: As noted in the preamble to the proposed rule, we intend to address the content and manner of quality reporting under this section in future rulemaking. In addition, the State Exchange Implementation Questions and Answers published by HHS on November 29, 2011 discusses the implementation of the quality rating system for QHPs at question 11.

Comment: Some commenters requested clarification on whether an Exchange is considered a business associate under HIPAA.

Response: In response to commenters' requests for clarification regarding Exchanges and HIPAA, we have added language to section § 155.200 clarifying the relationship between Exchanges and QHP issuers, which are HIPAA covered entities, to help States determine the applicability of HIPAA to their Exchange. The final rule provides States with a breadth of options for designing and implementing Exchange functions and operations. Therefore, it is not possible to state the applicability of the HIPAA Privacy and Security Rules to all Exchanges. We have added § 155.200(e) to clarify that an Exchange is not acting on behalf of a QHP when the Exchange engages in the minimum functions outlined in this final rule.

Because the Exchange, in performing functions under § 155.200, is not operating on behalf of a particular QHP issuer, but rather is acting on its own behalf in performing statutorily-required responsibilities to determine an individual's eligibility for enrollment in a QHP through the Exchange, it is not a HIPAA business associate of the QHP issuer in regard to its performance of these functions. However, an Exchange that chooses to perform functions other than or in addition to those in § 155.200 may be a HIPAA covered entity or business associate. For instance, a State may need to consider whether the Exchange performs eligibility assessments for Medicaid and CHIP, based on MAGI, or conducts eligibility determinations for Medicaid and CHIP as described in § 155.302(b).

As stated in the Exchange establishment proposed rule, each Exchange should engage in an analysis of its functions and operations to determine whether the Exchange is a covered entity or business associate, based on the definitions in 45 CFR 160.103. However, we believe that clarifying our conceptualization of the relationship between an Exchange and QHP issuers will assist Exchanges in their independent evaluation of the applicability of HIPAA. Please see further discussion of privacy and security in § 155.260.

Summary of Regulatory Changes

In the final rule, we made the following changes to § 155.200: we have removed the proposed paragraph (c), and instead included eligibility determinations as a minimum function through reference to subpart D in paragraph (a). We have also removed the proposed paragraph (d) related to appeals of eligibility determinations. In the final rule, paragraphs (c) and (d) now reflect the minimum functions related to oversight/financial integrity and quality activities, respectively. We have added a new paragraph (e) to clarify our intent that in carrying out its responsibilities under subpart C, an Exchange would not be considered to be operating on behalf of a QHP.

b. Partnership

In the Exchange establishment proposed rule, HHS introduced the concept of a Partnership model in which HHS and States work together on the operation of an Exchange. At a State grantee meeting on September 19, 2011, HHS provided additional information regarding the Partnership model.

A Partnership Exchange would be a variation of a Federally-facilitated Exchange. Section 1321(c) of the Affordable Care Act establishes that if a State does not have an approved Exchange, then HHS must establish an Exchange in that State; the statute does not authorize divided authority or responsibility. This means that HHS would have ultimate responsibility for and authority over the Partnership Exchange. In a Partnership Exchange, we intend to provide opportunities for a State to help operate the plan management function, some consumer assistance functions, or both. For successful operation of the Exchange in this model, we expect that States would agree under the terms of section 1311 grants to ensure cooperation from the State's insurance, Medicaid, and CHIP agencies to coordinate business processes, systems, data/information, and enforcement. Under such an arrangement, States could use section 1311 Exchange grant funding to pay for activities related to establishment of these Exchange functions, thereby maintaining existing relationships and allowing for easier transitions to State-based Exchanges in future years if a State elects to pursue Exchange approval.

Comment: Many commenters supported the goal of a Partnership, but voiced concerns about the potentially negative implications for a seamless consumer experience. Commenters urged HHS to ensure that consumers would not be able to differentiate an Exchange operated by a single entity from a Partnership Exchange. Other commenters recommended a highly

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transparent process so consumers would know where to file appeals and voice complaints and health insurance issuers would know which standards are enforced by which entity. Some commenters raised concerns about separating Exchange functionality at all, and urged HHS not to sacrifice a seamless consumer experience for State flexibility.

Response: 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.

Comment: Several commenters suggested other functions for State involvement in a Partnership instead of the plan management and consumer assistance, in particular suggesting that States perform Medicaid eligibility determinations. Some commenters recommended allowing a State to retain responsibility for making Medicaid eligibility determinations in order to avoid duplicating existing State systems or curtailing traditional State responsibilities. A few commenters suggested that there be a specific process to handle disputes between HHS and Medicaid regarding Medicaid eligibility if States retained that function in a Federally-facilitated Exchange, and one suggested that consumers be held harmless and enrolled in coverage during eligibility disputes. Meanwhile, other commenters urged HHS not to bifurcate eligibility determinations ***18326** between Federal and State entities out of concerns about the negative implications for the consumer experience and the complications such bifurcation would create. A small number also suggested that a State with a Federally-facilitated Exchange must accept Federal eligibility determinations.

Other proposed functions for Partnership included: the certificates of exemption described in § 155.200(b), quality rating system, enrollee satisfaction tools, determination of affordability and minimum value of employer-sponsored coverage, or eligibility determinations for advance payments of the premium tax credit. Other commenters suggested areas that should specifically be retained by a State in any circumstance, including State responsibility for overseeing licensure, solvency, market conduct, form approval and other operations of QHPs, overseeing licensed agents, and responding to consumer complaints.

Response: In this final rule, we address leveraging existing State resources and expertise regarding Medicaid in subpart D. Exchange responsibilities related to the quality rating system and enrollee satisfaction survey will be outlined in future rulemaking. In addition, HHS continues to explore how to leverage existing State insurance activities in several areas, including licensure, solvency, and network adequacy. The State Exchange Implementation Questions and Answers published on November 29, 2011 provides additional discussion in this area.

Comment: Some commenters suggested that we allow States to have a variety of options under a Partnership Exchange, while other commenters recommended that a standardized set of limited options would be the most effective way to ensure that a Partnership does not create significant administrative burden.

Response: We recognize that an unlimited number of options for organization of a Federally-facilitated Exchange would be extremely complicated to implement and operate, and believe that the options and flexibilities HHS has laid out will balance flexibility with administrative feasibility.

Comment: Many commenters, citing concerns about accountability, supported the approach of the Partnership being a form of a Federally-facilitated Exchange, while others preferred that States retain ultimate authority in a Partnership. Some of the commenters urged HHS to oppose any Partnership that would confuse or blur lines of authority and responsibility. A few commenters suggested that HHS have readiness assessments or performance metrics to measure how a State will perform, or is performing, a function under Partnership. One commenter suggested that HHS have no role in plan management if a State decides to operate this function, while another voiced concerns about how HHS would enforce certain decisions if a State is operating one or more Exchange functions.

Response: Section 1321(c) of the Affordable Care Act does not contemplate divided authority over an Exchange. In all organizations of a Federally-facilitated Exchange, the Secretary will retain ultimate responsibility and authority over operations

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and all inherently governmental functions. A State wishing to enter into a Partnership must agree to perform the function(s) within certain parameters, as agreed upon by the State and HHS.

Comment: Some commenters urged HHS not to allow a State to operate only an individual market or SHOP component of an Exchange through a Partnership.

Response: We believe that splitting the SHOP through a Partnership is not a reasonable or feasible option at this time and have not established that as an option.

Comment: Many commenters urged HHS to consult with stakeholders during the development of a Partnership with a given State.

Response: Section 155.105(f) clarifies that the Federally-facilitated Exchange must follow the stakeholder consultation standards in § 155.130. The Federally-facilitated Exchange will consult with a variety of stakeholders to ensure that the needs of the States in which it operates are met.

Comment: A few commenters requested that Tribal governments be eligible to participate in a Partnership.

Response: Currently, only States would be eligible to enter into a Partnership with HHS, as States are the entities designated in the Affordable Care Act as responsible for setting up an Exchange (see discussion of the Exchange establishment proposed rule for more detail (76 FR 41870). However, HHS will continue ongoing tribal consultation to ensure that Exchanges address the needs of tribal populations.

Summary of Regulatory Changes

We did not propose regulations on Partnership and have not added any in this final rule. Rather, further information will be provided in the context of future guidance on the Federally-facilitated Exchange.

c. Consumer Assistance Tools and Programs of an Exchange (§ 155.205)

In proposed § 155.205, we established that the Exchange must provide for the operation of a consumer assistance call center that is accessible via a toll-free telephone number, and outlined capabilities and suggested infrastructure as well as types of information we think will be most critical to consumer experience and informed decision-making. The proposed rule sought comment on ways to streamline and prevent duplication of effort by the Exchange call center and QHP issuers' customer call centers while ensuring that consumers have a variety of ways to learn about their coverage options and receive assistance.

We further proposed that an Exchange must maintain an Internet Web site that contains the following information on each available QHP: the premium and cost sharing information; the summary of benefits under section 2715 of the PHS Act; the identification of the QHP coverage (“metal”) level; the results of the enrollee satisfaction survey; the assigned quality ratings; the medical loss ratio; the transparency of coverage measures reported to the Exchange, and the provider directory.

We noted that we were evaluating the extent to which the Exchange Web site may satisfy the need to provide plan comparison functionality using HealthCare.gov, and invited comment on this issue. We also requested comment on a Web site standard that would allow applicants, enrollees, and individuals assisting them to store and access their personal account information and make changes.

We also proposed that the Exchange Web site be accessible to persons with disabilities and provide meaningful access to persons with limited English proficiency. In addition, we proposed that the Exchange post certain QHP financial information, and that an Exchange establish an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after

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the application of any advance payments of the premium tax credit and cost-sharing reductions. We invited comment on the extent to which States would benefit from a model calculator and suggestions on its design.

Finally, we proposed that the Exchange have a consumer assistance function, and that the Exchange conduct outreach and education activities to educate consumers about the Exchange and encourage participation separate ***18327** from the implementation of a Navigator program described in § 155.210.

Comment: Several commenters supported the significant flexibility in structuring a call center provided in proposed § 155.205(a). Other commenters suggested that HHS establish more detailed standards such as establishing key areas of competency for a call center service, including being able to provide information about QHPs, the categories of available assistance, and the application process. Some commenters recommended that an Exchange call center address additional topics, ranging from the ability to make appropriate referrals to other sources of information, to the capacity to provide enrollment assistance to hospitals and other providers encountering the uninsured. One commenter said that the call center should be able to respond to online chat.

Response: We accept the recommendation of commenters that Exchange discretion in establishing a call center should be maintained, and therefore have not established additional standards in § 155.205(a) of the final rule. The final rule does not preclude an Exchange from adopting additional standards or implementing the specific suggestions from commenters to provide more robust consumer assistance.

Comment: HHS received many comments regarding an Exchange's ability to make appropriate referrals through the call center in proposed § 155.205(a). Commenters specifically recommended that Exchanges have the capacity to refer consumers to Medicaid, Indian Health Service/Tribal/Urban (I/T/U) providers, Navigators and assisters, oral translation services, and family planning services. A commenter also suggested that the call center be able to appropriately address the special issues facing families with mixed immigration status. Several commenters asked that the call center refer consumers who were ineligible for coverage through the Exchange to safety net health providers and other low-cost, non-Exchange options. Some commenters suggested that the call center be able to appropriately refer discrimination complaints.

Response: We believe § 155.205(a) addresses this issue with the phrase "address the needs of consumers requesting assistance." In the preamble to the proposed rule, we noted that the Exchange call center should be a conduit to services like Navigators and State consumer programs (76 FR 41875). We maintain this expectation under this final rule and note that Exchanges have discretion to establish more specific standards.

Comment: Many commenters recommended that the call center be able to provide oral communication to people with limited English proficiency (LEP), and several suggested standards that assure service to those with hearing disabilities.

Response: We have amended the final rule to apply the meaningful access standards specified in the redesignated § 155.205(c)(1), (c)(2)(i), and (c)(3) to an Exchange call center. HHS will also issue further guidance on language access and such guidance will coordinate our accessibility standards with insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services and access standards.

Comment: HHS received comments about ways a call center can assure quality service, including training on important topics, establishing performance standards on topics like call wait times, abandonment rates, and call return time; or modeling call center performance standards on existing call centers, with 1-800 Medicare and the Michigan Health Insurance Consumer Assistance Program mentioned as positive examples. Commenters also suggested testing the call center with consumer focus groups, developing analytics on call center service issues, and updating an Exchange customer's account with a record of any services provided by call center personnel.

Response: We believe that § 155.205(a) as proposed outlines general standards to address the needs of consumers and we retain this language in the final rule. We did not propose and are not adding specific performance standards for Exchange call centers in this final rule, but we note that in connection with the operation of Federally-facilitated Exchanges, we will take these specific performance recommendations into consideration.

Comment: HHS received many comments on the need to coordinate call center services with other entities. Several commenters recommended that service issues handled by an Exchange call center versus those handled by a QHP issuer call center should be clearly delineated to avoid consumer confusion and unnecessary duplication, a topic for which we requested comment in the proposed rule. One commenter recommended limiting the Exchange call center services to pre-enrollment, leaving QHP issuers to provide customer service for QHP enrollees. Another commenter recommended a “no wrong number” approach to customer service, advising that State flexibility would best foster a solution. One commenter spoke of the need to integrate the call center with the Exchange Web site in order to provide personal service without having callers repeat information already entered via an online account. Another commenter asked that HHS clarify the different roles of eligibility workers and the call center.

Response: An Exchange must balance the need to prevent duplication against ensuring that consumers have a variety of ways to learn about their coverage options, an imperative supported by the flexibility in paragraph § 155.200(a). In regard to the differing roles between eligibility workers and the call center, we believe this is an operational issue that each Exchange must address. Thus, we are finalizing this provision as proposed.

Comment: Related to proposed § 155.200(b), many commenters remarked that the Web site www.Healthcare.gov's “Find Insurance Options” would work as a model for health plan comparison for the Exchange, though often with the caveat that this feature should be fully integrated into the Exchange Web site. A commenter also noted that Healthcare.gov provides a foundation but would need changes to be used for an Exchange. Some commenters opposed Healthcare.gov as a model because it does not have transactional functionality or a precise premium calculator. Another commenter urged HHS to also consider eHealthInsurance.com and Medicare.gov as models.

Response: HHS considered comments on the appropriateness of Healthcare.gov as a model for presenting comparative plan information, as well as comments suggesting consulting other models such as eHealthInsurance.com and Medicare.gov. We will take these recommendations into account in development of the model Internet Web site template and in future guidance.

Comment: With respect to the preamble discussion related to proposed § 155.205(b), commenters were generally supportive of the concept that Exchange Web sites allow applicants and enrollees to store and access their personal information in an online account or allow eligibility and enrollment application assisters to maintain records of an individual's application process. Some commenters raised privacy and security concerns, and one commenter suggested applying a privacy and security standard like that used by the Financial Industry ***18328** Regulatory Authority (FINRA) in its self-regulation of the securities industry, ensuring that actions by authorized representatives are recorded for consumer protection purposes.

Response: We believe that applicants, enrollees, and authorized third party assisters should have access to an online personal account with strong privacy and security protections and will consider these comments when developing the model Internet Web site template and guidance. We encourage Exchanges to consider the benefit of accounts, but are not establishing account functionality as a minimum Exchange Web site standard in this final rule.

Comment: Many commenters supported the proposal in § 155.205(b)(1)(ii) that the Exchange display the summary of benefits and coverage established in section 2715 of the PHS Act. Several noted that the summary of benefits should be searchable, not necessitate additional software to view, and include drug formulary information.

Response: Enrollees, consumers, and other stakeholders need access to a variety of cost and benefit information via the Exchange Web site to make an informed plan selection. Accordingly, we are finalizing the provisions in paragraphs § 155.205(b)(1)(i) and (ii), which direct an Exchange Web site to display premium and cost-sharing information and a summary of benefits and

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coverage for each QHP. We clarify that paragraphs (b)(1)(i) and (b)(1)(ii) are separate standards because the premium and cost-sharing information needs for an Exchange surpass those included in the summary of benefits and coverage document. We note that paragraph (b)(1)(ii) allows an Exchange the option of collecting the summary of benefits from issuers in a manner supporting a searchable format. The content of the summary of benefits and coverage is outside of the scope of this final rule and refer readers to the Summary of Benefits and Coverage and Uniform Glossary final rule, codified at § 147.200 of this title, published at 77 FR 8668 (Feb. 14, 2012).

Comment: With respect to the provider directory standard in proposed § 155.205(b)(1)(viii), a number of commenters recommended that an Exchange provide an up-to-date consolidated provider directory to enable consumers to see which QHPs a given provider participates in from the Exchange Web site. A few other commenters advised HHS to ensure that the Exchange link to a QHP's Web site provider directory for timely and accurate information. Another commenter asked that the final rule clarify that an online directory meets the standard in paragraph (b)(1)(viii), and that Exchanges do not need to provide paper provider directories.

Response: HHS considered the comments received on the Internet Web site's display of provider directory information. To maintain maximum flexibility for an Exchange, the final rule does not specify whether an Exchange should collect a consolidated provider directory or link to a QHP's Web site in order to meet the standards in paragraph (b)(1)(viii). Additional comments on the provider directories are addressed in § 156.230.

Comment: One commenter indicated that our proposed standard in § 155.205(b)(1)(vi) to display medical loss ratio on the Exchange Web site was inappropriate, comparing it to a manufacturer's cost to produce. Another commenter suggested dropping the proposed MLR display for the individual market Exchange, stating that it was too technical a concept to be useful for consumers.

Response: Issuers already report this data under the Affordable Care Act in accordance with section 2718 of the PHS Act, and displaying the medical loss ratio on the Exchange Web site makes this information accessible to consumers.

Comment: Several commenters noted that an Exchange should track which Web site features were most used, or caused consumers difficulty, in order to continually improve the Web site. Some of these commenters asked that usage information be publicly disclosed.

Response: Statistics on Web site usage may be helpful for Exchange quality assurance, and we will consider these comments when developing best practice guidelines for Exchanges. We make no modifications in the final rule to specifically regulate collection or dissemination of statistics on Web site usage.

Comment: Many commenters supported the proposed § 155.205(b)(2) standards regarding meaningful access to people with disabilities and persons with limited English proficiency, with some suggesting that HHS further clarify that the Web site must be fully accessible, with Web site materials and notices available in alternative formats. One commenter noted that the Exchange calculator and other online tools should be accessible and independently usable as much as possible for people with disabilities. Commenters suggested that all Web site language be at a sixth grade proficiency level. A number of commenters suggested that the Web site be available in Spanish and one or more languages prevalent in the Exchange service area. Many suggested that the Web site clearly display taglines in up to 15 different languages explaining how to access oral translation in those languages. In contrast, one commenter requested that HHS defer to a State on meaningful access standards because a State is best situated to determine local needs. Finally, several commenters suggested that meaningful access standards apply to information presented on the Web site on premiums, premium tax credits, individual responsibility exemptions, and the appeals process.

Response: We have made several changes in this final rule. We added paragraph § 155.205(c) to establish that communications be in plain language to help applicants and enrollees understand the information presented; the definition of "plain language" is discussed in § 155.20 of this final rule. We added § 155.205(c)(1) to specify that auxiliary aids and services be provided

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at no cost to the individual. Provisions on access for those with limited English proficiency are modified in new paragraph § 155.205(c)(2) to include oral translation, written translation, and taglines in non-English languages indicating the availability of language services. Finally, we added paragraph (c)(3) to establish that the Exchange must inform applicants and enrollees of the services in paragraph (1) and (2). We note that in this final rule, at § 155.230(b) and § 156.250, we apply the meaningful access standards to Exchange notices and QHP issuer notices, respectively. We note that the standards in this section do not preempt current guidance issued by the Office of Civil Rights.

We are not adding specific accessibility standards in this final rule, but intend to issue such standards in future guidance, seeking input first from States and other stakeholders about appropriate standards. Such guidance will coordinate our accessibility standards with insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services and access standards.

We retained the standard that Web sites must be accessible to people with disabilities and encourage States to review WCAG 2.0 level AA Web site standards, which have been considered for adoption as Section 508 standards in the recent proposed rule issued by the Architectural and Transportation Barriers Compliance Board (Access Board)76 FR 76640, December 8, 2011). See also Section 5.1.3 of the Guidance for Exchange and Medicaid Information ***18329** Technology (IT) Systems 1.0 published in November 2010.[FN2] We intend to publish future guidance on these standards.

Comment: With respect to the financial information described in proposed § 155.205(b)(3)(i), one commenter sought clarification on what HHS means by licensing costs. Another commenter recommended dropping the proposal in § 155.205(b)(3)(v) that Exchanges display losses due to waste, fraud and abuse, arguing that it would be speculative and inflammatory. Alternatively, several other commenters asked for more detail on Exchange reporting, and asked that HHS direct an Exchange to include all costs, including costs incurred in making a Medicaid eligibility determination, in the administrative cost of the Exchange.

Response: We did not accept the recommendations to establish additional standards and have maintained the proposed policy in the final rule, which is redesignated as subparagraph (b)(6). Section 1311(d)(7) of the Affordable Care Act directs the Exchange Web site to display losses due to waste, fraud and abuse. HHS will consider the request for greater clarity on licensing costs as we develop guidance to interpret and implement this standard.

Comment: Many commenters supported our proposal that the Exchange Web site provide information about Navigators and other assisters in § 155.205(b)(4). Several commenters suggested that HHS explicitly include the display of contact information for other assisters, especially the Exchange call center. Another commenter asked that brokers and agents only be listed if they are also Navigators. One tribal entity remarked that consumer assistance should include services provided by Indian Health Service/Tribal/Urban (I/T/U) organizations.

Response: We maintain the standard in redesignated § 155.205(b)(3) of this final rule. Exchanges have the flexibility to establish additional standards regarding posting information relating to Navigators and other assisters.

Comment: Many commenters were supportive of an Exchange Web site that facilitates a “one-stop” eligibility determination as described in § 155.205(b)(5) of the proposed rule. Commenters were supportive of the Web site allowing for enrollment in coverage. Another commenter stated that the Exchange should not be the only access point for coverage, and that HHS should address the need for consumer assistance for Web site-related purchasing mistakes.

Response: Exchange Web sites will not be the only access point for an individual to apply for coverage through the Exchange. Standards for enrollment initiated by an applicant through a non-Exchange Web site are described in an amended § 155.220 and § 156.265, which provide additional details about eligibility determinations and protections against an applicant's personal data from being inappropriately shared with other parties. Applications are also described in § 155.405(c) of the final rule. We have also modified the Web site's function in enrollment in the proposed § 155.205(b)(1), by clarifying in redesignated § 155.205(b)

(5) that an Exchange Web site facilitates the selection of a QHP by a qualified individual since enrollment is effectuated by the QHP issuer in a process described in § 156.265(b).

Comment: Many commenters expressed support for a Web site calculator proposed in § 155.205(c) that displays the estimated cost of coverage after the application of any expected advance payments of the premium tax credit and cost-sharing reductions. In general, these commenters urged simplicity and requested no additional calculation from the consumer. Several commenters recommended that HHS provide a national model calculator for efficiency and consistency across Exchanges. One commenter in particular asked that the calculator make cost-sharing reductions available to American Indians/Alaska Natives readily apparent. Another commenter suggested that the Web site provide a standard way for a consumer to take less than the available advance payment of the premium tax credit. A few other commenters suggested that the Web site have decision support to help a consumer see how a change in income would affect advance payments of the premium tax credit and make a plan selection accordingly. Several commenters suggested that the Exchange specify that an "out-of-pocket" estimate be part of the Exchange calculator in order to help consumers avoid evaluating cost by premium alone. Finally, one commenter suggested that the calculator account for the variation in cost sharing for "in-network" versus "out-of-network" services.

Response: We will consider these recommendations as we develop guidance, best practices, and the model Web site template, but we are not finalizing more specific standards for the electronic calculator in this final rule as we are codifying the statutory provision related to the calculator.

Comment: Commenters were generally supportive of Exchanges providing consumer assistance as described in § 155.205(d) of the proposed rule. Many asked that an Exchange complete a consumer needs assessment before designing its consumer assistance program. HHS received many comments on the need to conduct outreach and education for hard to reach populations described in proposed § 155.205(e). Many commenters remarked that assistance should be able to serve those with disabilities or limited English proficiency, suggesting standards for consumer assistance such as oral translation for all limited English proficient individuals, or simply that such services be culturally and linguistically appropriate. Some commented that consumer assistance workers should be knowledgeable of the Indian Health System. One commenter remarked that consumer assistance should be accessible across multiple channels, including Web site, telephone, and in-person. Several commenters remarked on the need for in-person assistance, with one commenter suggesting the Internal Revenue Service's Volunteer Income Tax Assistance Program as a model, another commenter recommending agents and brokers for consumer assistance, and a third suggesting that assistance be provided as much as possible by nonprofit organizations. Others suggested that an outreach program be coordinated with public programs because of the likely overlap in eligibility, or with providers like Federally Qualified Health Centers and essential community providers. Other commenters pointed to existing enrollment campaigns for lessons learned, such as the need to build in time to "ramp up" an enrollment campaign.

Response: We will consider comments we received on consumer assistance in § 155.205(d) in the development of guidance. In this final rule, we maintain this provision as proposed and believe that it provides sufficient discretion to further develop the consumer assistance function. We have modified § 155.205(e) in this final rule to direct Exchanges to provide education regarding insurance affordability programs to ensure coordination with public programs. HHS received many helpful comments on how to ensure effective consumer ***18330** assistance and outreach and will consider these as we develop guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.205 of the proposed rule, with the following modifications: we renumbered proposed paragraphs (b)(3) through (b)(6) as (b)(2) to (b)(5) in the final rule. We clarified in paragraph (b)(5) of this final rule that a qualified individual may select a QHP on the Exchange Web site to initiate the enrollment process, rather than completing the entirety of the enrollment process on the Web site. We moved the standard regarding the calculator to paragraph (b)(6) of this final rule. We redesignated paragraph (c)(1) and clarified standards for persons with disabilities, including the provision of auxiliary aids and services at no cost to the individual and that Exchange Web sites must be accessible. We added paragraph (c)(2) to outline standards for limited English proficient persons, including that oral translation be available, written translation be available, and that the availability of language services be displayed with taglines written in each respective language, and

in paragraph (c)(3) that individuals must be made aware of the availability of these services. Finally, we made several minor technical and non-substantive changes.

d. Navigator Program Standards (§ 155.210)

In § 155.210, we proposed Navigator program standards for both the individual market Exchange and SHOP. We first proposed that Exchanges must award grant funds to public or private entities or individuals to serve as Navigators, and described the eligibility standards for and the types of entities to which the Exchange may award Navigator grants. We also identified the minimum duties of Navigators, including standards for the information and services provided by Navigators. We sought comment on how best to ensure that the information provided by Navigators is accurate and complete and whether HHS should identify additional standards for Navigators in future guidance.

We further proposed that a Navigator must meet any licensing, certification or other standards prescribed by the State or Exchange, as appropriate, and may not have a conflict of interest during the term as Navigator. We sought comment on whether we should propose additional standards on Exchanges to make determinations regarding conflicts of interest.

In addition, we proposed that the Exchange include at least two types of Navigators from the list of eligible entities included in the Affordable Care Act. We sought comment as to whether we should ensure that at least one community and consumer-focused non-profit organization be designated as a Navigator by an Exchange, or whether we should provide that Navigator grantees reflect a cross-section of stakeholders.

We also proposed to codify the statutory prohibitions on Navigator conduct in the Exchange, specifically that health insurance issuers are prohibited from serving as Navigators and that Navigators must not receive any compensation from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. We sought comment on this issue and whether there are ways to manage any potential conflicts of interest that might arise.

Finally, we proposed to codify the statutory restriction that the Exchange cannot support the Navigator program with Federal funds received by the State for the establishment of Exchanges. For a more detailed discussion of how this statutory prohibition applies in States where Navigators address Medicaid and CHIP administrative functions, please refer to the preamble of the Exchange establishment proposed rule (76 FR 41878). We also noted that we were considering a standard that the Navigator program be operational with services available to consumers no later than the first day of the initial open enrollment period.

General Standards

Comment: Regarding proposed § 155.210(a), several commenters had specific recommendations regarding the types of and content of contractual agreements that should exist between Navigators and Exchanges.

Response: The final rule does not specify the type of or contents of the contractual agreements between Exchanges and Navigators, other than codifying the statutory provision that Navigators receive grants. Exchanges can design the grant agreements as they deem appropriate so long as they ensure that Navigators are completing, at least, the minimum duties outlined in § 155.210(e) of the final rule.

Comment: Several commenters recommended additional standards for Navigator programs established under proposed § 155.210(a), including a needs assessment of the population in the geographic areas in which Navigators will serve consumers and an ongoing evaluation system to gauge Navigator performance.

Response: While a needs assessment is likely to yield useful information in developing the Navigator program, we do not accept the commenters' suggestion that Navigator programs conduct such assessments. We note that many States have already begun research on the needs of the populations an Exchange could serve. To the extent that needs assessments undertaken as part of Exchange establishment and planning do not inform which types of Navigators to select and how Navigators can best serve

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potential Exchange enrollees, we encourage States to conduct them. But the final rule does not direct States to conduct additional research. Additionally, we strongly encourage Exchanges to implement regular reviews and assessments of their Navigators.

Comment: A significant number of commenters expressed the importance of mitigating Navigator conflict of interest and of ensuring Navigator accountability. Many commenters asked that HHS issue specific conflict of interest standards that would apply to all entities interested in serving as Navigators, and some made specific recommendations regarding what should be included in such standards. Several commenters, including consumer and patient advocacy groups and State agencies, also requested that we define "conflict of interest" as used in § 155.210(b)(1)(iv) of the proposed rule, while another commenter suggested that States should have the flexibility to determine if a conflict of interest exists for Navigators.

Response: The final rule contains restrictions on Navigator conduct that are intended to eliminate possible sources of conflicts of interest. However, the baseline standards that we have specified will likely not be sufficient to comprise a robust set of conflict of interest standards in all Exchanges. As such, § 155.210(b)(1) of the final rule establishes that Exchanges develop and disseminate a set of conflict of interest standards to ensure appropriate integrity of Navigators. Exchanges will be best-equipped to determine what additional conflict of interest standards are appropriate for their markets, and we strongly urge Exchanges to develop standards that are sufficient to help ensure that consumers receive accurate and unbiased information at all times from all Navigators. We also clarify here that "conflict of interest," as used in § 155.210(c)(1)(iv) of the final rule, means that a Navigator has a private or personal interest sufficient to influence, or appear to influence, the objective ***18331** exercise of his or her official duties; for purposes of this rule, it includes the conflict of interest standards developed by each Exchange.

We urge Exchanges to develop conflict of interest standards that include, but are not limited to, areas such as financial considerations; non-financial considerations; the impact of a family member's employment or activities with other potentially conflicted entities; Navigator disclosures regarding existing financial and non-financial relationships with other entities; Exchange monitoring of Navigator-based enrollment patterns; legal and financial recourses for consumers that have been adversely affected by a Navigator with a conflict of interest; and applicable civil and criminal penalties for Navigators that act in a manner inconsistent with the conflict of interest standards set forth by the Exchange. Additionally, we will be releasing model conflict of interest standards in forthcoming guidance.

Comment: We requested comment on standards related to training in the proposed rule and received a large number of responses on this issue. Several commenters suggested that HHS establish minimum standards for Navigator training, including templates for the format and content of Navigator training materials. Some commenters suggested that Navigators be trained to specifically serve the needs of varying groups, including but not limited to: low-income individuals; limited English proficient individuals; tribal organizations; individuals with disabilities; and individuals with mental health or substance abuse needs. Other commenters urged HHS to defer to States in relation to Navigator training and standards beyond those established in the proposed rule.

Response: Due in part to the sensitivity of information that will be available to Navigators, newly added § 155.210(b)(2) of the final rule directs Exchanges to establish training standards that apply to all persons performing Navigator duties under the terms of a Navigator grant, including both paid and unpaid staff of entities serving as Navigators. We plan to issue training model standards in forthcoming guidance to supplement, not replace, the need for Navigator applicants to demonstrate that they can carry out the minimum duties of a Navigator as listed in § 155.210(e) of the final rule. We encourage Exchanges to conduct ongoing and recurring training for Navigators.

Comment: One comment from a consumer advocacy organization requested that HHS specifically indicate that the Gramm-Leach-Bliley Act (Pub. L. 106-102) does not apply to the Navigator program as Navigators will not be selling insurance.

Response: The Gramm-Leach-Bliley Act (GLBA) is intended to enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, insurance companies, and other financial service providers, and for other purposes. To the extent a Navigator is not licensed to sell insurance, we believe the GLBA would not

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apply. The GLBA will apply to agents and brokers as it currently does, including agents and brokers that choose to serve as Navigators. However, other Navigator grantees will not be affected. Navigators must meet other training, conflict of interest, and privacy and security standards established by the Exchange.

Comment: We received many comments expressing support for a standard that Navigator programs be operational with services available to consumers no later than the first day of the initial open enrollment period. Some commenters noted that while they support the proposed start date, they prefer an earlier operational start date.

Response: We have not directed Navigator programs to be operational by the first day of the initial open enrollment period. However, we encourage Navigator programs to be operational with services available to consumers by October 1, 2013, for State-based Exchanges that are approved or conditionally approved by January 1, 2013, or the start of any annual open enrollment period in subsequent years for State-based Exchanges certified after January 1, 2013.

Entities Eligible to be a Navigator

Comment: Many commenters proposed that States, Exchanges, or HHS should set appropriate certification or licensing standards for Navigators. A few commenters proposed that HHS set a broad range of certification or licensing standards that States or Exchanges could tailor to meet their own needs, while others suggested specific programs upon which Exchanges could model Navigator certification standards, such as the Medicare State Health Insurance Assistance Programs, ombudsman programs, area agencies on aging, and Promotoras, a community health worker model that has been adopted into many Latino communities in the United States.

Response: We understand and appreciate the concerns of commenters that recommended certification or licensure standards for Navigators; we have finalized in this rule a primary role for Exchanges and States in the creation, development and enforcement of such standards. We encourage Exchanges to set certification or licensing standards for Navigators in accordance with the guidelines set forth in this final rule and any State law(s) that may apply. However, without some minimum standards, significant variability may develop that could put consumers at a disadvantage. Therefore, HHS has added § 155.210(b)(2) of the final rule to indicate that Exchanges must develop a set of training standards to ensure Navigator competency in the needs of underserved and vulnerable populations, eligibility and enrollment procedures, and the range of public programs and QHP options available through the Exchange. Additionally, given the policy set forth in § 155.210(c)(1)(v) that Navigators comply with the privacy and security standards adopted by the Exchanges under § 155.260, the training standards must also ensure that Navigators are trained in the proper handling of tax data and other personal information. HHS also plans to issue additional guidance on the model standards for Navigator training and best practices for certification or licensure standards.

Comment: A majority of commenters proposed that Navigators should not have to hold an agent or broker license or errors and omissions liability coverage in order to be certified or licensed as a Navigator. Conversely, a small number of commenters suggested that Navigators hold an agent or broker license as well as errors and omissions coverage and that Navigators should be subject to the same licensing and education standards established for agents and brokers.

Response: We accept the commenters' suggestion that States and Exchanges should not be able to stipulate that Navigators hold an agent or broker license, and we clarify that States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage. “Agent or broker” is defined in § 155.20 as “a person or entity licensed by the State as an agent, broker, or insurance producer.” Thus, establishing licensure standards for Navigators would mean that all Navigators would be agents and brokers, and would violate the standard set forth § 155.210(c)(2) of the final rule that at least two types of entities must serve as Navigators. Additionally, we do not think that holding an agent or broker license is necessary or sufficient to perform the duties of a Navigator as these licenses generally do not address ***18332** training, among other things, about public coverage options.

Comment: Several commenters addressed the need for Navigators to have expertise in serving American Indian/Alaska Native communities and on the ability of Navigators to adequately address the needs of American Indians/Alaska Natives. In addition,

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a few commenters suggested we modify the language proposed in § 155.210(b)(1)(iii) such that Navigators serving tribal communities should be exempt from any State licensing or certification standards, as well as from conflict of interest standards.

Response: Exchanges that include one or more Federally-recognized tribes within their geographic area must engage in regular and meaningful consultation and collaboration with tribes in accordance with § 155.130(f) of this final rule. In section 155.210(c)(2), we have identified Tribes, Tribal organizations, and urban Indian organizations as eligible entities to serve as Navigators. Development of the Navigator program should be an important element of Exchanges' consultation with Tribal governments. The Navigator program will help ensure that American Indians/Alaska Natives participate in Exchanges.

Comment: Commenters recommended that when the geographic area of an Exchange includes an Indian Tribe, tribal organization, or Urban Indian organization, that at least one of these organizations must be included as a Navigator within this Exchange. Another commenter recommended that HHS include directives to Navigator programs and contractors to provide resources directly to Tribes so they can conduct Navigator tasks within their own communities.

Response: Although Indian Tribes, tribal organizations, or Urban Indian organizations are listed in § 155.205(c)(2)(viii) as potential Navigators, we believe that the Exchange should have flexibility regarding the granting of Navigator awards. However, as noted previously, development of the Navigator program should be a critical element of an Exchange's consultation with tribal governments, and tribal governments should have the opportunity to provide early input on the development of the Navigator program.

Comment: Several commenters articulated the need for Navigators to be non-discriminatory in performing their duties. Commenters recommended that Navigators should comply with the non-discrimination standards that apply to the Exchange as a whole.

Response: We clarify that because Navigators are third parties under agreement (that is, the grant agreement) with the Exchange, the non-discrimination standards that apply to Exchanges in § 155.120(c) will also apply to entities seeking to become Navigators.

Comment: Regarding § 155.205(b)(2), a majority of commenters supported the provision suggested in the proposed rule to establish that at least one of the two types of entities eligible to serve as Navigators must be a community or consumer-focused non-profit entity (76 FR 41877). Several commenters recommended expanding the list of categories to include additional entities. A small number of commenters thought States should have sole discretion over the determination of which entities may serve as Navigators. One commenter favored allowing States to determine the need for a Navigator program; another recommended using licensed insurance professionals to facilitate enrollment; and a small number stated that the standard that two types of entities must be Navigators was unnecessary and counterproductive.

Response: We accept the commenters' suggestion that at least one entity that serves as a Navigator should be a community or consumer-focused non-profit, and have amended § 155.210(c)(2) to convey this policy. The categories listed in the final rule in § 155.210(c)(2) represent a broad spectrum of organizations, but are not meant to be an exhaustive list of potential Navigators. As stated in § 155.210(c)(2)(viii), other public or private entities that meet the standards of the Navigator program may be eligible to receive a Navigator grant. When establishing a Navigator program, Exchanges should plan to have a sufficient number of Navigators available to assist qualified individuals and employers from various geographic areas and with varying needs who wish to enroll in QHPs within their State.

Comment: One comment stated that a Navigator should never be an individual person, but instead a verifiable and appropriately regulated entity or institution.

Response: We believe that the standard to meet licensure and certification standards in § 155.210(c), and the prohibition against health insurance issuers, and those who receive any consideration directly or indirectly from any health insurance issuer in

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connection with the enrollment in the Exchange, from receiving Navigator grants in § 155.210(d) will serve as sufficient regulation against fraud by individuals or organizations who qualify to be Navigators.

Prohibitions on Navigator Conduct

Comment: Many commenters discussed the impact that Navigator compensation, or "consideration" as used in § 155.210(c)(2) of proposed rule, would have on a Navigator's obligation to provide impartial assistance and avoid conflicts of interest. The majority of these commenters recommended that Navigators be prohibited from receiving compensation from health insurance issuers for enrolling individuals in plans outside of the Exchange, while some commenters expressed support for the compensation restrictions as proposed. Several commenters requested that a prohibition on enrollment-based compensation from a health issuer not prohibit Navigator programs from utilizing Medicaid or CHIP funds for appropriate Navigator activities. Some commenters also recommended that such a prohibition not preclude Navigators from receiving grants from health insurance issuers for activities unrelated to enrolling individuals in plans inside of the Exchange. Many commenters requested clarification of the term "consideration."

Response: Prohibiting Navigators from receiving compensation from health insurance issuers for enrolling individuals in health insurance plans is an important way to mitigate potential conflict of interest, and we have amended the final rule in § 155.210(d)(4) to establish this prohibition. Permitting Navigators to receive such compensation would introduce a financial conflict of interest which would run counter to the focus of the Navigator program as a consumer-centered assistance resource. We clarify that this prohibition applies to Navigators broadly, including staff of an entity serving as a Navigator or entities that serve as Navigators for one Exchange while simultaneously serving in another capacity for another Exchange. Additionally, we clarify that this prohibition does not preclude Navigators from receiving grants from the Exchange that are funded through the collection of user fees.

We note that the final rule does not inherently prohibit Navigators from receiving grants and other consideration from health insurance issuers for activities unrelated to enrollment into health plans, although we remain concerned that such relationships—financial and otherwise—may present a significant conflict of interest for Navigators. We urge Exchanges to consider the ramifications of such ***18333** relationships when developing conflict of interest standards for their Navigator programs.

We also clarify that "consideration," as used in § 155.210(d)(4) of the final rule, should be interpreted to both mean financial compensation—including monetary or in-kind of any type, including grants—as well as any other type of influence a health insurance issuer could use, including but not limited to things such as gifts and free travel, which may result in steering individuals to particular QHPs offered in the Exchange or plans outside of the Exchange.

Duties of a Navigator

Comment: Many commenters supported the Navigator duties proposed in § 155.210(d), and some suggested that the duty to "maintain expertise in eligibility, enrollment, and program specifications" should include knowledge about Exchanges, Medicaid, CHIP, other private and public health insurance programs, appeals, and rules related to cost-sharing. Other commenters recommended other specific minimum duties for Navigators, including providing information about total plan costs, assisting consumers with applying for advance payments of premium tax credit and other cost-sharing reductions, and making consumers aware of the tax implications of their enrollment decisions.

Response: The final rule maintains most of the duties set forth in the proposed rule, except as re-assigned as § 155.210(e) and reflecting edited language in § 155.210(e)(3). The change in § 155.210(e)(3) is a technical correction to ensure consistency with our clarification in § 155.205(b)(7). Similarly, a Navigator facilitating a QHP selection for a consumer initiates the enrollment process, which is then conducted by the Exchange. Section 155.400(a)(2) of this final rule describes the subsequent step in the enrollment process, and directs Exchanges to transmit the QHP selection to the appropriate QHP issuer.

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We believe that Navigators should make consumers aware of the tax implications of their enrollment decisions, and consider this to be included in § 155.210(e)(1) of the final rule. Navigators should also provide information about the costs of coverage and assist consumers with applying for advanced payments of the premium tax credit and cost-sharing reductions, and we clarify that § 155.210(e)(2) and § 155.210(e)(3) of the final rule are intended to include such activities. We also clarify that such assistance could result in an individual receiving an eligibility determination for other insurance affordability programs. Additionally, we note that Exchanges can establish additional minimum Navigator duties and encourage Exchanges to determine whether additional Navigator duties may be appropriate.

Comment: A significant number of commenters recommended that Navigators be accessible to all consumers, including those with disabilities, and that all information provided under § 155.210(d)(5) of the proposed rule by Navigators be provided orally as well as in writing.

Response: Navigators need to be accessible to individuals with disabilities, and redesignated § 155.210(e)(5) of the final rule establishes that Navigators must ensure accessibility and usability for individuals with disabilities, which we believe includes accessibility by individuals with hearing or visual impairments and using enrollment tools, written in plain language, that are easily accessible by consumers. We believe this provision will help ensure that Navigators minimize obstacles to access for all potential enrollees and remain accessible to consumers. Exchanges have the flexibility to develop materials or to assign the responsibility to Navigators.

Comment: Many commenters expressed the need for Navigators to be linguistically and culturally competent, as described in § 155.210(d)(5) of the proposed rule, and a significant number recommended training in this area. Commenters had numerous specific recommendations regarding how Navigators would be able to best accomplish this duty, and other commenters wanted additional clarity regarding this standard. Some commenters recommended that Navigator programs select diverse Navigators as a method of reinforcing linguistic and cultural competence. One commenter suggested that having a consumer's family members or friends serve as interpreters should not be permitted to fulfill the obligation to provide culturally and linguistic appropriate services.

Response: Redesignated § 155.210(e)(5) establishes that Navigators must provide information in a way that is culturally and linguistically accessible to ensure that as many consumers as possible can benefit from Navigator programs. The linguistic and cultural accessibility standard applies broadly across the duties of a Navigator, including public education and outreach activities. We encourage Exchanges to undertake cultural and linguistic analysis of the needs of the populations they intend to serve and to develop training programs that ensure Navigators can meet the needs of such populations. We note that we do not believe that this standard can be met by simply having consumers' family members or friends serve as interpreters. As previously stated, future guidance will set forth model standards related to linguistic and cultural competency.

Comment: Regarding the duties of a Navigator outlined in § 155.210(d) of the proposed rule, several commenters expressed the importance of data and the use of information technology for Navigator programs, including Navigator collection of data and narratives regarding consumer experiences. Some consumers also stated that Navigators should collaborate with other programs and entities, including other consumer assistance programs and State governments, so that all groups could mutually share information.

Response: The final rule does not establish that Navigators or the Navigator program must collect data or to ensure compatibility with existing information systems. However, Exchanges have the flexibility to use such tools to ensure that Navigators and Exchanges are best serving consumers.

Funding for Navigators

Comment: One commenter recommended that Navigator compensation by an Exchange described in § 155.210(e) of the proposed rule be only in the form of block grants, while another commenter recommended that Navigator grants include distribution on a per capita basis for enrolling individuals in QHPs offered through the Exchange.

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Response: We do not outline a specific compensation structure for Navigators, and we maintain the proposed approach to funding in § 155.210(f) of the final rule. This approach does not alter section 1311(i)(6) of the Affordable Care Act that establishes that all funds for Navigator grants come from the operational funds of the Exchange. We note, however, that operational funds of the Exchange may be revenue received by the Exchange through user fees or other revenue sources, so long as the Exchange is self-sustaining. We anticipate that there may be public or private grants available to support certain Exchange functions, such as education and outreach; once received for the purposes of funding Exchange operations, these funds would be operational funds.

***18334** Comment: We received numerous comments suggesting that we monitor Navigator programs to ensure that they have sufficient funding under proposed § 155.210(e) to meet the needs of all potential enrollees, and several commenters recommended that we issue guidance on minimum funding levels needed to operate sustainable Navigator programs.

Response: While States and Exchanges should ensure that Navigator programs have sufficient funds to ensure that all potential enrollees are capable of being assisted and guided in eligibility and decision-making for coverage in the Exchanges, we believe that minimum funding level for Navigator program needs will vary by State and by populations and therefore do not establish a minimum in § 155.210(f) of the final rule.

Comment: We received several comments regarding the use of Medicaid or CHIP funds when Navigators perform administrative functions for those programs. The majority of commenters, primarily consumer and patient advocacy groups, were supportive of using Federal Medicaid and CHIP funds for this purpose, while a small minority was opposed to such an approach. One commenter recommended that Navigators not perform Medicaid or CHIP administrative functions, stating that these activities are the purview of the State Medicaid program.

Response: We continue to support the position that if a State chooses to permit Navigators to perform or assist with Medicaid and CHIP administrative functions, Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities. A more detailed discussion of this position is in the proposed rule (76 FR 41878).

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.210 of the proposed rule, with the following modifications. In new paragraph (b), we provide that an Exchange must develop and publicly disseminate conflict of interest and training standards for all entities that serve as Navigators. In paragraph (c)(1)(v), we apply the privacy and security standards adopted by the Exchange, as established in § 155.260, to Navigators. In paragraph (c)(2), we provided that at least one entity serving as a Navigator must be a community and consumer-focused non-profit. We clarified in paragraphs (d)(2) and (d)(3) that subsidiaries of health insurance issuers and associations that include members of or lobby on behalf of the insurance industry are prohibited from serving as Navigators. In paragraph (d)(4) we clarified that Navigators may not receive compensation from a health insurance issuer in connection with the enrollment of individuals or employees in any health plan, including both QHPs and non-QHPs. Finally, in paragraph (e)(3) we clarified that Navigators must assist consumers in selecting a QHP, thereby initiating the enrollment process.

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

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (a)(3) of this section as an interim final provision, and we are seeking comments on it.

In § 155.220, we proposed to codify section 1312(e) of the Affordable Care Act that gives States the option to permit agents or brokers to enroll individuals and employers in QHPs. To ensure that individuals and small groups have access to information about agents and brokers should they wish to use one, we proposed to permit an Exchange to display information about agents and brokers on its Web site or in other publicly available materials. Additionally, recognizing that an Exchange may wish to work with web-based entities and other entities with experience in health plan enrollment, we sought comment on the functions

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that such entities could perform, the potential scope of how these entities would interact with the Exchange, and the standards that should apply to an entity performing functions in place of, or on behalf of, an Exchange while acknowledging and meeting the statutory limitation that premium tax credits and cost-sharing reductions be limited to enrollment through the Exchange. We also sought comment on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any implications for security or privacy of such an arrangement.

Comment: A number of commenters sought clarification on whether and how the involvement of agents and brokers described in proposed § 155.220 may serve as Navigators under § 155.210. Many commenters sought further clarification as to the distinction between the role of agents or brokers and the role of Navigators in the Exchange.

Response: In general, the responsibilities of a Navigator differ from the activities that an agent or broker. For example, the duties of a Navigator described under § 155.210(e) of the final rule include providing information regarding various health programs, beyond private health insurance plans, and providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. Moreover, any individual or entity serving as a Navigator may not be compensated for enrolling individuals in QHPs or health plans outside of the Exchange; as such, an agent or broker serving as a Navigator would not be permitted to receive compensation from a health insurance issuer for enrolling individuals in particular health plans. That said, nothing precludes an Exchange's Navigator program from including agents and brokers, subject to the conditions of § 155.210.

Comment: Several commenters expressed support for the proposed § 155.220(a) and the level of flexibility it affords State Exchanges to determine the role of agents and brokers and web-based entities in the Exchange marketplace. Several commenters specifically expressed support for the manner in which the accompanying preamble to the proposed rule described the Exchange as accountable for the actions of web-based entities.

Response: We accept the recommendation that Exchanges have the flexibility to determine the role of agents and brokers, including web-based entities, in their marketplaces. We have retained the language in § 155.220(a), which codifies the statutory flexibility that States may determine whether agents and brokers may enroll individuals, employers and employees in QHPs and provide assistance to qualified individuals applying for financial assistance.

Comment: HHS received several comments urging us to prohibit agents and brokers, including web-based brokers, from performing eligibility determinations.

Response: The Exchange must perform eligibility determinations, subject to the standards and flexibility outlined in subpart D of this final rule. We note that an individual cannot enroll in a QHP through the Exchange, nor can a QHP issuer enroll a qualified individual in a QHP through the Exchange, unless such individual completes the single streamlined application to determine eligibility as described in § 155.405 and is determined eligible. We have clarified in § 156.265(b)(1) that that enrollment by QHP issuer may be considered “enrollment through the Exchange” only after the Exchange notifies the QHP ***18335** issuer that the individual has received an eligibility determination, the individual is qualified to enroll in a QHP through the Exchange, and the Exchange transmits enrollment information to the QHP issuer consistent with § 155.400(a). In § 155.220(c)(1), we also specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual completes the application and eligibility verification process through the Exchange Web site. We acknowledge and clarify that nothing in this final rule prohibits a QHP issuer from selling QHP coverage directly or through an agent or broker, so long as the standards of § 156.255(b) are met; however, such sales and enrollment are not “enrollment through the Exchange” and such enrollees are not eligible for the benefits that are tied to enrollment through the Exchange.

Comment: With respect to proposed § 155.220(a), several commenters sought clarification of the role agents and brokers in enrolling individuals in QHPs. Several commenters urged us to strengthen the role of agents and brokers in the Exchange by further clarifying their ability to participate in the Exchange marketplace. With respect to the preamble discussion of web-based entities, several commenters urged HHS to permit web-based entities in particular to enroll individuals eligible for advance

payments of the premium tax credit and cost-sharing reductions in QHPs so that such individuals may have access to the same avenues for QHP enrollment as those individuals who do not receive financial assistance.

Response: We accept the recommendation that we provide Exchanges with discretion to leverage the market presence of agents and brokers, including web-based entities that are licensed by the State (web-brokers), to draw consumers to the Exchange and to QHPs. We have amended § 155.220 to include minimum standards for the process by which an agent or broker may help enroll an individual in a QHP in a manner that constitutes enrollment through the Exchange. This is intended to include traditional agents and brokers, as well as web-brokers. This process must include the completion by the individual of a single streamlined application to determine eligibility through the Exchange's Web site, as described in § 155.405; the transmission of enrollment information by the Exchange to the QHP issuer to allow the issuer to effectuate enrollment of qualified individuals in the QHP; and any standards set forth in an agreement between the agent or broker and the Exchange. We note that there may be various means a State may choose to integrate agents, brokers and web-brokers consistent with the standards described in this section for enrollment through the Exchange. Agents and brokers may assist individuals enrolling directly through the Exchange Web site and may serve as Navigators consistent with standards described in § 155.210. We also afford Exchanges discretion to allow agents and brokers to use their own Web sites to assist individuals in completing the QHP selection process, as long as such a Web site conforms to the standards identified in § 155.220(c)(3). While Exchanges that pursue this option would be able to leverage the market presence of web-brokers in drawing consumers to the Exchange and QHPs, we note that the Exchanges will also have to share data and coordinate closely with such entities.

Comment: With respect to proposed § 155.220(a), many commenters urged us to set standards around the use of agents and brokers in order to ensure certain consumer protections. These suggestions included having Exchanges to monitor and oversee all agents and brokers enrolling individuals and small groups in QHPs; establishing provisions to mitigate agents' and brokers' incentives to steer consumers to enroll in certain QHPs or to non-QHPs; setting uniform commissions for agents and brokers or establishing that issuers must compensate agents and brokers the same amount for Exchange and non-Exchange plans; prohibiting commissions for agents and brokers in the Exchange altogether; establishing certain disclosures by agents and brokers, including disclosure of their commission and whether or not the agent or broker has been the subject of any sanctions; applying privacy and confidentiality standards to agents and brokers; prohibiting Exchanges from directing individuals or small groups to enroll only through an agent or broker; prohibiting advertising by agents or brokers; or prohibiting agents and brokers from the Exchange altogether.

A number of commenters also expressed concern regarding the role of third-party web-based entities enrolling individuals in QHPs. Several commenters emphasized that such external entities should be held to the same standards as the Exchange; should not be permitted to perform eligibility determinations; or should be held to certain consumer protection standards to prevent steering.

Response: We recognize the importance of consumer protections with respect to agents and broker interactions. We also recognize the States' role in licensing and overseeing agents and brokers and have allowed States to determine which standards would apply to agents and brokers acting in the Exchange, if the State chooses to permit agents and brokers to enroll individuals and small groups in QHPs through the Exchange. In order to address commenters' concerns while maintaining the State's primary role in overseeing agents and brokers, we have added paragraph (d) to ensure that agents and brokers must comply with an agreement with the Exchange under which the agent or broker would comply with the Exchange's privacy and security standards that are adopted consistent with § 155.260 and § 155.270. We have also added paragraph (e) to ensure that agents and brokers comply with applicable State law.

We also recognize that the role of web-brokers may evolve upon implementation of Exchanges, and that Exchanges may seek to involve web-brokers in the enrollment process using a variety of technologies. We have set forth standards in this rule to ensure that consumers enjoy a seamless experience with appropriate consumer protections if an Exchange chooses to allow web-brokers to participate in Exchange enrollment activities. In order to address commenters' particular concerns around the role of web-based entities, we note that eligibility determinations must be conducted by the Exchange and enrollment information

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must be transmitted to the QHP issuer by the Exchange. We have added paragraph (c)(3) to § 155.220 to ensure that Web sites used by agents or brokers to enroll individuals in a manner that constitutes enrollment through the Exchange provide consumers with access to the same information as they would if they used the Exchange Web site instead. Based on several commenters' suggestion that we address agents' and brokers' ability to steer or incentivize consumers to enroll in certain QHPs, and commenters' general concern about the fact that the existence of such Web sites may confuse consumers, we have inserted standards under paragraph (c)(3) of this section to prevent such web-brokers from providing financial incentives and to establish that such Web sites must allow consumers to withdraw from the web-broker's process and use the Exchange Web site instead at any time. Furthermore, the web-brokers would also be subject to the standards inserted ***18336** under paragraph (d) and (e) regarding compliance with an agreement with the Exchange and State law, respectively.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.220 of the proposed rule, with several modifications. In the new paragraph (a)(2), we clarify that agents and brokers may enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange. In new paragraph (a)(3), we clarify that agents and brokers may assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. As noted elsewhere in this rule, paragraph (a)(3) is being published as interim. We outline the parameters of what is considered enrollment through the Exchange in the newly added paragraph (c), including that an agent or broker must ensure that an individual completes the eligibility verification process through the Exchange and that the Exchange transmits enrollment information to the QHP issuer consistent with § 155.400(a). In paragraphs (d) and (e), respectively, we establish that agents or brokers must comply with the terms of an agreement with the Exchange as well as applicable State laws. New paragraph (c)(3) establishes standards that would apply for an agent or broker's Internet Web site were to be used to assist individuals in selecting a QHP within the framework of enrollment through the Exchange.

f. General Standards for Exchange Notices (§ 155.230)

In § 155.230, we proposed standards for any notice sent by an Exchange in accordance with part 155. We additionally proposed that all applications, forms, and notices be provided in plain language, and be written in a manner that provides meaningful access to individuals with limited English proficiency and ensures effective communication for people with disabilities. We sought comment on whether we should codify specific examples of meaningful access in the final rule. We also proposed that the Exchange annually re-evaluate the appropriateness and usability of all applications, forms, and notices and consult with HHS when changes are made.

Comment: Several commenters expressed support for proposed § 155.230(a) that provides that any notice sent by the Exchange in accordance with part 155 must be in writing and include the information described in paragraphs (a)(1) through (a)(3). Many commenters further specified that the Exchange should send a second notice, or multiple notices, when the action taken in a notice (of eligibility determination) will result in a termination of coverage or another adverse action. Some commenters provided other specific recommendations about the content, timing, and formatting of notices, particularly for the purpose of clarity and applicability of relevant information on the part of the consumer. For example, some commenters specified that notices should include the relevant and appropriate range of customer service resource contact information based on the specific individual's location or circumstances. Some commenters suggested that HHS issue model notices or best practices for crafting notices for States, and commenters suggested that HHS develop templates or minimum standards of forms and notices.

Response: We believe that notices should be in writing, electronically whenever possible, and we are taking specific content, timing, and format-related recommendations we received from commenters into consideration as we move forward with development of model Exchange-issued notices. While § 155.230(a)(1) through (a)(3) outline some specific content standards for notices, we plan to issue model notices. In addition to the content specific standards described under § 155.230(a), we expect that notices will also include the date on which the notice is sent. In § 155.230(a)(3) we add that a notice must include the reason for the intended action.

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Comment: Several commenters recommended that applicants and enrollees should be able to specify their preferred method of communication for notices, including the option to receive duplicative notices, and that electronic notices should fulfill the Exchanges' obligation to provide notices in writing in accordance with § 155.230(a). A few commenters requested clarification concerning whether Medicaid/CHIP will provide future guidance on the use of electronic communications.

Response: In the final rule, we do not make changes to address the use of electronic notices. In coordination with Medicaid and CHIP, we will address standards related to electronic notices and coordination of notices between the Exchange, Medicaid, and CHIP in future rulemaking. We note that our goal is to allow for electronic notices wherever practical. Future rulemaking in coordination with Medicaid and CHIP will also increase our ability to align standards across programs.

Comment: One commenter recommended that HHS consider whether it is necessary to set a specific timeline or clarify how quickly applications and notices must be processed by the Exchange. Another commenter suggested that the language for § 155.230 be expanded to refer to "applications, forms, notices and any other documents sent by an Exchange."

Response: We have not included general timeliness standards in § 155.230 of this final rule, as we did not propose them. However, subpart D contains timeliness standards related to eligibility determinations as interim final rules. In addition, as we develop model notices and future guidance, we will consider both notice timeliness standards and the applicability of § 155.230 to other documents issued by the Exchange.

Comment: A few commenters recommended that HHS remove "if applicable" from proposed § 155.230(a)(2) that reads: "An explanation of appeal rights, if applicable."

Response: Section 155.230 applies to all notices in accordance with part 155. However, in some cases, a notice of appeal rights is not relevant. For example, the notice of the annual open enrollment period in accordance with § 155.410(d) does not provide information specific to an individual and is not appealable. In contrast, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any determination notice issued to the applicant in accordance with § 155.310(g), § 155.330(e), or § 155.335(h) of subpart D. We intend to address appeal rights and procedures in future rulemaking.

Comment: A majority of commenters supported the approach described in § 155.230(b) of the proposed rule, while others suggested that HHS add more detail to accessibility standards. Many commenters recommended that we provide specific standards and thresholds for translation of written information, and be understandable to limited English proficient populations. One common suggested threshold was to provide written translations where 5 percent or 500 limited English proficient individuals reside in the State or Exchange service area, whichever is less. Many commenters also recommended we add specific standards with respect to oral interpretation, including at no cost to the individual, and informing individuals how to access these services through use of "taglines" in at least 15 languages. A few commenters asked for ***18337** flexibility for States in developing language services standards as States' populations and needs differ, and one commenter expressed concern that a specific, uniform standard could pose an unreasonable burden.

Response: In response to these comments, we have modified our proposed regulation at § 155.230(b) to cross-reference the accessibility, readability, and translation and oral interpretation standards outlined in § 155.205(c). We plan to put forth guidelines relating to these standards in upcoming guidance.

Comment: Many commenters noted the importance of health literacy and the need to provide information that is readable and understandable. A few commenters suggested that the reading level of informational materials should be not greater than the 6th grade reading level.

Response: We recognize the importance of health literacy and significance of providing readable and understandable information. We will take these comments into consideration as we develop guidance that sets more specific standards and

thresholds for readability, and as we develop joint guidance with the Department of Labor related to "plain language." However, we have decided not to add specific reading level standards in the final rule.

Comment: While some commenters expressed support for the proposed § 155.230(c) that the Exchange review notices on an annual basis, other commenters were concerned about the burdensome and costly nature of an annual review. Some commenters instead suggested that such a review occur every three years or "periodically." Several commenters recommended that Exchanges have flexibility in how they implement provision of notices and provided specific examples (that is, flexibility in content), while one commenter advised that Federal standards should provide a floor for notices but not diminish stronger standards that the State may have for notices. Commenters who supported an annual review also suggested that Exchanges seek consumer and stakeholder input as notices are developed and changes to notices are made. Some commenters also expressed support for or sought clarification related to how a State must consult with HHS when changes are made to notices, particularly regarding the scope of such a consultation. A few commenters suggested that notices should be reviewed annually as a part of the recertification process.

Response: In § 155.230(c) of the final rule, we revise the language from the proposed rule to provide that the Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices without specifying the interval at which such review must occur. Due to commenters' concerns about the feasibility and burden of an annual review and the request for flexibility regarding notices implementation, we removed the standard that this review must occur on an annual basis. We anticipate that the model notices developed by HHS will help to ensure that Exchanges include the appropriate content for their notices and reduce administrative burden and cost to Exchanges. We will consider the feasibility of reviewing notices, and notably any proposed changes made to notices, and will consider stakeholder input, particularly Exchanges and State Medicaid programs, as the model notices are developed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.230 of the proposed rule, with several modifications: we clarify in paragraph (b) that applications, forms and notices must comply with the readability and accessibility standards established in § 155.205(c) for the Exchange Internet Web site. In paragraph (c), we removed the proposed provision that the Exchange must re-evaluate applications, forms, and notices on an annual basis and also removed that the Exchange must consult with HHS when changes are made. In § 155.230(a)(3), we add that a notice must include the reason for the intended action.

g. Payment of Premiums (§ 155.240)

In § 155.240, we proposed that Exchanges must always allow an individual, at his or her option, to pay the premium directly to the QHP issuer. In addition, we proposed that an Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals, subject to the terms and conditions determined by the Exchange. We solicited comment on how such an approach might work in an Exchange. We also invited comment on how to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of "Indian" that apply for other Exchange provisions. With respect to the operation of a SHOP, we proposed that an Exchange must accept payment of an aggregate premium by a qualified employer.

Finally, we proposed that an Exchange may facilitate electronic collection and payment of premiums. We sought comment concerning Exchange flexibility in establishing the premium payment process and what Federal regulatory standards would be appropriate to ensure fiduciary accountability when an Exchange collects premiums.

Comment: One commenter suggested that QHP issuers report to an Exchange if an individual pays the issuer directly under the option described in § 155.240(a).

Response: We believe that this information will be transmitted from a QHP issuer and an Exchange through the process of effectuating enrollment through the Exchange and through the process to initiate advance payments of the premium tax credit

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and cost-sharing reductions. We outline reporting standards related to enrollment and notification if an individual stops payment in § 155.400, § 155.430, and § 156.270.

Comment: One commenter suggested that issuers should be responsible for collecting premiums directly from individuals, as described in proposed § 155.240(a), but that the Exchange should be permitted to garnish wages or undertake other legal means to collect unpaid premiums owed to QHP issuers.

Response: We clarify that nothing in the final rule imposes a responsibility on Exchanges to pursue unpaid premiums on behalf of a QHP issuer. We do not believe the Exchange should take on debt collection responsibilities for issuers.

Comment: With regard to proposed § 155.240(a), one commenter suggested that a possible interpretation of section 1312(b) of the Affordable Care Act is that payment facilitation by an Exchange could be considered direct payment by the individual to the QHP issuer.

Response: We interpret section 1312(b) of the Affordable Care Act to mean that individuals always have the option to pay a QHP issuer directly, and therefore, we maintain this policy as proposed.

Comment: In response to § 155.240(b) of the proposed rule, several commenters recommended that Exchanges must allow Indian tribes, tribal organizations, and urban Indian organizations to pay the unsubsidized portion of QHP premiums on behalf of enrollees. Some commenters noted that Indian tribes have a right to use Federal funds to pay insurance premiums on behalf of their members and a sovereign right to use their own funds for that purpose. Other commenters recommended that the Exchange accepts aggregated payments from employers so ***18338** it should also accept aggregated payments from tribes, tribal organizations, and urban Indian organizations. A few commenters recommended that HHS eliminate the qualifier, "subject to the terms and conditions determined by the Exchange," in the final rule.

Response: We did not accept the recommendation that Exchanges must permit Indian tribes, tribal organizations and urban Indian organizations to pay premiums on behalf of enrollees. Premium aggregation is a unique function of the SHOP Exchange, and is not identified as a function of the individual market Exchange. However, we recognize that some Exchanges may wish to work with tribal governments to facilitate payment on behalf of enrollees, including aggregated payment. We encourage Exchanges to include this option as part of its consultation with tribal governments. This rule does not prohibit a QHP issuer from accepting third-party payments of premiums from tribal governments, tribal organizations, or urban Indian organizations for enrollees through the Exchange.

Comment: Many commenters supported the option for an Exchange to act as a premium facilitator or aggregator for the individual market, as permitted under § 155.240(d). Several commenters suggested strengthening the standard by establishing that Exchanges must have the capacity to facilitate payments in the individual market citing benefits such as ease for consumer, consistent source of payments for QHP issuers, program integrity, and provision of real-time enrollment and payment data for Exchange monitoring. Others suggested a standard that Exchanges set a default payment, and suggested that Exchanges provide multiple avenues for payment including premium facilitation, direct to issuer, in person, online, by phone, by mail, and through cash, debit, credit, check, or automatic electronic transfers. One commenter suggested that the Exchange Blueprint address how complexity added by multiple payment options would be mitigated and another commenter recommended that an individual select the payment methodology at the time of enrollment for that benefit year.

Response: Premium aggregation has potential benefits for individuals, but we also do not think that there are sufficient disadvantages in having individuals pay QHP issuers directly to warrant establishing premium aggregation as a minimum standard. We believe that the final rule balances the potential benefits of premium collection in the individual market with State flexibility. We encourage all Exchanges to provide consumers with multiple payment options that facilitate enrollment and avoid creating payment processes that create barriers. We note that Exchanges have the flexibility to create a default payment mechanism through the Exchange, and to direct individuals to select a payment option for a year at the time of enrollment.

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Comment: Several commenters oppose proposed § 155.240(d) that allows for an Exchange to facilitate the collection and payment of premiums for the individual market. Commenters were concerned with several areas including cost, the timeliness of payments getting from consumers to the issue, and the additional complexity in the case of errors.

Response: We believe that premium aggregation may add value to an Exchange for consumers through ease of payment and to QHP issuers through having a single source of payment. Without premium aggregation in the small group market, a single entity would have to pay a variety of QHP issuers to administer its group health plan. However, the burden for paying premiums directly to QHP issuers is much less for individuals and families who are likely to be enrolled in a single QHP. Thus, premium aggregation is a minimum function of a SHOP, while it is optional for the individual market. We note that because an Exchange will need to establish premium aggregation functionality for a SHOP, it may be able to offer this option to individuals without additional up-front costs.

Comment: One commenter suggested that proposed § 155.240(d) ban paperwork for financial transactions and, instead, call for the use of electronic methods exclusively to lower administrative costs and allow quick feedback between Exchanges, qualified individuals, qualified employers, and QHP issuers.

Response: We believe that electronic payment methods have many benefits, and encourage Exchanges to use them where possible, but also acknowledge that electronic payment methods may not always be optimal for all consumers and may not be possible for all Exchanges. Therefore, it is not a minimum standard in this final rule.

Comment: Most commenters supported the proposed § 155.240(e) to adopt electronic means of collecting premium payments by individuals and employers, and the accompanying application of the privacy and standards outlined in § 155.260 and § 155.270. One commenter recommended deleting the cross reference to § 155.260, because this section related to privacy and security, not electronic transaction standards.

Response: We have maintained the cross-reference to § 155.260 in this final rule. Section 155.240(e) is meant to establish compliance with both electronic transactions standards in § 155.270 and privacy and security provisions of § 155.260. Because personally identifiable information may be exchanged in the process of premium payment, we believe the protections for collection, use and disclosure of information contained in standard transactions for premium payments are as vital as the format of these transactions.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.240 with the exception of the removal of proposed paragraph (c), as we believe that payment of premiums by qualified employers is sufficiently addressed in § 155.705. The other paragraphs have been re-numbered accordingly in the final rule.

h. Privacy and Security of Information (§ 155.260)

In proposed § 155.260, we addressed the privacy and security standards Exchanges must establish and follow. Specifically, we proposed that the Exchange apply appropriate security and privacy protections when collecting, using, disclosing or disposing of any personally identifiable information. In addition, we proposed that an Exchange apply these standards on contractors or sub-contractors through contracts or agreements with the Exchange.

We defined personally identifiable information (PII) and proposed prohibiting the collection, use, or disclosure of PII by the Exchanges unless: (1) required or permitted by § 155.260 of this subpart or other applicable law, and (2) the collection, use, or disclosure is made in accordance with subpart E of this part, § 155.200(c) of this subpart and section 1942 of the Act. We invited comment as to whether and how we should restrict the method of disposal in this section.

We also proposed that the security standards of the Exchange be consistent with HIPAA security rules described at 45 CFR 164.306, 164.308, 164.310, 164.312, and 164.314. We solicited comment on the aptness of adopting the HIPAA Privacy Rule's standards for Exchanges. Alternatively, we proposed to provide States with the flexibility to create a more appropriate and tailored standard, given the varied types of ***18339** information to which the Exchange would have access. We noted that we were considering directing each Exchange to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs), and sought comment on the appropriateness of FIPPs in this context and the best means to integrate FIPPs into the privacy policies and operating procedures of individual Exchanges. We listed examples of FIPPs-based principles derived from the Nationwide Privacy and Security Framework for the Electronic Exchange of Individually Identifiable Health Information, which is a model developed by the Office of the National Coordinator for Health IT. These are not purely FIPPs principles, but examples of how they may be used to develop robust privacy and security standards.

We also proposed that security policies and procedures must be in writing and available to the Secretary of HHS, and must identify any applicable laws that the Exchange will need to follow. In addition, we proposed that any data matching arrangements between the Exchange and agencies that administer Medicaid and CHIP for the exchange of eligibility information be consistent with all applicable laws. We also proposed that return information is kept confidential under section 6103 of the Code.

Finally, we proposed that any person that knowingly and willfully uses or discloses personally identifiable information inappropriately would be subject to a civil money penalty of not more than $25,000 per disclosure and any other applicable penalties that may be prescribed by law.

Comment: Many commenters recommended that HHS set a national minimum standard for use and disclosure of personally identifiable information (PII) under proposed § 155.260(b) rather than allow each Exchange flexibility to develop and implement standards customized to its operations. One commenter stated that HHS should harmonize State and Federal laws for the development and operation of information technology systems across all States. Commenters suggested adopting different existing privacy and/or security standards alone or in various combinations, including the Fair Information Practice Principles (FIPPs) model adopted by the Office of the National Coordinator for Health Information Technology, HIPAA Privacy, HIPAA Security, the Privacy Act, Medicaid standards at section 1902(a)(7) of the Act, the confidentiality and disclosure provisions of the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program (42 U.S.C. 1320b-7), the HITECH Act, and the Gramm-Leach-Bliley Act (GLBA).

Response: We recognize that there should be robust minimum privacy and security standards to ensure the confidentiality and integrity of PII created, collected, used, or disclosed by an Exchange. We also accept the comment that each Exchange will need to consider any State and Federal laws governing individuals' privacy and security rights for the geographic area(s) in which it operates in order to ensure PII is protected against any reasonably anticipated uses or disclosures that are not permitted or required by law. We acknowledge the current variance among States' laws governing privacy and security, but believe that eliminating this variance would, in many cases, apply Federal standards to existing State privacy and security frameworks. This would be prohibitively expensive for many States, and could be detrimental to the goal of maintaining the confidentiality of PII. In addition, multiple security frameworks increase the complexity of the technological environment—if a State must follow two different frameworks, there is an increased risk of applying the wrong security controls to the Exchange. Finally, but equally important, we recognize the need for flexibility in the implementation of these standards in order to minimize implementation costs. The imposition of uniform standards would increase costs related to re-training staff, engaging contractors, investing in additional physical and technological infrastructure, and other tasks related to implementation of the new standards. We believe it would increase the complexity of State operations, with associated risks and costs, without providing meaningful improvements to the protection of PII.

In the final rule, we do not establish a single, baseline standard. We direct an Exchange to put in place safeguards that ensure a set of critical security outcomes, and we present a framework within which an Exchange must create its privacy and security policies and protocols. We specify that an Exchange establish and implement privacy and security standards that are consistent with the FIPPs-based principles identified in the “Nationwide Privacy and Security Framework for Electronic

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Exchange of Individually Identifiable Health Information," the model adopted by the Office of the National Coordinator for Health Information Technology.[FN3] In addition to these FIPPs-based principles, § 155.260(a)(4) of this final rule directs Exchanges to establish and implement operational, technical, administrative, and physical safeguards that will ensure a set of defined privacy and security outcomes. We believe the standards in this final rule will minimize burden by allowing HHS and the States to leverage existing security infrastructure and allow Exchanges to tailor their privacy and security approaches to the types of information Exchanges will create, collect, use, and disclose, while providing a baseline set of standards and critical outcomes upon which all States must base their privacy and security policies and protocols.

We plan to release guidance to assist States in developing and implementing privacy and security policies and protocols that fulfill the standards of this section. In addition, HHS will assist States in the development of policies and protocols as part of the reviews and technical assistance provided to grantees under the section 1311(a) of the Affordable Care Act.

Comment: A large group of commenters requested that HHS codify sections 1411(g), 1413(c)(2), and 1414(a) of the Affordable Care Act. Several commenters recommended amending the language in proposed § 155.260(b)(1)(i) to explicitly establish that, based on section 1411(g) of the Affordable Care Act, information may not be created, collected, used, or disclosed unless "strictly necessary." One commenter recommended that we remove the reference to "other applicable law" and replace it with specific references to sections 1411(g) and 1557 of the Affordable Care Act, sections 1942 and 1137 of the Act, and the Privacy Act of 1974.

Response: We believe that privacy and security of PII is of utmost importance. Accordingly, in the final rule, we have made major changes to the Exchange privacy and security standards, both to give more specific guidance to States as they implement the Exchange program, and to ensure confidentiality for individuals who may interact with Exchanges. As stated in the preamble to the proposed rule, we looked to sections 1411(g), 1413(c)(2), and 1414(a) of the Affordable Care Act as the basis for many of the provisions in the proposed regulatory text. First, we removed proposed paragraph (a), which defined personally identifiable information in the context of the Exchange program. This is a broadly ***18340** used term across Federal agencies, and has been defined in the Office of Management and Budget Memorandum M-07-16. In order to reduce duplicative guidance or potentially conflicting regulatory language, we have removed this portion of the proposed rule, and point to the aforementioned memorandum as the source of this definition.

Paragraph (a)(1) of the final rule specifically addresses PII that is created or collected for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code. This paragraph limits the purposes for which the Exchange can use this information to those outlined in § 155.200 of this subpart.

Paragraph (a)(2) is broader in scope than paragraph (a)(1), and includes all information collected for the purposes of carrying out Exchange minimum functions described in § 155.200. This paragraph prohibits the creation, collection, use or disclosure of PII unless the manner in which the Exchange does so is consistent with the privacy and security standards outlined in § 155.260(a).

Paragraphs (a)(3) through (a)(4) outline the privacy and security principles and critical outcomes, and set expectations for development of privacy and security protocols by Exchanges, and new paragraph (a)(5) specifies that the Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls. We also inserted the provision from section 1413(c)(1) of the Affordable Care Act that an Exchange must develop and utilize secure electronic interfaces when sharing PII in § 155.260(a)(6).

We are not amending the final rule to codify section 1414(a) of the Affordable Care Act, because it falls under the jurisdiction of the Department of the Treasury. We are not codifying section 1557 of the Affordable Care Act because it is outside the scope of this rule. We are not codifying section 1137 of the Act, which includes standards for States' income and eligibility verification systems, in this final rule because it does not impose any additional privacy or security standards. In addition, section 1413(c)(3) of the Affordable Care Act simply directs that an Exchange can only determine eligibility on the basis of reliable, third

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party data, which is outside the scope of this section. We note that while the final rule does not propose to codify these listed provisions, Exchanges will need to comply with applicable laws that are outside the scope of this rulemaking.

Comment: A number of commenters requested clarification regarding HIPAA and Exchanges. One commenter requested that HHS declare that HIPAA applies to all Exchanges, but many commenters discouraged the use of this standard. A few commenters specifically requested that HHS not use HIPAA as the privacy standard. One commenter stated that applying HIPAA Privacy to non-HIPAA entities might permit broader collection, use, and disclosure of data than was intended by Congress in statutory limits set forth in section 1411(g) of the Affordable Care Act. Another commenter added that HIPAA lacks controls associated with new technologies.

Response: We believe HIPAA is not broad enough to adequately protect the various types of PII that will be created, collected, used, and disclosed by Exchanges and individuals or entities who have access to information created, collected, used, and disclosed by Exchanges. We recognize that there will be aspects of Exchanges, as health insurance marketplaces, that will not be reached by the HIPAA regulations governing health plans, certain providers, and clearinghouses (that is, "HIPAA covered entities"). In clarifying these points, however, it is important to recognize that the privacy and security standards that are adopted in this rule do not obviate the need for HIPAA covered entities to meet the HIPAA Privacy and Security Rules' standards. The Exchange sections of the Affordable Care Act did not alter the applicability of HIPAA to HIPAA covered entities.

To avoid any further confusion on this point, we believe that it is advisable to remove any specific regulatory references to HIPAA in proposed § 155.260(b), which we have redesignated as § 155.260(a) of this final rule. We replaced such references with the standards outlined in the first response in this section. We believe that the privacy and security standards in the final rule are analogs of the HIPAA policies in the proposed rule, with similar standards and restrictions. As stated in the preamble discussion to § 155.260 in the proposed rule, each State will need to conduct an analysis of its operations and functions to determine its HIPAA status based on the definitions in 45 CFR 160.103, and, when applicable, meet any and all obligations under those regulations in addition to any Exchange standards. For instance, a State may need to consider whether the Exchange performs eligibility assessments for Medicaid and CHIP, based on MAGI, or conducts eligibility determinations for Medicaid and CHIP as described in § 155.302(b).

We have inserted language in § 155.200 of the final rule that will clarify the relationship between an Exchange and a QHP—as noted therein, nothing in this final rule should be construed to create a relationship between an Exchange and a QHP whereby an Exchange performs functions on behalf of a QHP. Further, we intend to release guidance that will assist States in determining the applicability of HIPAA and other Federal laws to Exchanges.

Comment: Several commenters suggested that HHS encourage States to apply privacy and security standards that are stricter than the minimum standard set forth by HHS regulations. Others asked that HHS make clear in the final rule that, even if an Exchange is covered by a single standard, it will continue to be subject to additional rules set by HHS and the States. Commenters asserted that State law regarding privacy and security should remain applicable. One commenter stated that HHS should provide States with the flexibility to enact more stringent standards based on those States' determination of the most appropriate standard.

Response: We accept commenters' suggestion that States retain the discretion to apply more stringent standards than the minimum privacy and security standards imposed by this section. Nothing in this final rule prevents or otherwise impairs the applicability of more stringent State law. Equally, we note that nothing in this final rule obviates the need to meet any other applicable Federal privacy and security laws.

Comment: One commenter asserted that HHS does not have the authority to require Exchanges to provide access to its data protection policies and procedures to HHS. The commenter requested that HHS provide an explanation of why it wants or needs access to an Exchange's data protection policies and procedures and what it plans to do with that information. The commenter also stated that HHS has no enforcement authority over State-based Exchanges and therefore may not take "action" against an Exchange with data protection policies and procedures the Secretary deems "inadequate." In contrast, several commenters

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supported the provision in the proposed rule that Exchanges develop policies and procedures regarding the use, disclosure, and disposal of PII. Many ***18341** commenters asked that these policies and procedures be available to the public, and that HHS ensure that Exchanges engage stakeholders, including consumers, in the development of these policies and allow for public comment prior to submission to the Secretary. A few commenters asserted that these policies and procedures be part of the written Exchange Blueprint, in accordance with § 155.105 of the proposed rule, or another similar document that is available to the public.

Response: The Secretary has broad authority under section 1321(a) of the Affordable Care Act to issue appropriate regulations and standards with respect to the operation of Exchanges. Due to the private nature of the information provided to Exchanges, we believe that a process that allows the Secretary to ensure continued compliance with the privacy and security standards of § 155.260 is not only appropriate, but necessary. According to section 1321(c) of the Affordable Care Act, the Secretary has the authority to determine whether a State Exchange meets the requisite standards to operate. If the Exchange fails to meet these standards, the Secretary may establish and operate a Federally-facilitated Exchange in that State.

In addition, the Affordable Care Act also gives HHS an audit enforcement mechanism under section 1313. We believe the Secretary has broad authority to ensure the submission of these policies in accordance with 1313(a)(3) of the Affordable Care Act. This information is necessary to ensure the integrity of the Exchange and its related activities and to protect confidential consumer information. However, Exchanges do not have to release these policies and protocols to the public because this disclosure might reveal information that could damage the State's ability to maintain the integrity and security of its systems. Finally, while we have not included the privacy and security policies and protocols in the Exchange Blueprint, we believe we have the authority to do so if deemed appropriate by the Secretary.

Comment: Many commenters recommended that the privacy and security standards in proposed § 155.260 apply to application assisters, Navigators, contractors, other individuals who have access to PII gathered from individuals or available through an Exchange. One commenter asserted that the final rule should clearly affirm the obligation of these parties to abide by all Federal confidentiality and privacy laws.

Response: Individuals who have agreements with an Exchange that can collect, use, or disclose PII as part of their Exchange-related activities should comply with the final rule's privacy and security standards. However, we do not believe the Affordable Care Act grants the Secretary the authority to regulate all individuals and entities directly. Such authority is limited to the Exchange, who can impose these standards on individuals and entities that enter into agreements with the Exchange, such as contractors, agents, and brokers, and HHS grantees, such as Navigators. We have added § 155.260(b) of the final rule, which ensures that Exchanges impose privacy and security standards that are the same or more stringent than the privacy and security standards in § 155.260(a) as a condition of the agreement with other individuals or entities that will receive information through the Exchange.

Comment: Several commenters asked that HHS provide notice to individuals who share PII with an Exchange. Commenters also asked that HHS direct Exchanges to notify individuals of their privacy rights and note why the information is being collected prior to asking individuals to submit PII. One commenter said HHS should not share protected health information (PHI) without written consent before each disclosure.

Response: We believe the FIPPs-based principles in the final rule ensure that an Exchange will make individuals aware of the purpose of any information collection as well as the privacy policies that affect individuals and their PII. We have added language to new section § 155.260(a)(3)(iv) that an Exchange must develop privacy and security policies and protocols that are consistent with the FIPPs-based principle of “Individual Choice,” which states that individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information. In addition, in new § 155.260(a)(3)(iii), we establish that an Exchange's policies and protocols must be consistent with the principle of “Openness and Transparency,” which states that there should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable health information. In addition,

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if a State determines that its Exchange is a HIPAA covered entity or business associate, as defined in 45 CFR 160.103, that Exchange must adhere to any applicable HIPAA privacy and security standards, including those regarding the protection of protected health information (PHI). The final rule addresses only personally identifiable information, as defined in § 155.260(a) and does not modify HIPAA.

Comment: A handful of commenters stated that Exchanges should obtain specific authorization from individuals prior to using any PII for marketing purposes. Some commenters requested that HHS prohibit Exchanges from sharing any information for marketing or fundraising purposes altogether. One commenter stated that HHS should specifically prohibit Exchanges from selling data, or allowing access to PII collected for Exchange purposes for data mining. Another commenter stated that HHS should specifically prohibit any secondary uses of PII that are not specifically authorized.

Response: Section 155.260(a) does not permit the use or disclosure of PII for marketing or fundraising purposes. The final rule clarifies that PII collected for those purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, can only be used to the extent such information is necessary to carry out minimum functions in § 155.200 of this subpart.

Comment: Two commenters stated that HHS should be able to collect demographic information on a voluntary basis through the Exchange. Commenters believe that collection of demographic information would help to provide essential health information on vulnerable or underserved populations, facilitate tailored outreach and aid in enrollment activities, and provide input in the development of prevention and health care programming that address disparities.

Response: Section 1411(g) of the Affordable Care Act does not prohibit the collection of demographic data. We respond to this issue in greater depth in the preamble to § 155.405, which addresses the single, streamlined application.

Comment: Several commenters requested that HHS specify in the final rule that Social Security numbers should be collected for limited purposes. These commenters stated that Social Security numbers should be shared only for the purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions. Two commenters stated that Social Security numbers should be shared only for the purpose of identification of an individual.

***18342** Response: Sections 1411(b) and (c) of the Affordable Care Act give the Secretary the authority to ensure that applicants for enrollment in a QHP offered through an Exchange provide a Social Security number so that an Exchange can perform the requisite eligibility determination. While we believe that an individual's Social Security number should be collected and used for limited purposes, the use of an individual's Social Security number is essential to complete functions beyond identification —for example, the verifications described in sections 1411(c), (d), and (e) of the Affordable Care Act.

Comment: One commenter stated that HHS should establish criteria for the collection and retention of information when a consumer is a survivor or victim of domestic violence based on policies of child support collection programs.

Response: We do not believe that the final rule should contain the specific data collection for vulnerable populations for purposes other than those defined in the statute.

Comment: Two commenters asked that HHS ensure that Exchanges promptly notify potentially affected enrollees in the event of a data breach or unauthorized access to PII. One commenter suggested that HHS ensure that an Exchange conducts an investigation and hold the breaching party accountable, both legally and financially, for notification and investigation following the breach or unauthorized access.

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Response: We do not plan to include the specific notification procedures in the final rule. Consistent with this approach, we do not include specific policies for investigation of data breaches in this final rule. We do, however, plan to release guidance that addresses breach procedures.

Comment: One commenter requested that the final rule include privacy and security standards for storage, retention, and response to legal and civil matters. Another commenter stated that HHS should not retain PII longer than is necessary to carry out an authorized Exchange function.

Response: While the rule does not specifically mention storage, retention, or response to legal and civil matters, we believe that the final rule adequately addresses privacy and security standards for all potential uses of data, including storage and retention. We therefore do not include these elements in the final rule. We expect privacy and security standards developed by the Exchange will address the storage of information when it is not in use. Also, the Exchange policies and protocols must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials. We also believe that Exchanges should not retain PII longer than necessary. Retention times for Federally-facilitated Exchanges will be approved by the National Archives and Records Administration. As these retention times have not yet been issued for these Exchanges, and as we believe that a single standard for retention should apply to all Exchanges, we plan to release guidance on this topic at a later date.

Comment: One commenter asserted that HHS should not create one central location for personal information. The commenter challenged the government's ability to protect personal information.

Response: This comment regarding the storage of personal information is operational in nature and outside the scope of this rule. We plan to release guidance describing the approach for collection and storage of PII. We believe that the privacy and security standards in the final rule are sufficiently robust to protect the types of PII that will be created, collected, used, and disclosed by Exchanges.

Comment: A few commenters suggested that HHS should define the operational solutions for Exchange policies and protocols for privacy and security. One commenter said that Exchanges should create usage logs that are subject to audit to ensure the data are being accessed appropriately and only for business purposes. Another commenter stated that HHS should implement procedures related to identity theft to address cases where an applicant or enrollee reports that someone has fraudulently submitted information in his or her name. One commenter recommended that HHS collect data in a manner that allows for de-identification so that data can be made available for other purposes, such as research and analysis.

Response: We believe that having policies and protocols to protect against identify theft and fraudulent enrollment is critical. However, setting operational solutions for complying with regulatory standards in this section is outside the scope of the rule. HHS will release guidance identifying potential operational solutions for storing and tracking data, identifying and preventing fraudulent submissions to the Exchange, and de-identifying data.

Comment: A number of commenters recommended that HHS address the issue of authentication of individuals who access PII through the Exchange. One commenter asserted that HHS should ensure that Exchanges authenticate all entities and individuals interacting with the Exchanges. Commenters also cautioned HHS to develop authentication procedures that are minimally burdensome and do not discourage or prevent lawful consumer access to the Exchange. One commenter stated that authentication procedures should be proportionate to the risks associated with the corresponding activities. This commenter also stated that authentication procedures should leverage commercially available database sources, a method currently in use by States to authenticate identity.

Response: Exchanges will need robust authentication procedures that are effective, efficient, and minimally burdensome for both States and individuals. We have added language to the final rule that Exchanges must implement safeguards to ensure that personally identifiable information is disclosed only to those authorized to receive or view it. In addition, we expanded the

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scope of the privacy and security standards by stating explicitly that these standards must apply, as a condition of contract or agreement with an Exchange, to individuals or entities, including but not limited to Navigators, agents, and brokers, that: (1) gain access to personally identifiable information submitted to an Exchange; or (2) create, collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.260 of the proposed rule regarding privacy standards, with the following modifications: in an effort to prevent confusion and duplication in terminology, we removed paragraph (a), which defined personally identifiable information (PII) in the context of the Exchange program. This is a term used broadly by all Federal agencies, and the term is defined in a 2007 OMB Memorandum, which we point to in the preceding preamble discussion.

We redesignated proposed paragraph (b) as new paragraph (a). In paragraph (a)(1) of the final rule, we added that, where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, as defined in § 155.20; determining eligibility for enrollment in a qualified health plan; determining eligibility for other ***18343** insurance affordability programs, as defined in 155.20; or determining eligibility for the exemptions from individual responsibility provisions described in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information only to the extent such information is necessary to carry out the functions described in § 155.200 of this subpart. This paragraph limits the purposes for which the Exchange can use this information to those outlined in § 155.200 of this subpart. Paragraph (a)(2) is broader in scope than the type of PII described in (a)(1), and includes all personally identifiable information collected for the purposes of carrying out Exchange minimum functions described in § 155.200. This paragraph prohibits the creation, collection, use or disclosure of PII unless the manner in which the Exchange does so is consistent with the privacy and security standards outlined in § 155.260. In the final rule, we removed the provision from proposed paragraph (b)(2) for Exchanges to establish and follow operational, administrative, physical and technical security standards that, if carried out by a HIPAA covered entity would meet the standards at 45 CFR 164.306, 164.308, 164.310, 164.312 and 164.314. In its place we clarify that the Exchange must not create, collect, use or disclose PII unless the manner in which they do so is consistent with the standards of § 155.260. In new sections (a)(3)(i) through (viii), we outlined the principles that an Exchange must use in the development of its privacy and security standards. These include individual access; correction; openness and transparency; individual choice; collection, use, and disclosure limitations; data quality and integrity; safeguards; and accountability.

As described in new text added to (a)(4)(i) through (vi), an Exchange must establish and implement a set of operational, technical, administrative and physical safeguards that ensure the confidentiality, integrity, and availability of PII created, collected, used, and disclosed by the Exchange; that personally identifiable information is only used by or disclosed to those authorized to receive or view it; return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code; personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information; and personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or established by law.

New paragraph (a)(5) directs the Exchange to monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of the controls. In new paragraph (a)(6), we added a standard that the Exchange develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

In new paragraph (b), we added that, except for tax return information, when creation, collection, use, or disclosure is not otherwise required by law, an Exchange must establish the same or more stringent privacy and security standards (as those in § 155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that gain access to personally identifiable information submitted to an Exchange; or create, collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

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New paragraph (c) directs the Exchange to ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

In new paragraph (e), we added language to clarify that the standards for data matching and sharing between the Exchanges and Medicaid, CHIP, and BHP, where applicable, are triggered when these entities share PII. In addition, we added paragraph (e)(1) through (e)(4), which state that data matching or sharing agreements must: meet any applicable requirements described in this section; meet any applicable requirements described in sections 1413(c)(1) and (c)(2) of the Affordable Care Act; be equal to or more stringent that the requirements for Medicaid programs under section 1942 of the Act; and, for those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

In paragraph (g), we added that the civil penalty applies to each instance of knowing and willful improper use or disclosure of information. We redesignated proposed paragraph (b)(4) as new paragraph (d), and redesignated proposed paragraph (d) as new paragraph (f).

i. Use of standards and protocols for electronic transactions (§ 155.270)

In § 155.270 of the proposed rule, we proposed that the Exchange apply the HIPAA administrative simplification standards adopted by the Secretary in accordance with 45 CFR parts 160 and 162 when the Exchange performs electronic transactions with a covered entity. In addition, we proposed to codify the Health Information Technology (HIT) enrollment standards and protocols that were developed in accordance with section 3021 of the PHS Act, which was added by section 1561 of the Affordable Care Act, and that were adopted by the Secretary.[FN4] Specifically, we proposed that these aforementioned standards and protocols be incorporated within Exchange information technology systems.

Comment: HHS received several comments supporting our proposal to apply HIPAA administrative simplification standards, including the use of national standards and protocols for electronic transactions in § 155.270. However, one commenter expressed concern about the potential for gaps in the 005010 standard adopted by the Secretary in accordance with HIPAA. Another commenter, who supported the application of the administration simplification standards, added that HHS should apply any new transaction standards or protocols developed to supplement the HIPAA transactions consistently across all State-based Exchanges to promote administrative simplification among QHP issuers and eligibility services integrated with Exchanges.

Response: HIPAA administrative simplification standards are the appropriate standards for transactions that occur between the Exchange and covered entities, such as issuers, to continue the promotion of uniformity in administration and information interoperability of the Exchange activities as part of the larger health insurance industry. If Exchanges choose to implement standards in addition to those established in 45 CFR parts 160 and 162, they will continue to be in compliance with the final rule. As we work with Exchanges in connection with the information reporting standards for enrollment purposes to QHP issuers and/or Medicaid and CHIP agencies, we will be mindful of the potential for gaps in the 005010 standard adopted by the Secretary in accordance with HIPAA and will fully adhere to privacy and security standards in § 155.260 and § 155.270.

***18344** Comment: One commenter recommended that "operating rules" be included in the phrase "the Exchange must use standards, implementation specifications, and code sets adopted by DHHS" in § 155.270(a), noting that proposed § 155.240(e) contains language that an Exchange must use "the standards and operating rules referenced in § 155.260 and § 155.270" when conducting electronic transactions with QHPs involving premium payments or electronic fund transfers.

Response: We accept the commenter's recommendation to add the phrase "operating rules" to the proposed regulation text. In the final rule, we amended § 155.270(a) to include the term "operating rules" to address communications involving Exchanges that are subject to HIPAA administrative simplification.

Comment: Several commenters supported § 155.270(b) of the proposed rule, which directs an Exchange to incorporate standards developed by the Secretary in accordance with section 1561 of the Affordable Care Act, which amends the PHS Act and directs

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HHS to develop interoperable and secure standards and protocols for electronic enrollment transactions in consultation with the HIT Policy and HIT Standards committees. However, some commenters expressed concern about the ongoing usefulness of the committees' recommendations. Two commenters stated that the recommendations of those committees are now outdated. Another stated that a weakness in the cited HIT enrollment standards and protocols is the fact that these standards are not applicable to web services. Commenters noted that these standards and protocols facilitate the transfer of consumer eligibility, enrollment, and disenrollment information, but do not fill the need for standards that would apply to web services versions of HIPAA transactions. One commenter said it is critical that Exchanges design electronic data formatting and transmission standards that are uniform, easily implemented by QHP issuers, and leverage electronic data formatting and transmission standards that are already in use by health insurance carriers. Commenters also suggested that HHS recommend that Exchanges use specific data exchange formats and transmission standards such as those already established under the Health Insurance Portability and Accountability Act of 1996 and by CMS (for example, the 834 Enrollment, Online Enrollment Center (OEC) file format, and Health Plan Management System (HPMS) reporting).

Response: It will be important to leverage electronic data formatting and transmission standards that are already in use. However, we also believe that adhering to the broad standards and protocols developed by the Secretary, in collaboration with the HIT Policy and Standards committees, in accordance with section 3021 of the PHS Act, will provide standardization while allowing for the flexibility to leverage existing standards. We plan to issue guidance to help States determine appropriate transmission standards and data exchange formats for their Exchanges. We will also be consulting with the HIT Policy and HIT Standards committees at regular intervals to update the cited HIT enrollment standards and protocols to be more applicable to web services and to incorporate updates from Exchange electronic data formatting and transmission standards to broader standardization efforts. We also note that § 155.270 controls only how the Exchange sends information electronically to HIPAA covered entities. Section § 155.260 addresses privacy and security standards.

Comment: A few commenters expressed concern about the privacy and security of information being shared via electronic transactions in accordance with proposed § 155.270. Some commenters requested that this section reference the limitations on use and disclosure in § 155.260 of this subpart, which sets privacy and security standards for Exchanges. These commenters also recommended codifying section 1413(c)(1) of the Affordable Care Act, which directs States to develop secure interfaces for electronic data sharing. Another group of commenters expressed concern that co-mingling of data used for different purposes would create threats to the privacy of PII. These commenters requested that HHS ensure that Exchanges maintain a division between information that is stored and information that is used for eligibility determinations and redeterminations, with strict standards for disclosure or release of stored data.

Response: We believe the commenter's suggestion to include a regulatory citation to § 155.260 would be redundant because the privacy and security standards and protections in § 155.260 will apply to all transactions in which data are created, used, collected, stored, or disposed of by Exchanges. We also note that section 1413(c) of the Affordable Care Act is codified in section § 155.260(b)(3) and § 155.260(c). In addition, we note that the privacy and security standards cited in § 155.260 apply to both stored information and information used for eligibility determinations and redeterminations. Finally, while we acknowledge that stored data and data in active use warrant different privacy and security protocols, we believe that the privacy and security standards in § 155.260 direct Exchanges to have safeguards in place to prevent improper use, collection, or disclosure of information, whether the data are at rest or in transit. We therefore do not think it is necessary to address this distinction in our final regulation.

Comment: One commenter recommended that HHS adopt an operating rule that would apply to web services versions of the HIPAA transactions. This commenter encouraged HHS to consider the CORE Phase II rules, which have significant industry support, and to develop new standards that are not addressed in the CORE Phase II rules.

Response: It is important for HHS to adopt a standard for web-based transactions; however, detailed discussion on the adoption of such standards is outside the scope of this final rule. In this final regulation, we maintain the policy that Exchanges must apply and follow HIPAA standard transactions when engaging in electronic exchanges of information with Covered Entities.

Comment: One commenter requested clarification about whether it was in the intention of HHS to ensure that all electronic transactions with covered entities be consistent with the standards of 45 CFR parts 160 and 162. The commenter stated that this would direct all Medicaid agencies and issuers to use only standard transactions when conducting electronic transactions with Exchanges. Further, if it is the intent of HHS to permit, rather than require, these entities to conduct standard transactions with Exchanges, the commenter expressed that proposed § 155.270(a) should be rewritten to state this clearly. In addition, this commenter requested that HHS clarify whether Exchanges must conduct standard transactions with non-covered entities, such as employers and banks or their respective agents that request to do so. This clarification would ensure that employers and others that are now conducting (or may in the future conduct) such standard transactions as eligibility for a health plan, enrollment or disenrollment in a health plan, or health plan premium payments may be assured they can do so as standard transactions with exchanges.

Response: It is the intention of HHS to require, rather than to permit, adherence to the standards, ***18345** implementation specifications, and code sets adopted by the Secretary in 45 CFR parts 160 and 162, but only to the extent that the Exchange is performing electronic transactions with a covered entity. It is not the intention of HHS to establish standardized HIPAA transactions when Exchanges perform electronic transactions with non-covered entities, such as employers or banks. However, the Exchange has the flexibility to choose to use those standards, even if they are not minimum standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.270 of the proposed rule, with the following modification: in paragraph (a), we added a provision for Exchanges to use the operating rules adopted by the Secretary in 45 CFR parts 160 and 162.

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

In this subpart, we proposed standards that the Exchange will use to determine eligibility for Exchange participation and insurance affordability programs. In the proposed rule and in this final rule, we organized the standards as follows: eligibility standards, eligibility determination process, and applicant information verification process.

a. Definitions and General Standards for Eligibility Determinations (§ 155.300)

In § 155.300, we proposed definitions for this subpart. Virtually all of the definitions proposed in this section were taken from other proposed regulations, including the Exchange establishment proposed rule which was published prior to the Exchange eligibility proposed rule. Specifically, in this section, we proposed definitions or interpretations for "adoption taxpayer identification number," "applicable Medicaid modified adjusted gross income (MAGI)-based income standard," "applicable CHIP modified adjusted gross income (MAGI)-based income standard," "application filer," "Federal Poverty Level," "Indian," "insurance affordability programs," "minimum value," "non-citizen," "primary taxpayer," "State CHIP Agency," "State Medicaid Agency," and "tax dependent." We also proposed rules related to the applicability of Medicaid and CHIP rules and the acceptance of attestations.

Comment: A few commenters discussed the use of the term "MAGI" in the proposed rule. A commenter recommended referencing the term "MAGI-based standard for Medicaid and CHIP," as defined in the Medicaid proposed rule, and the term "MAGI," as defined in the Treasury proposed rule. One commenter also asked that the differences in the use of MAGI for Medicaid eligibility, such as income exemptions described in the Medicaid proposed rule, be specified in § 155.300.

Response: We recognize the need to reference the definitions of "MAGI" and "MAGI-based income" in § 155.300(a), and in this final rule include a reference to MAGI, as defined in 36B(d)(2)(B) of the Code, and MAGI-based income, as defined in 42 CFR 435.603(e). To clarify, we use "MAGI" with respect to household income for advance payments of the premium tax credit and cost-sharing reductions, and "MAGI-based income" with respect to household income for Medicaid and CHIP. We

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note that to further clarify this, we have added cross-references whenever “household income” is used throughout this subpart to specify whether it is in reference to household income for purposes of advance payments of the premium tax credit and cost-sharing reductions, as defined in section 36B(d)(2) of the Code, or household income for purposes of Medicaid and CHIP, as defined in 42 CFR 435.603(d).

Comment: We received a number of comments regarding the definition of Federal Poverty Level (FPL), as proposed in § 155.300(a). The definition, as proposed, specified that the FPL table used for eligibility for advance payments of the premium tax credit and cost-sharing reductions for a coverage year must be the table published as of the first day of Exchange open enrollment for the coverage year; commenters recommended that this definition be aligned with the definition of FPL used for Medicaid and CHIP eligibility, which uses the FPL table available at the time of an eligibility determination.

Response: We acknowledge the commenters' concerns. However, section 36B(d)(3) of the Code, as added by section 1401(a) of the Affordable Care Act, clearly defines the FPL table that must be used for eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions in such a way that it is distinct from the FPL table that is used for Medicaid and CHIP eligibility during much of the year. Therefore, HHS will maintain the proposed definition of FPL in the final rule. To the definition of “Federal poverty level”, we also included “or FPL”; throughout the final rule we also remove references to Treasury regulations when using the term FPL since the term is defined in this section using the same definition as in section 36B of the Code.

Comment: We received many comments asking HHS to define “incarcerated, other than pending the disposition of charges” in proposed § 155.300. Several commenters also recommended that such a definition be similar to the definition of “inmate of a public institution,” as used by the Medicaid program (42 CFR 435.1010).

Response: We acknowledge commenters' suggestion that we further define the term “incarcerated, other than pending the disposition of charges,” as used in § 155.305(a)(2), and we intend to clarify this term in future guidance. We note that 42 CFR 435.1010 defines the term “inmate of a public institution”, which is broader than the term “incarcerated” as used in this part; therefore, we do not have the authority or reason to adopt the broader definition, as the term “incarcerated” is used in the statute.

Comment: Commenters asked that we amend our definitions of “State Medicaid Agency” and “State CHIP Agency” to explicitly include those offices that administer them in the U.S. Territories.

Response: We acknowledge the suggestion, but are maintaining the proposed definitions in the final rule. These definitions reference Medicaid and CHIP regulations, which address Territories separately. Furthermore, the definition of “State” as included in section 1304(d) of the Affordable Care Act does not include Territories, and since this final rule implements only certain provisions of Title I of the Affordable Care Act that relate to States and Exchanges, we do not include Territories in these definitions.

Comment: We received several comments providing alternative interpretations of the definition of “Indian” than that which was included in the Exchange establishment and eligibility proposed rules. Some commenters suggested our definition is too narrow and inconsistent with Federal law. One commenter recommended that Indian be defined as a person who is a member of an Indian tribe or any person who is a member of an Indian tribe as defined in subsection (d) of the Indian Health Care Improvement Act (IHCIA), not limited to only Federally-recognized tribes. Other commenters stated that they believed that HHS's interpretation is not supported by the plain language of section 4 of IHCIA or section 4(d) of the Indian Self-Determination and ***18346** Education Assistance Act (ISDEAA) and believe that it is contrary to general principles of Indian law. Several commenters recommend that at a minimum HHS recognize that the definitions under the ISDEAA and IHCIA are operationally the same. Several commenters recommend that this rule align its definition with the Medicaid/CHIP definition found in 42 CFR 447.50.

Response: Since the Affordable Care Act statutory provisions identifying the specific benefits available to Indians incorporate section 4 of the IHCIA (for purposes of the special enrollment period described in § 155.420(d)(8)) and section 4(d) of the

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ISDEAA (for purposes of the cost-sharing provisions described in § 155.300(a) and (b)) for the definition of Indian, we are unable to adopt the Medicaid/CHIP definition under 42 CFR 447.50. Therefore, we maintain our proposed definition in this final rule. However, since both the ISDEAA and IHCIA operationally mean the same thing, there is uniformity among the definition of Indian for purposes of the Exchange-related benefits described in this final rule. We accept that the definitions of "Indian" as provided under section 4(d) of ISDEAA (codified at 25 U.S.C. 450 et seq.) and section 4 of IHCIA (codified at 25 U.S.C. 1603) operationally mean the same thing: an individual who is a member of an Indian tribe. In their definitions of an "Indian tribe," both of these acts have nearly identical language that refers to a number of Indian entities (tribes, bands, nations, or other organized groups or communities) that are included in this definition on the basis that they are "recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians."

Comment: One commenter asked that we clarify that the use of "attestation" does not prohibit the Exchange from obtaining electronic data and then asking an applicant to validate it, with the goal of increasing the efficiency and accuracy of the eligibility process.

Response: A key principle in our approach to the eligibility process is to streamline this verification process and maximize the use of electronic data. In many cases, we anticipate that the dynamic, electronic application process will take the approach that is recommended by the commenter. In other cases, it will be necessary to obtain information prior to verifying it. In general, the language of the final rule does not mandate a specific sequencing of activities, and is designed to allow flexibility within standards to ensure that the eligibility process can evolve to align with changes in technology and the availability of authoritative data. We also note that we will be providing a model application, which will include sequencing for the various steps needed in the eligibility process. Consequently, we are maintaining the language from the proposed rule. We look forward to working closely with States to achieve our shared goal of a streamlined eligibility process, including through the many areas in which we are providing flexibility to allow for continuous quality improvement in access to affordable health insurance.

We note that we have removed the language that specified that additional individuals, including a parent, caretaker or someone acting responsibly on behalf of such an individual, could provide attestations. The definition of application filer, which is now located in § 155.20, includes references to all individuals who may provide attestations; applicants, authorized representatives, and if the applicant is a minor or incapacitated, someone acting responsibly on behalf of the applicant. We have also replaced all references in this subpart regarding application filers providing attestations with references to applicants providing attestations, since the language in § 155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

Comment: We received comment regarding our definition of primary taxpayer. A commenter expressed concern that an individual may not know his future filing status.

Response: While this final rule revises the term "primary taxpayer" to "tax filer," to incorporate both spouses in a situation in which a married couple is filing jointly, we keep the proposed definition with minor revisions. Section 36B of the Code governs eligibility for the premium tax credit and advance payments of the premium tax credit, and specifies that it is based on the annual household income for a tax family for the year for which coverage is requested, which necessitates an understanding of an applicant's expected tax household for such year. We acknowledge challenges in communicating with individuals during the application process, including regarding tax filing status, and intend to work closely with stakeholders to develop effective communication strategies and tools.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.300 of the proposed rule, with the following modifications:

We removed the definition of "application filer," and moved the definition to § 155.20, as a definition applicable for all of part 155; we address this change in comment response for § 155.20. In the definition of "applicable CHIP MAGI-based income standard," we changed the reference from 42 CFR 457.05(a) to 42 CFR 457.310(b)(1) to align with the Medicaid final rule.

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For the definition of "minimum value", we clarified that the definition is used to describe coverage in an eligible employer-sponsored plan, and that minimum value means that an eligible employer-sponsored plan meets the standards with respect to coverage of the total allowed costs of benefits set forth in section 36B(c)(2)(C)(ii) of the Code. We added language to the definition of "State Medicaid agency" to clarify that the State Medicaid agency may be established or designated by the State in accordance with Medicaid regulations. For the definition of "insurance affordability program" we cross-referenced 42 CFR 435.4, but clarify that those programs included in this definition are the State Medicaid program under Title XIX of the Act, CHIP under Title XXI of the Act, the BHP under section 1331 of the Affordable Care Act, advance payments of the premium tax credit under section 36B of the Code, and cost-sharing reductions under section 1402 of the Affordable Care Act.

As further explained in response to comments later in § 155.305, we also changed the definition of "primary taxpayer" to "tax filer," which reflects that the role includes either spouse in a joint-filing situation, and changed the term throughout the subpart. Within the definition, we also added "or a married couple," to clarify that a tax filer may be an individual or a married couple, and deleted subparagraph (1)(iv), which included language clarifying that a primary taxpayer could be either spouse in a married couple, as this language is now redundant. In paragraph (a), we added a definition for "modified adjusted gross income" and a definition of "MAGI-based income." We also change the rule described in paragraph (b) to clarify that the Medicaid and CHIP regulations referred to in this subpart will be implemented in accordance with the policies and procedures as applied by the State Medicaid or State CHIP agency or as approved by the agency in the agreement described in 155.435(a). In response to comments, we also added new paragraph (d), which describes a rule for the Exchange when determining whether information is "reasonably compatible"; this clarification is ***18347** discussed in more detail in § 155.315 comment response.

We also made technical changes to this section. In paragraph (c), we changed the reference to § 155.310(e)(2)(ii) to § 155.310(d)(2)(ii). For the definition of "applicable Medicaid MAGI-based income standard," we changed the reference to 42 CFR 435.1200(c)(3) to 42 CFR 435.1200(b)(2).

Lastly, throughout this subpart, we have removed cross-references to the Treasury proposed rule and replaced them with cross-references to the applicable language in section 36B of the Code, as added by section 1401(a) of the Affordable Care Act, as the Treasury proposed rule will not be finalized as of the publication of this rule. Upon publication of the Treasury final rule, we intend to replace the statutory references with the appropriate regulatory references.

b. Options for conducting eligibility determinations (§ 155.302)

Based on comments and feedback to the proposed rule, we are revising the rule to include this section as an interim final provision, and we are seeking comments on it.

Comment: We received a number of comments expressing support for a policy in which eligibility processes were integrated across the Exchange, Medicaid, and CHIP in order to ensure a seamless experience for consumers. Commenters further stressed the importance of a single entity conducting all eligibility determinations. We also received comments asking that States be permitted to rely on the Federal government for certain eligibility functions, and that State Medicaid and CHIP agencies be permitted to exercise final control over eligibility determinations for Medicaid and CHIP based on applications submitted to the Exchange, particularly when the State does not operate an Exchange. In particular, commenters asked that the Federal government offer to perform eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, based on an argument that this is not a current part of State processes, should be uniform across States, and is connected to the advance payment of premium tax credits with Federal funds. Another commenter suggested that rather than have the Federal government assume responsibility for an entire eligibility function, we should isolate certain components of the eligibility function.

Response: While a fully-integrated eligibility process will best achieve a seamless experience for applicants, we adopt the suggestion of the commenters who requested more flexibility for States regarding Medicaid and CHIP eligibility determinations. With appropriate standards, this approach could both maintain the seamless consumer experience while allowing States to design the eligibility process to best match their current systems and capacity. Accordingly, while the majority of subpart D

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continues to refer to all functions being carried out by the Exchange, in new § 155.302 of this final rule, we specify that the Exchange may fulfill these provisions through different options or combinations of options, subject to standards described in § 155.302(d). The standards in § 155.302(d) are intended to ensure that this approach to eligibility determinations still affords applicants a seamless path to enrollment in coverage and that it does not increase administrative burden and costs; we use certain performance standards identified in paragraphs (b), (c) and (d) and the agreements among the relevant agencies to achieve this. We clarify that these options are separate and distinct from the "State Partnership" model described in the preamble of § 155.200 of this final rule. We intend to provide further guidance on the implementation of these options, including the roles and responsibilities of the various parties, in the future.

First, in § 155.302(a), we clarify that the Exchange may fulfill its minimum functions under this subpart by either executing all eligibility functions, directly or through contracting arrangements described in § 155.110(a), or through one or both of the approaches identified in paragraphs (b) and (c) when other entities determine the eligibility of applicants for insurance affordability programs.

Second, in § 155.302(b), we identify that the Exchange may conduct an assessment of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP. Such an arrangement is permissible provided that the Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with Medicaid and CHIP regulations, without regard to how such standards are implemented by the State Medicaid and CHIP agencies. That is, the assessment must follow verification rules and procedures that could be adopted by a State Medicaid or CHIP agency, although the use of this option is not contingent on the State Medicaid or CHIP agency doing so.

In paragraph (b)(2), we provide that notices and other activities that must be conducted in connection with an eligibility determination for Medicaid or CHIP are conducted by the Exchange consistent with the standards identified in this subpart or by the applicable State Medicaid or State CHIP agency consistent with applicable law.

In paragraph (b)(3), we outline the procedures the Exchange must follow when, based on the assessment conducted consistent with the standards in paragraph (b)(1), the Exchange finds an applicant potentially eligible for Medicaid or CHIP. We note that "potentially eligible" does not mean that the individual's income, as determined by the Exchange, necessarily is at or below the applicable Medicaid or CHIP MAGI-based income standard. We would expect in the interagency agreements between the State Medicaid and CHIP agencies and the Exchange, the Exchange's determination of which applications will be transferred for further action by the Medicaid and CHIP agencies will depend in part on the extent to which their verification procedures are consistent with those followed by the State Medicaid and CHIP agencies. The Exchange would transmit such an individual's information to the State Medicaid or CHIP agency in accordance with paragraph (b)(3) for additional processing, although the Exchange would consider him or her as ineligible for Medicaid or CHIP for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notified the Exchange that the individual was eligible for Medicaid or CHIP. We will work with Exchanges to establish a reasonable application of the term "potentially eligible" taking into account an Exchange's assessment procedures.

In paragraph (b)(4), we describe the procedures that the Exchange must follow when, based on an assessment conducted in accordance with paragraph (b)(1), the Exchange finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards. The Exchange must consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, and notify the applicant and provide him or her with the opportunity to withdraw his or her application for Medicaid and CHIP. To the extent that an applicant withdraws his or her application for Medicaid and CHIP (for example, if he ***18348** or she is approved for advance payments based in part on an assessment that he or she is not potentially eligible for Medicaid and CHIP), the applicant would not receive a formal approval or denial of Medicaid and CHIP; the alternative is for the applicant to request that the Exchange transmit the application to the State Medicaid and CHIP agency for additional processing.

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As noted above, in addition to providing the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP, in paragraph (b)(4)(i)(B), the Exchange must notify and provide the applicant with the opportunity to request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies. For an applicant who requests a full Medicaid and CHIP determination, the Exchange must transmit all information as provided as part of the application, update, or renewal that initiated the assessment and any information obtained or verified by the Exchange to the State Medicaid and CHIP agency. The Exchange must also consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant has been determined eligible for Medicaid or CHIP.

The arrangement under paragraph (b) would also provide that the Exchange must adhere to the eligibility determination made by the Medicaid or CHIP agency, and that the Exchange and the applicable State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We expect that these agreements will establish the responsibilities across the parties, and we will work with States to help develop such agreements. We note that we include rules related to assessments of eligibility for Medicaid and CHIP in paragraph (b)(1), to reinforce this concept. The standards and responsibilities of the Exchange, which we include for this agreement, complement the standards in 42 CFR 435.1200(d) of the Medicaid final rule. In accordance with these standards, we expect that when an assessment is conducted by the Exchange and transmitted to the State Medicaid or CHIP agency, and the Exchange is providing advance payments pending an eligibility determination for Medicaid and CHIP, the Exchange will receive a notification of the final determination of eligibility for Medicaid and CHIP made by the receiving agency. Together, these standards aim to avoid the duplication of requests for information from applicants and verification of information, and ensure timely eligibility determinations despite the ‘hand-offs' to different agencies or entities. Furthermore, we believe the inclusion of the functions and the standards for the agreements described in § 155.302 are consistent with our goal of ensuring a seamless eligibility process. We also note that while defining what constitutes eligibility for minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions is outside the scope of this regulation, we clarify that our understanding is that if the Exchange conducts an assessment in accordance with paragraph (b) of this section and does not find that an applicant is eligible for Medicaid and CHIP, such finding is sufficient to meet the eligibility criteria specified in § 155.305(f)(1)(ii)(B) with respect to Medicaid and CHIP.

Third, in § 155.302(c) of the final rule, we describe that the Exchange must implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS. We also describe that such an arrangement must provide that all verifications, notices, and other activities conducted in connection with determining eligibility for advance payments of the premium tax credit and cost-sharing reductions are conducted by either the Exchange in accordance with all of the applicable standards described in this subpart or by HHS in accordance with the agreement between HHS and the Exchange. We also direct that the Exchange transmit all applicant information and other information obtained or verified by the Exchange to HHS. The Exchange would then adhere to HHS's determination for advance payments of the premium tax credit and cost-sharing reductions. The Exchange and HHS would also need to enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions. As with the option described in § 155.302(b), we include particular standards and responsibilities which are designed to eliminate duplicative requests for information from applicants and ensure timely eligibility determinations.

In § 155.302(d) we outline the standards to which the Exchange must adhere when assessments of eligibility for Medicaid and CHIP based on MAGI and eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) and (c); such standards include that all eligibility processes are streamlined and coordinated across applicable agencies, that such arrangement does not increase administrative costs and burden on applicants, enrollees, beneficiaries, or application filers, or increase delay, and that applicable requirements under part 155 and section 6103 of the Code are met.

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Lastly, we note that all of the above configuration options will necessitate coordination between the Exchange, HHS, and the State Medicaid and CHIP agency. We will work closely with States to develop operational solutions that will result in a high-quality eligibility process, which in turn will result in achievement of our shared coverage goals and a sustainable Exchange.

Summary of Regulatory Changes

We are finalizing the following provisions at § 155.302 and requesting comment. In paragraph (a), we provided that the Exchange may choose to satisfy the standards of subpart D directly or through contracting arrangements, or through one or a combination of options described in paragraphs (b) and (c), subject to additional standards outlined in paragraph (d).

If the Medicaid or CHIP agency retains final control of eligibility determinations for Medicaid and CHIP, in paragraph (b), we described that notwithstanding the standards of this subpart the Exchange may conduct assessments of eligibility for Medicaid and CHIP based on MAGI rather than the eligibility determinations for Medicaid and CHIP provided that: the Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented by the State Medicaid and CHIP agencies; notices and other activities conducted in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law; when the Exchange assesses an individual as potentially eligible for Medicaid or CHIP, the Exchange transmits all information provided as a part of the application, update, or ***18349** renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid or CHIP agency via secure electronic interface; when the Exchange finds an individual not potentially eligible for Medicaid and CHIP, the Exchange considers the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions and must notify such applicant, and provide him or her with the opportunity to either withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid or CHIP by the State Medicaid and CHIP agencies. When an applicant requests a full determination of eligibility for Medicaid and CHIP, the Exchange must transmit all information obtained or verified by the Exchange to the State Medicaid and CHIP agencies promptly and without undue delay and consider such an applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP. Furthermore, under the arrangement described in paragraph (b), the Exchange must adhere to the eligibility determination for Medicaid or CHIP made by the State Medicaid or CHIP agency, and the Exchange and the State Medicaid and CHIP agencies must enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We note that in such an arrangement if the Exchange the State Medicaid and CHIP agencies are using the same information technology infrastructure formal transmissions may not be needed.

In paragraph (c), we establish that notwithstanding the standards of this subpart the Exchange may implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS. Under such option we provide: that verifications, notices, and other activities necessary in connection with an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS, in accordance with the agreement between the Exchange and HHS; the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the eligibility determination, and any information obtained or verified by the Exchange, to HHS via secure electronic interface, promptly and without undue delay; the Exchange adheres to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions made by HHS; and the Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions.

In paragraph (d), we outline the standards to which assessments and eligibility determinations described in paragraph (b) and (c) must adhere, including that eligibility processes are streamlined and coordinated across insurance affordability programs; such arrangement does not increase administrative costs and burdens on individuals or increase delay; and any applicable standards under § 155.260 or § 155.270, § 155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure,

maintenance, or use of information will be met. All such changes adopted for this section of the final rule are described in responses to comments for § 155.302.

c. Eligibility Standards (§ 155.305)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it.

In § 155.305, we proposed to codify the eligibility standards for enrollment in a QHP and for insurance affordability programs. Specifically, we proposed that the Exchange determine an applicant eligible for enrollment in a QHP if he or she meets the basic standards for enrollment in a QHP outlined in the Affordable Care Act, including that the individual must be a citizen, national, or a non-citizen who is lawfully present, not incarcerated, and be reasonably expected to remain so for the entire period for which enrollment is sought. We solicited comments regarding the language that an individual be "reasonably expected," for the entire period for which enrollment is sought, to be a citizen, national, or non-citizen lawfully present, and on how this policy can be implemented in a way that is straightforward for individuals to understand and for the Exchange to implement.

We also proposed that in order to be eligible to enroll in a QHP, an individual must intend to reside in the State in the service area of the Exchange. We clarified that this residency standard is designed to apply to all Exchanges, including regional and subsidiary Exchanges. In general, we proposed to align the Exchange residency standard with the Medicaid residency standards proposed in 42 CFR 435.403 of the Medicaid proposed rule (76 FR 51148). We clarified that this residency standard does not require an individual to intend to reside for the entire benefit year. We also proposed that the Exchange follow additional Medicaid residency standards (which were proposed in the August 17, 2011 Medicaid rule at 42 CFR 435.403) and the policy of the State Medicaid or CHIP agency to the extent that an individual is specifically described in that section and not under paragraphs (a)(3)(i) or (ii).

We proposed that for a spouse or a tax dependent who resides outside the service area of the tax filer's Exchange, the spouse or tax dependent will be permitted to either: (1) enroll in a QHP through the Exchange that services the area in which he or she resides or intends to reside; or (2) enroll in a QHP through the Exchange that services the area in which his or her tax filer intends to reside or resides, as applicable. We also solicited comment on any standards regarding in-network adequacy for out-of-State dependents that we should consider in a different section of the proposed rule. We also noted that HHS intends to allow State Medicaid agencies to continue to have State-specific rules with respect to residency for students under the Medicaid program, and solicited comments on whether different residency rules should be maintained for enrollment in a QHP or whether a unified approach should be adopted.

We proposed that the Exchange determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in § 155.410 and § 155.420. We also proposed that the Exchange determine applicants' eligibility for Medicaid and CHIP. Specifically, we proposed that the Exchange determine eligibility for Medicaid based on categories utilizing the applicable Medicaid MAGI-based income standard, and that the Exchange determine eligibility for CHIP if an applicant meets the standards of 42 CFR 457.310 through 457.320 and has a household income within the applicable CHIP MAGI-based income standard. Additionally, we proposed to codify that if a BHP is operating in the service area of the Exchange, the Exchange will determine an applicant's eligibility for ***18350** the BHP, using the statutory criteria for eligibility.

We also proposed that the Exchange determine eligibility for advance payments of the premium tax credit based on eligibility standards proposed in paragraph (f)(1) and (f)(2), and that the Exchange may provide advance payments of the premium tax credit only for an applicant who is enrolled in a QHP through the Exchange. Additionally, we clarified that the Exchange must determine a tax filer ineligible to receive advance payments of the premium tax credit if HHS notifies the Exchange that the tax filer or his or her spouse received advance payments for a prior year for which tax data would be utilized for income verification and did not comply with the requirement to file a tax return and reconcile the advance payments of the premium tax credit for such year. In the event the Exchange determines that a tax filer is eligible to receive advance payments of the premium

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tax credit, we proposed that the Exchange calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B-3 of the Treasury proposed rule (76 FR 50931).

We also proposed that the Exchange require an application filer to provide the social security number (SSN) of the tax filer if an application filer attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized for verification of household income and family size. We solicited comments on how the Exchange can maximize the accuracy of the initial eligibility determination and establish a robust process for individuals to report changes in income to alleviate stakeholder concerns about income fluctuations during the year that may result in large reconciliation payments.

Finally, we proposed that the Exchange must determine applicants eligible for cost-sharing reductions based on eligibility standards described in paragraph (g), and we note that special eligibility standards for cost-sharing reductions based on Indian status are described in § 155.350 of this subpart. Specifically, we clarified in the proposed rule that an individual with household income that exceeds 250 percent of the FPL who is not an Indian is not eligible for cost-sharing reductions. We codified the statute such that an applicant must be enrolled in a QHP in the silver level of coverage in order to receive cost-sharing reductions. Lastly, we proposed three eligibility categories for cost-sharing reductions, and proposed that the Exchange transmit information about an enrollee's category to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of reductions.

Comments: We received comments regarding the provision in proposed § 155.305(a)(1) which states that an individual must be “reasonably expected” to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought. One commenter recommended that the final rule remove the “reasonably expected” standard as it would limit non-citizens' eligibility to enroll in a QHP.

Response: The final rule maintains the “reasonably expected” standard in accordance with section 1312(f)(3) of the Affordable Care Act. We do not interpret this provision to mean that an applicant must be lawfully present for an entire coverage year; rather, we anticipate that the verification process will address whether an applicant's lawful presence is time-limited, and if so, the Exchange will determine his or her eligibility for the period of time for which his or her lawful presence has been verified. We anticipate providing future guidance on this topic, with a focus on minimizing administrative complexity and burden.

Comment: We received a number of comments related to and in support of the eligibility standard in proposed § 155.305(a)(2) that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, with the exception of incarceration pending the disposition of charges. Several commenters expressed concerns and provided recommendations about how to coordinate and promote continuity of care for individuals who will be transitioning from incarceration, and some commenters expressed this concern in regard to specific populations of incarcerated individuals. One commenter recommended that prisoners should be able to apply for coverage through the Exchange in advance of their release so that coverage can be effective on their release date, while another commenter noted that we should provide that Exchanges must accept applications in the event they are submitted on behalf of an inmate of a correctional facility. Also, one commenter suggested that prisoners should not be held responsible for reporting changes if they become incarcerated, and prisoners should not be held liable for repayment of advance payments of the premium tax credit for which they would be liable if they are receiving them and then become incarcerated.

Response: In § 155.305(a)(2) of the proposed rule, we codified section 1312(f)(1)(B) of the Affordable Care Act, which specifies that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, other than incarceration pending the disposition of charges. HHS will consider commenters' recommendations related to promoting continuity of care for individuals leaving incarceration in future guidance. Since the Exchange will accept applications and make eligibility determinations throughout the year, an inmate would not be precluded from applying for coverage through the Exchange in an effort to coordinate an effective date of coverage with his or her release date. We also note that § 155.420(d)(7) provides a special enrollment period (“A qualified individual or enrollee who gains access to new QHPs as a result of a permanent move”) which covers individuals who are released from incarceration.

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The final rule maintains the provision specifying that an enrollee must report any change with respect to the eligibility standards in § 155.305, which includes when an enrollee becomes incarcerated, other than incarceration pending the disposition of charges, as it is important for the Exchange to be able to discontinue the enrollment and recompute any advance payments or cost-sharing reductions to account for the change in eligibility. As with other changes that affect eligibility for enrollment in a QHP, not reporting such a change so that advance payments of the premium tax credit can be adjusted accordingly exposes a tax filer to the risk of repayment of advance payments of premium tax credits at tax filing.

In addition, we note that we clarify in § 155.330(b)(4) of the final rule that an application filer may report a change on behalf of an enrollee, which, for example, allows a member of an enrollee's household to report the enrollee's incarceration. Also, in § 155.330(d)(2) of this final rule, we allow for flexibility for Exchanges to periodically check trusted data sources, provided that the data matching program meets certain standards; this provision could allow an Exchange to engage in data matching on incarceration to provide an additional avenue to capture changes.

Comment: We received a number of comments related to the residency standards for enrollment in a QHP, described in proposed § 155.320(a)(3). Several commenters recommended that the residency standards across the Exchange, Medicaid and CHIP be aligned and uniform so as to limit States' discretion in precluding certain transient populations from having continuous coverage throughout the ***18351** year. Several commenters recommended that we align with the Medicaid "intent to reside" standard, and include the two provisions from the residency standard as proposed in the Medicaid proposed rule at 42 CFR 435.403(h)(1)(ii). One commenter suggested that we add the following alternative as a means of satisfying the residency standard: "Has entered the State with a job commitment (whether or not he or she is currently employed)." A few commenters recommended that we should adopt a more stringent residency standard than included in the Medicaid proposed rule.

Response: We intend to align the residency standards with those of the Medicaid regulations; therefore, we are revising § 155.305(a)(3) in this final rule in response to commenters' recommendations that we align residency standards with Medicaid and CHIP and in consideration of changes made from the Medicaid proposed rule to the Medicaid final rule. For example, in § 155.305(a)(3)(i)(B), this final rule provides that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not the applicant is currently employed). This provision was included in the Medicaid proposed rule and is included in the Medicaid final rule; we include it here to provide consistency between these rules. We add language throughout § 155.305(a)(3) to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards, to clarify that an individual must be physically present in the service area of the Exchange in order to be eligible for enrollment in a QHP through that Exchange. We note, however, that this does not preclude an individual from submitting an application and receiving an eligibility determination in advance of relocating to a new State; in such a situation, his or her eligibility will not be effective until he or she is "living" in the new State. We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule.

Comment: We received a number of comments related to the proposal in § 155.305(a)(3)(iv) related to residency standards for family members who meet the applicable residency standard for a different Exchange service area than of one or both of the tax filers. While several commenters supported the provision in the proposed rule that dependents and spouses may enroll in a QHP offered through the Exchange in the service area where they reside or through the Exchange serving the area where a tax filer meets the applicable residency standard (or in the case of a spouse who is married filing jointly, another tax filer meets the applicable residency standard), several commenters opposed this provision. If this policy is maintained, one commenter recommended that HHS develop a system for Exchanges to easily apportion premium tax credits among family members. Several commenters expressed concern that a person who purchases coverage from a QHP offered through the Exchange where he or she does not live would likely encounter difficulties in finding care as well as significant additional costs from the use of out-of-network providers. In addition, the QHP issuer would be limited in its ability to facilitate use of the highest quality and most efficient providers and coordinate care across providers and settings. Commenters encouraged HHS to consider limiting this option. Several commenters recommended that HHS establish an electronic mechanism for Exchanges to communicate with each other, as well as sought clarification about how the Exchanges will coordinate tax credits for members of the same tax

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household purchasing coverage in QHPs through different Exchanges and other specific operational details around verification and the eligibility process. One commenter noted that this would be a simpler process if a tax filer could purchase coverage for a dependent or spouse in the other State's Exchange through the tax filer's Exchange via a link or web portal.

Response: We maintain the residency standard in § 155.305(a)(3)(iv) of the final rule with limited modifications. All of the modifications result from a change in our terminology from “primary taxpayer” to “tax filer” in an effort to reduce confusion that could be associated with the term “primary taxpayer,” notably since primary taxpayer generally refers to the first name on the tax return of two individuals who are married, but both individuals are tax filers and there is no significance to which is the primary taxpayer for purposes of the premium tax credit (this change has been made throughout the final rule). The remaining changes are to clarify that any member of a tax household that has members in multiple Exchange service areas may enroll in a QHP through any of the Exchanges for which one of the household's tax filers meets the applicable residency standard; the exception to this standard is that when both tax filers enroll in a QHP through the same Exchange, the tax filers' dependents may choose either the Exchange through which the tax filers are enrolled or an Exchange for which the dependents meet the applicable residency standard in paragraphs (a)(3)(i)-(iii). Taken together, we expect that these residency standards will ensure that enrollees in QHPs through the Exchange have appropriate access to services.

Regarding comments suggesting that Exchanges should be able to apportion premium tax credits among family members, we will provide additional information in the future in coordination with the IRS. We note that the apportionment of advance payments will need to occur when a single tax household is covered by more than one QHP. Regarding comments we received related to network adequacy, a more detailed response is provided in § 156.230 of this final rule. We also note that multi-State plans certified by and under contract with the Director of the Office of Personnel Management may provide another option in such scenarios. In response to comments recommending that we create an electronic mechanism by which Exchanges can communicate with each other and other operational details of the eligibility process, HHS is considering commenters' recommendations regarding how best to coordinate cross-Exchange activities.

Comment: A few commenters strongly supported limiting enrollment to a single open enrollment period per year.

Response: The language in § 155.305(b) of the proposed rule specified that the Exchange determine an applicant eligible for an enrollment period in accordance with the provisions regarding enrollment periods in § 155.410 and § 155.420.

Comment: A number of commenters expressed overall support for the Exchange conducting Medicaid and CHIP eligibility determinations, and some suggested that the regulation be amended to include a standard that an Exchange determine eligibility for Medicaid on any basis of eligibility offered in that State (such as optional eligibility categories and categories that do not use the MAGI standard). Some commenters expressed support for uniformity and standardization around eligibility and enrollment in general. Several commenters recommended that HHS provide that the Exchange must collect information related to non-MAGI eligibility to ensure that applicants can truly avail themselves of a “no wrong door” application process for Medicaid. A few commenters supported the clarification that eligibility for emergency Medicaid services does not ***18352** count as Medicaid eligibility for purposes of eligibility for premium tax credit and cost-sharing reductions through the Exchange. Another recommended that there should be an emphasis on child-only plans through the Exchange for those children who are not eligible for Medicaid.

Response: Sections 155.345(b) and (d) of the final rule specify that the Exchange must assess information provided by an applicant who is not eligible for Medicaid based on standards specified in § 155.305(c) to determine whether he or she is potentially eligible for Medicaid in a category that does not use the MAGI standard, and refer any potentially eligible individuals to the Medicaid agency for an eligibility determination. In addition, § 155.345(c) of the final rule specifies that the Exchange must provide an opportunity for an applicant to request a full Medicaid eligibility determination based on factors not considered in § 155.305(c). We believe that this proposal creates a streamlined eligibility process for the vast majority of applicants, while also allowing applicants who may be eligible for a category that does not use the MAGI standard to access a more streamlined

process than is available today, without requiring the Exchange to accommodate all of the complexity associated with the categories of Medicaid that were not modified by the Affordable Care Act.

In order to maintain a single, streamlined application, and in accordance with section 1413(b)(2) of the Affordable Care Act, applicants will not be asked for more information than is needed for the Exchange to make an eligibility determination for insurance affordability programs based on MAGI, apart from collecting basic information to assess individuals for potential Medicaid eligibility on a non-MAGI basis, for example a single triggering question. Applicants will always have the opportunity to request a full determination of eligibility for Medicaid. We also note that we know that several States are considering leveraging a single Exchange/Medicaid/CHIP technology platform in future years to also accommodate non-MAGI Medicaid applicants, which is permitted under the statute and final rule. In response to commenters requesting clarification about whether eligibility for Medicaid coverage that is limited to emergency services counts as minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, this determination is subject to other rulemaking. We note, however, that individuals who are not lawfully present, are not eligible for enrollment in a QHP, let alone for enrollment in a QHP that is supported by advance payments and cost-sharing reductions. We also note that immigration status is not a factor for emergency Medicaid eligibility. In this final rule, we also revise § 155.305(c) to streamline references to Medicaid citizenship and immigration status and residency eligibility standards, and align with the Medicaid MAGI-based assessment described under 42 CFR 435.911(c)(1). Lastly, regarding child-only plans, we note that the Exchange will inform an applicant of all of the QHPs for which he or she is eligible, including any child-only plans.

Comment: We received a range of comments related to performance measurement and oversight tools related to eligibility and enrollment. One commenter recommended a modification of Federal audit tools to ensure that States are evaluated based on the number of eligible people they correctly enroll for coverage. Some commenters recommended that QHP issuers should not be held responsible for any errors that the Exchange may make in the eligibility determination process, while some commenters sought clarification of an Exchange's liability for inaccurate eligibility determinations. Other commenters requested State flexibility when operational challenges impede a seamless eligibility and enrollment process (including, for example, transitioning enrollees from one insurance affordability program to another).

Response: We plan to regulate in the future on oversight tools and performance measurements in future rulemaking and guidance. We will consider commenters' recommendations regarding oversight tools and performance measurement as we develop future guidance on this topic.

Comment: Several commenters strongly supported the Exchange sharing common eligibility standards with Medicaid, CHIP, and the BHP, and determining eligibility for the BHP. Several commenters suggested that the Exchange should conduct eligibility determinations for other programs that are not related to health insurance coverage, such as the Supplemental Nutrition Assistance Program and the National School Lunch Program. Other commenters stated that individuals who are served by those programs should also be enrolled in the appropriate health care program if they are not already enrolled. At least one commenter recommended that those applying for unemployment insurance also be directed towards health benefits for which they might be eligible.

Response: In the final rule, we do not require the level of integration between the Exchange and other human services programs that some commenters recommended. This would not preclude a State from leveraging the technology platform and supporting infrastructure for insurance affordability programs for other health and human services programs in the future, provided that privacy and security standards (and applicable cost allocation rules) are met, particularly regarding the use and disclosure of information provided to the Exchange by applicants and Federal agencies. To this end, on August 10, 2011 and January 23, 2012, CMS, the Administration for Children and Families (ACF), and the Food and Nutrition Service (FNS) issued joint letters providing guidance on the limited exception to cost allocation guidelines which allows Federally-funded human services programs to benefit from Medicaid, CHIP, and Exchange technology investments.

Comment: We received a number of comments related to eligibility standards for advance payments of the premium tax credit, in particular regarding compliance with the filing requirement described in proposed § 155.305(f)(4). Some commenters recommended that the final rule clarify that if a tax filer is determined eligible for advance payments of the premium tax credit but opts not to take advance payments, his or her ability to file for the credit at the end of the tax year is not affected; commenters also asked whether such a scenario would adversely affect his or her eligibility for cost-sharing reductions. One commenter requested clarification regarding the length of time for which a taxpayer would be deemed ineligible for advance payment of premium tax credit following a failure to file a tax return. Some commenters suggested States should have the flexibility to discontinue eligibility for advance payments of the premium tax credit and Medicaid if Federal tax filings are not current.

Response: We clarify that when a tax filer is determined eligible for advance payments of the premium tax credit but opts to not have advance payments made on his or her behalf, the tax filer may still claim the premium tax credit on his or her tax return; further, such action does not adversely affect his or her eligibility for cost-sharing reductions. Regarding § 155.305(f)(4), we note that the language of the proposed rule, which we maintain in the final rule, specifies that the ***18353** Exchange may not determine a tax filer eligible for advance payments if advance payments of the premium tax credit were made on behalf of the tax filer, or either spouse if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size, and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

We also note that a tax filer faced with this bar to eligibility may be able to regain eligibility by filing a tax return and reconciling the advance payments of the premium tax credit. Lastly, we do not have authority to discontinue Medicaid eligibility based on a failure to file a tax return. In the final rule, we also make a correction to the eligibility criteria for advance payments of the premium tax credit at § 155.305(f)(1)(ii) to align with the statutory requirement in section 36B(c)(1)(A) of the Code; the Exchange must generally determine that the tax filer is expected to have a household income of greater than or equal to 100 percent of the FPL.

Comment: We received several comments requesting clarification as to how eligibility will be determined for specific household composition scenarios. One comment, for example, asked for clarification regarding situations in States that recognize same-sex marriages or civil unions.

Response: In § 155.305(f) in this final rule, we use a number of cross-references to section 36B of the Code which governs the premium tax credit; these rules are the same rules that are used to determine eligibility for advance payments of the premium tax credit. Consequently, we refer commenters to those rules for details regarding family and family size. Similarly, in § 155.305(c) and (d), we use a number of cross-references to 42 CFR parts 435 and 457, which contain the Medicaid and CHIP rules for household composition; we refer commenters to those rules for details regarding these provisions.

Comment: We received a comment asking that we address the issue of deeming a sponsor's income to non-citizen applicants for Federal means tested public benefits; specifically, the commenter asked whether that policy is applicable to calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions. The same commenter suggested that for applicants who are determined ineligible for Medicaid as a result of accounting for sponsor income and whose annual household income is below 100 percent FPL, we should apply the special rule described in § 155.305(f)(2) that would allow such applicants to be determined eligible for advance payments of the premium tax credits.

Response: We intend to work closely with Treasury to address the applicability of sponsor deeming in the calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions through future rulemaking or guidance. Such rulemaking or guidance will also address the relationship between sponsor deeming and the special rule described in § 155.305(f)(2).

Comment: Several commenters expressed concern about the affordability of coverage for low-income individuals, notably lawfully present immigrants who are eligible for advance payments of the premium tax credit but ineligible for Medicaid. Some commenters requested clarification that lawfully present non-citizens with incomes below 100 percent FPL could be determined eligible for cost-sharing reductions in the 100 to 150 percent FPL eligibility category.

Response: In response to comments received regarding lawfully present non-citizens with incomes below 100 percent FPL and eligibility for cost-sharing reductions, we are clarifying in § 155.305(g)(2)(i) of the final rule that an individual who is eligible for advance payments of the premium tax credit under § 155.305(f)(2) (non-citizens who are lawfully present and are ineligible for Medicaid) fall within the 100 to 150 percent FPL eligibility category for purposes of determining eligibility for cost-sharing reductions. We also correct § 155.305(f)(1)(i) to provide that an applicant who expects to have a household income of greater than or equal to 100 percent FPL may be determined eligible for advance payments of the premium tax credit; this is a technical correction to comply with section 36B(c)(1)(A) of the Code.

Comment: Several commenters suggested we clarify the relationship between advance payments of the premium tax credit and other forms of coverage, such as CHIP or Medicare, for determining eligibility as well as for the calculation of the premium tax credit.

Response: We note that comments of this nature are outside the scope of this rule and are within the jurisdiction of the Secretary of the Treasury.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.305 of the proposed rule, with several modifications: we added language throughout § 155.305(a)(3) of the final rule to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards. In addition, in § 155.305(a)(3)(i)(B), we include in the final rule that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not currently employed). We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule. In paragraph (c)(1), we also added a standard that the Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI (that is, citizenship or immigration status, residency, etc.), as certified by the Medicaid agency at 435.1200(b)(2), and added a cross-reference to 42 CFR 435.603(d) for household income, in addition to the other criteria described under this paragraph. In paragraph (d), we added a cross-reference to 42 CFR 435.603(d) for household income.

In paragraph (f)(1)(i), we have changed "at least 100 percent" to "greater than or equal to 100 percent" to align with statutory language. In paragraph (f)(1)(ii)(B), we codified the exception for coverage in the individual market. In paragraph (f)(4), we have added, "or either spouse if the tax filer is a married couple," and clarified that applicable Treasury provisions requires a tax filer on whose behalf advance payments are made to both file an income tax return, and as a part of that return, to reconcile the advance payments made.

We have combined and restructured paragraphs (g) and (h) of the proposed rule into paragraphs (g)(1) and (g)(2) of the final rule. In paragraph (g)(2)(i) we have added a provision to implement section 1402(b) of the Affordable Care Act, which provides a special rule for non-citizens who are lawfully present; this revision clarifies that individuals who are expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested and who are also eligible for advance payments of the premium tax credit under paragraph (f)(2) are eligible for cost-sharing reductions.

***18354** In paragraph (g)(3), we have added language implementing section 1402 of the Affordable Care Act, which provides cost-sharing reductions at a policy level, in situations where multiple tax households are covered by a single policy. In this paragraph, we specify a hierarchy of available cost-sharing provisions, and explain that when multiple tax households are covered on a single policy, the Exchange will apply only the first category of cost-sharing reductions listed in this paragraph.

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The categories are listed such that the lowest level of cost-sharing reductions will be provided to the combined households. We note that the tax households are always free to purchase separate policies, and in doing so, receive the benefit of all cost-sharing provisions for which they are eligible.

Lastly, in paragraph (g)(4) we added language to clarify that household income for the purposes of eligibility for cost-sharing reductions is defined in accordance with section 36B(d)(2) of the Code, which is the same definition used for advance payments of the premium tax credit. We also clarified that the time period for measuring income for cost-sharing reductions is the same as for advance payments of the premium tax credit.

We also made technical changes to the final rule. In § 155.305(c), we changed the reference to 42 CFR 435.1200(c)(1) to 42 CFR 435.1200(b)(2), and throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in § 155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

d. Eligibility Determination Process (§ 155.310)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (e) of this section as an interim final provision, and we are seeking comments on it.

In § 155.310, we proposed the process by which the Exchange will determine an individual's eligibility for enrollment in a QHP through the Exchange and for insurance affordability programs. Specifically, we proposed that the Exchange must accept applications from individuals in the form and manner described in § 155.405, and included standards around the collection of information from non-applicants. We also proposed that the Exchange permit an individual to decline an eligibility determination for insurance affordability programs. In addition, we proposed that the Exchange accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during a benefit year. After the Exchange has collected and verified all necessary data, we proposed that the Exchange conduct an eligibility determination in accordance with the standards described in § 155.305 of this part.

We also proposed that the Exchange allow an applicant who is determined eligible for advance payments of the premium tax credit to accept less than the expected annual amount of advance payments authorized. We clarified that the Exchange may provide advance payments on behalf of a tax filer only if the tax filer first attests that he or she will meet the tax-related provisions discussed in the definition of tax filer, including that he or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her tax family.

We also proposed that if the Exchange determines an applicant is eligible for Medicaid or CHIP, the Exchange will notify the State Medicaid or CHIP agency and transmit relevant information, including information from the application and the results of verifications, to the relevant agency promptly and without undue delay. We also proposed that effective dates for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions be implemented in accordance with the dates specified in § 155.410(c) and (f) and § 155.420(b).

We proposed that the Exchange provide an applicant with a timely, written notice of his or her eligibility determination, including the applicant's eligibility for insurance affordability programs, as appropriate. We also proposed that when the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based, in part, on a finding that the applicant's employer does not provide minimum essential coverage, provides coverage that is not affordable, or provides coverage that does not meet the minimum value standard, the Exchange must notify the employer and identify the employee.

Finally, we proposed rules regarding the duration of an eligibility determination for an applicant who is determined eligible for enrollment in a QHP but does not select a QHP within his or her enrollment period in accordance with subpart E of this part. We

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solicited comments on whether a new determination should be conducted after a specific period of time has passed and whether the application process should begin anew in some or all situations.

Comment: We received a few comments recommending the adoption of a timeliness standard within which the Exchange would need to complete an eligibility determination. Most of these commenters recommended requiring that the Exchange adhere to the Medicaid timeliness standard as outlined in 42 CFR 435.911(a)(2), which provides that the Medicaid agency must establish a standard for determining an individual's eligibility and informing the individual of his or her eligibility determination that does not exceed 45 days.

Response: We recognize that there is a need for a timeliness standard for Exchange eligibility determinations. We add paragraph (e) which states that the Exchange must conduct an eligibility determination promptly and without undue delay. We also include that the Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable. We intend to further interpret this timeliness standard in future guidance in coordination with standards established for the Medicaid and CHIP programs.

We note that we think it is reasonable that the majority of eligibility determinations will be completed in a very short period of time and encourage the Exchange to continuously monitor and identify ways to shorten the time it takes to process an application and notify an applicant of his or her eligibility determination. We plan to work closely with States to establish a more detailed understanding of the timing needed for an eligibility determination as well as how the length of time needed can be reduced, and will provide future guidance on timeliness standards.

Comment: We received a substantial number of comments in support of our proposed policy, as described in § 155.310(a)(2), that the Exchange may not require an individual who is not seeking coverage for himself or herself to provide a SSN except as provided in proposed § 155.305(f)(6) (when he or she is the tax filer and the application filer attests that the tax filer has a SSN and has filed a tax return for the year ***18355** for which the tax data would be utilized for verification of household and family size). While the majority of commenters supported the policy on the collection of SSNs, as proposed in § 155.310(a)(2) and § 155.305(f)(6), a few commenters suggested adding language to reinforce the applicability of guidance on the collection of SSNs issued on September 21, 2000 by CMS (then HCFA), the Administration of Children and Families, and the Food and Nutrition Service (the 'Tri-Agency guidance'); others asked that we cross-reference the companion provision in the Medicaid proposed regulation (42 CFR 435.907(e)(1)).

Response: First, in new § 155.310(a)(3)(i), we have clarified that the Exchange must collect a SSN from an applicant who has a SSN. We have also moved the proposed provision in § 155.310(a)(2) to § 155.310(a)(3)(ii). We clarify that this provision only provides that the Exchange must collect SSNs from a non-applicant if he or she is the tax filer, has a SSN, and has filed a tax return for the year for which tax data would be utilized. We believe this provision is necessary given the standards for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, as described in sections 1402(f)(3), 1411(b)(3) and 1412(b) of the Affordable Care Act, which provide that the most recent tax data available be the basis for determining eligibility for these benefits to the extent such tax data is available.

In addition, we note that section 36B(d)(2)(A)(ii)(II) of the Code specifies that household income for purposes of premium tax credits includes the MAGI of any individuals who have a filing requirement. As previously noted, a SSN must be used to obtain tax data from the IRS, and the IRS will not provide the tax data of a dependent who had a filing requirement without the dependent's SSN. As noted above, while the Exchange will require an individual who is seeking coverage for himself or herself who has a SSN to provide it, the Exchange will only require an individual who is not seeking coverage for himself or herself to provide a SSN if he or she is a tax filer who meets the standard described in paragraph (f)(6). That is, in the limited number of cases in which a dependent is not seeking coverage for himself or herself, the Exchange will not require such a dependent to provide his or her SSN, although the dependent may provide it on a voluntary basis. However, we believe that § 155.305(f)

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(6), as proposed, is permissible under section 1412, given that a) whether a dependent has a filing requirement may change frequently, resulting in a change in circumstances that allows the Exchange to use an alternate verification process; and b) we believe that it will be challenging for an applicant to determine whether a dependent was or will be required to file (versus a voluntary filing). Further, we do not believe that it is appropriate to add a provision to require the Exchange to collect the SSN for every dependent who is not seeking coverage for himself or herself, regardless of whether he or she had a filing requirement, because this would go beyond what is needed to obtain tax data for those who had a requirement to file. As such, we maintain this provision in the final rule. To the extent that a dependent who is not seeking coverage for himself or herself has income that needs to be considered for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, the Exchange will verify it through an alternate verification process.

We believe that these provisions also comply with the statutory standards contained in section 1411(g)(1) of the Affordable Care Act, which specifies that the Exchange must not require an applicant to provide information beyond what is necessary to support the eligibility and enrollment process. Given the statutory standards, we believe these are the appropriate application of the Tri-Agency guidance. We intend to continue to review these issues in the context of all insurance affordability programs and to develop a single, streamlined application that accommodates these policy and eligibility differences.

In addition, we have added § 155.315(b), which clarifies that in accordance with section 1411 of the Affordable Care Act, the Exchange will transmit SSNs to HHS for validation with SSA. This is separate from the provision regarding citizenship verification, and only serves to ensure that SSNs provided to the Exchange can be used for subsequent transactions, including for verification of family size and household income with IRS. We clarify that in accordance with section 1411(e)(3) of the Affordable Care Act, which governs inconsistencies regarding SSNs, to the extent that the Exchange is unable to validate a SSN, the Exchange will follow the inconsistency procedures specified in § 155.315(f).

Comment: We received a number of comments in support of our proposed policy to allow applicants to opt out of an eligibility determination for insurance affordability programs but to not allow applicants to choose among a subset of insurance affordability programs in proposed § 155.310(b). Only one commenter did not support the provision to allow individuals to opt out of screening for insurance affordability programs, citing that it is more important to provide a uniform eligibility determination for all applicants to increase the likelihood that individuals have access to affordable coverage options. One commenter also suggested that the final rule provide certain exceptions to the provision barring individuals from selecting among insurance affordability programs.

Response: We believe it is important to preserve the option for an applicant to bypass the examination of his or her household income and other information that may result in a lengthier eligibility process, and allow him or her to enroll directly in a QHP without financial assistance if he or she so chooses. Therefore, in the final rule, we are maintaining the provision in § 155.310(b) with some clarification; the Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange, but that the Exchange may not permit an applicant to request an eligibility determination for less than all insurance affordability programs. We expect that an Exchange could implement this provision by allowing an applicant to opt-out of an eligibility determination for all insurance affordability programs.

We also maintain that an applicant may not choose between insurance affordability programs since section 36B(c)(2)(B) of the Code specifies that a tax filer is ineligible for advance payments of the premium tax credit for any applicant who is eligible for other minimum essential coverage.

Comment: A number of commenters, particularly consumer groups, noted support for the provision in proposed § 155.310(d)(2), which would allow an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible; however, the majority of these commenters recommended that HHS complement this provision with a standard that the Exchange must provide detailed consumer education and tools regarding the premium tax credit and reconciliation. We also received a number of comments which raised concerns that individuals may not fully understand the

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responsibilities associated with receiving advance payments of the premium tax credit; such commenters recommended that HHS provide more detail concerning ***18356** what information will be provided to consumers about reconciliation.

Response: We amended the final rule in § 155.310(d)(2)(ii) to state that the Exchange may authorize advance payments of the premium tax credit on behalf of a tax filer only if the Exchange obtains certain attestations regarding advance payments of the premium tax credit from a tax filer. We intend to provide further guidance regarding the additional attestations that may be asked of individuals, which may include an attestation from a tax filer acknowledging that he or she understands the potential impact of reconciliation.

Comment: We received a number of comments regarding the standards for Exchanges to notify the State Medicaid or CHIP agency upon determining an applicant eligible for Medicaid or CHIP and transmit relevant information promptly and without undue delay described in proposed § 155.310(d)(3). Commenters recommended that HHS provide a timeliness standard that is more specific than "promptly and without undue delay," and suggested adding language to provide the Exchange must transmit the relevant information "within no more than 24 hours."

A few commenters also recommended aligning with Medicaid language to clarify that "relevant information" transmitted to Medicaid or CHIP agencies include "the electronic account containing the finding of Medicaid or CHIP eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such a finding."

Response: We considered the recommendation to adopt a specific time standard for the transmittal of information between the Exchange and State Medicaid or CHIP agencies; however, we believe that the timeliness standard in the regulation text at paragraph (e) provides the necessary flexibility to accommodate technological advances. We anticipate that we will interpret and clarify this standard in guidance. Furthermore, this standard is aligned with the Medicaid standard described in 42 CFR 435.911(c)(1); CMS also plans to issue guidance to clarify this standard.

We also considered comments asking HHS to specify the meaning of "relevant information." We recognize that clarification is necessary, and in the final rule, replace the phrase "relevant information" in § 155.310(d)(3), with "all information necessary to effectuate coverage in Medicaid or CHIP." Although this is not the identical language used in Medicaid regulations, we believe it is the appropriate standard to adequately address the concern raised by the commenter.

Comment: We received a variety of comments related to the notification of eligibility determination, described in proposed § 155.310(g). Several commenters asked that we amend the language in this provision to provide that such a notice must be "written," as we specified in the proposed rule governing general notice standards in § 155.230(a). One commenter suggested adding language to allow applicants or enrollees to choose to have notices sent to other parties, such as application assisters or authorized representatives; another recommended adding a notice to individuals when an application is incomplete.

Response: Because paragraph § 155.230(a) of the proposed rule specifies that notices issued by the Exchange must be "written," this general notice standard would apply to the notification of eligibility determination, which we clarify in § 155.310(g) in this final rule. We will further address notices and the roles of application assisters and authorized representatives in future rulemaking and guidance.

Comment: We received a large number of comments on proposed § 155.310(g) regarding the content and scope of employer notices of an employee's eligibility for advance payments of the premium tax credit and cost-sharing reductions. These commenters suggested that HHS limit employer notices to a subset of employers to provide greater privacy protections for consumers. Most commenters stated that the employer should be notified of an employee's receipt of advanced payment of the premium tax credit or cost-sharing reductions only if this determination might trigger an employer responsibility payment. Some commenters asserted that the appropriate trigger for an employer to receive notification is if the employer has 50 or more full time equivalent employees and the employer has full-time employees that receive advanced payment of the premium

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tax credit or cost-sharing reductions through the Exchange. One commenter said that only employers that offer unaffordable coverage should receive a notification and employers that offer no coverage should not receive any employee information.

Response: While we recognize that the employer responsibility provisions of section 4980H of the Code apply only to employers with 50 or more full-time equivalent employees, section 1411(e)(4)(B)(iii) of the Affordable Care Act imposes the obligation to provide the notice regardless of the size of the employer. Therefore, we are not limiting the scope of the notice standard in this final rule to a subset of employers. We anticipate that HHS may provide additional guidance regarding how the content of the notice can be structured so as to minimize potential employer confusion associated with whether a determination will have implications under section 4980H of the Code.

Further, we are aware that employer contact information may not always be available, because a person fails to provide it, or provides incorrect information, or that person changed employers, or a host of other reasons. We will work with Exchanges and employers on this to develop a solution for situations in which the Exchange does not have a seamless way to reach the correct employer for the purposes of delivering the notice.

Comment: Other commenters raised additional privacy concerns regarding the content of notices sent to employers under proposed § 155.310(g). Several commenters suggested that the Exchange provide the employer with the minimum amount information necessary to evaluate liability for the employer responsibility payment. One commenter suggested that the Exchange should only transmit information necessary under law—the employee name and taxpayer identification number. This commenter stressed that the regulation should specify that the taxpayer identification number (TIN) should be used, and not the SSN, in accordance with section 1311(d)(4)(I)) of the Affordable Care Act. One commenter suggested that even the employee name should not be disclosed. Finally, a few commenters noted that HHS should be sensitive to the fact that some employees do not want their employers to know their household income.

Response: For the purposes of the employer notice under section 1411(e)(4)(B)(iii) of the Affordable Care Act, we believe that only the minimum necessary personally identifiable information should be released to an employer. The Affordable Care Act provides that the Exchange must notify an employer that his or her employee has been determined eligible for advance payments of the premium tax credit and that the employer may appeal such eligibility determination. The proposed rule provided only that the notice identify the employee. However, based on sections 1411(e)(4)(B)(iii), 1411(e)(4)(C), and 1411(f)(2)(B) of the Affordable Care Act, our final regulation provides that if an enrollee is eligible for ***18357** a premium tax credit or cost-sharing reductions because that enrollee's employer does not provide minimum essential coverage through an eligible employer-sponsored plan, or that the employer provides coverage but it is not affordable or does not meet minimum value, the Exchange must notify the employer, identifying the employee, relating the opportunity to appeal, indicating that the employee has been determined eligible for advance payments of the premium tax credit, and indicating that the employer may be liable for a shared responsibility payment under section 4980H of the Code if the employer has 50 or more full-time workers. We note that we do not expect the Exchange to relay to the employer the exact reason for which the applicant was determined eligible, or to provide any tax return information to the employer. Rather, the notice should indicate the list (above) of potential reasons for the determination. We have amended the final rule, redesignating proposed section (g) as section (h) and adding sections (h)(2) and (h)(3) to § 155.310 to clarify these standards.

The notice will not disclose an enrollee's household income or any other taxpayer information, except the enrollee's name or other personal identifier. We anticipate that additional guidance regarding the content of the notification will be released in the future.

Comment: One commenter expressed concern about potential HIPAA violations that may occur if an applicant provides the wrong employer contact information, and an incorrect employer receives the notification, with respect to the notices sent in accordance with proposed § 155.310(g).

Response: To the extent the Exchange is not a HIPAA covered entity or business associate, the Exchange would be subject only to the privacy and security standards of 155.260. If a State has determined that its Exchange is a HIPAA covered entity or business associate, to the extent the Exchange was merely acting on incorrect information provided to the Exchange by an applicant, there would be no HIPAA violation. In addition, we do not expect that the notice will result in a violation of applicable privacy and security standards in this section. We acknowledge that the notices outlined under this section will contain personally identifiable information, such as the name of enrollees. However, we think any inadvertent disclosure would be mitigated by the fact that only minimal information about the individual will be included in the employer notice; thus, we do not believe that this standard poses a substantial threat to individual privacy. In addition, we plan to disseminate guidance to Exchanges on practices designed to minimize the instances of individuals or entities other than the enrollee's actual employer receiving the notice.

Comment: A number of commenters asked that Exchanges inform employers that retaliation based on the notices sent in accordance with § 155.310(g) is prohibited and that evidence of retaliation could subject the employer to a penalty.

Response: We note that section 1558 of the Affordable Care Act, which amends the Fair Labor Standards Act and is within the jurisdiction of the Department of Labor, includes a prohibition on an employer discharging or discriminating against an employee because the employee has received a premium tax credit or cost-sharing reductions. Because of this statutory provision, we do not believe additional standards are necessary in this final rule.

Comment: One commenter suggested that IRS, and not HHS, effectuate the notice described in § 155.310(h) because (1) IRS has information about employers subject to free rider assessments, and (2) IRS maintains a database of employer contacts for the transmission of sensitive personal information. Another commenter suggested that reporting to employers should be consolidated and centralized into a Federal process, with information provided on a monthly or quarterly basis.

Response: Section 1411(e)(4)(B)(iii) provides that this notice must be provided to employers by Exchanges in connection with certain eligibility determinations. It is not within the discretion of the Secretary to shift responsibility for provision of this notice to the IRS. We do support reducing reporting burden by consolidating and streamlining reporting, if feasible. In addition, we plan to issue guidance to help Exchanges develop an operational strategy for reporting.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.310 of the proposed rule, with a few modifications. In paragraph (b), we clarified that the choice of an applicant is whether to allow the Exchange to determine his or her eligibility for insurance affordability programs. In paragraph (d)(2)(ii), we added language specifying that attestations from the tax filer will be attestations regarding advance payments of the premium tax credits. In paragraph (d)(3), we removed the reference to “relevant” information and further clarified that the Exchange must transmit all information from the records of the Exchange promptly and without undue delay to such agency that is necessary for the State Medicaid or CHIP agency to provide the applicant with coverage. In paragraph (e), we adopted a provision which provides that the Exchange must conduct eligibility determinations promptly and without undue delay.

In paragraph (f), we clarified in the header that the effective dates outlined are effective dates for eligibility, and not for coverage. Consistent with changes we discuss in § 155.420, we also added language in paragraphs (f)(1) and (f)(2) to differentiate between effective dates for initial eligibility determinations, which will be implemented in accordance with § 155.410(c) and (f) and § 155.420(b), as applicable, and effective dates for redeterminations, which will be implemented in accordance with the dates specified in § 155.330(f) and 155.335(i), as applicable. In paragraph (g), we added language to specify that the notice of eligibility determination must be written, consistent with other notice standards. We redesignated proposed paragraph (g) as new paragraph (h). In new paragraph (h), we added three additional standards, in accordance with section 1411(e)(4) of the Affordable Care Act, for the content of the notice to employers. In addition to identifying the employee, the notice must indicate that the employee has been determined eligible for advance payments of the premium tax credit; that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and that the employer has the right to appeal the determination.

Also included in this final rule are several technical corrections from the proposed text. In paragraph (a)(1), we removed the reference to 45 CFR and changed the phrase to "specified in § 155.405 of this chapter." In paragraph (b), we added the words "insurance affordability" before "programs" as a clarification.

e. Verification Process Related to Eligibility for Enrollment in a QHP (§ 155.315)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it.

In § 155.315, we proposed the general standard that the Exchange must verify or obtain information to determine that an applicant is eligible for enrollment in ***18358** a QHP, unless a request for modification is granted in accordance with proposed paragraph (f) of this section.

To verify whether an applicant for coverage through the Exchange is a citizen, national, or otherwise lawfully present individual in accordance with section 1312(f)(3) of the Affordable Care Act, we proposed to codify the role of the Secretary (through HHS) as an intermediary between the Exchange and other Federal officials, specifically the Social Security Administration and the Department of Homeland Security. In the case of an inconsistency related to citizenship, status as a national, or lawful presence, we proposed that the time period for the resolution is 90 days from the date on which the notice of inconsistency is received. We also clarified that the date on which the notice is received means 5 days after the date on the notice, unless the applicant shows that he or she did not receive the notice within the 5 day period.

We also proposed that the Exchange verify an applicant's residency by accepting an applicant's attestation without further verification or following the procedures of the State Medicaid or CHIP agency, if such agency examines electronic data sources for all applicants. We also proposed that the Exchange may examine data sources regarding residency to the extent that information provided by an applicant regarding residency is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. In addition, we proposed that a document that provides evidence of immigration status may not be used alone to determine State residency. We also proposed that the Exchange verify an applicant's attestation that he or she is not incarcerated. We solicited comment as to what electronic data sources are available and should be authorized by HHS for Exchange purposes, including whether access to such data sources should be provided as a Federally-managed service like citizenship and immigration status information from SSA and DHS.

Further, we proposed that when an individual attests to information and such attestation is inconsistent with other data in the records of the Exchange, the Exchange must make a reasonable effort to identify and resolve the issues. If the Exchange is unable to resolve the inconsistencies, we proposed that the Exchange notify the applicant of the inconsistency. After providing this notice, we proposed that the Exchange provide 90 days from the date on which the notice is sent for the applicant to resolve the issues, either with the Exchange or with the agency or office that maintains the data source that is inconsistent with the attestation. We also proposed that the period during which an applicant may resolve the inconsistency may be extended by the Exchange if the applicant can provide evidence that a good faith effort has been made to obtain additional documentation.

We further proposed that the Exchange allow an individual who is otherwise eligible for enrollment in a QHP, advance payments of the premium tax credit or cost-sharing reductions to receive such coverage and financial assistance during the resolution period, provided that the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit received during the resolution period are subject to reconciliation. We also proposed that if after the conclusion of the resolution period, the Exchange is unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart and notify the applicant of such determination. We clarified that the Exchange must make effective this eligibility determination no earlier than 10 days after and no later than 30 days after the date on which such notice is sent.

Finally, we also proposed that HHS may approve an Exchange Blueprint to change the methods used to collect and verify information, within certain standards. We also proposed that the Exchange must not require an applicant to provide information beyond the minimum necessary to support eligibility and enrollment processes.

Comment: We received a few comments asking that we establish standards for the collection, use and safeguarding of data used to verify applicant information, as described throughout proposed § 155.315. We received a few comments suggesting that we incorporate specific safeguards and protections for information used in the verification of citizenship and immigration status, proposed in § 155.315(b). Commenters suggested including language stating that information related to the verification of citizenship and immigration status be used only for purpose of verifying eligibility for enrollment in a QHP and that pending such verification, coverage should not be delayed, denied, reduced or terminated.

Response: We address the privacy and security of information and the specific standards and protocols for the transmission of data in § 155.260 and § 155.270 of this final rule and note that these provisions apply to the transactions described throughout subpart D, including § 155.315. Language in § 155.260 provides that information must provided to or obtained by the Exchange for the purposes of determining eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, under sections 1411(b) through (e) of the Affordable Care Act, or exemptions from the individual responsibility provisions in section 5000A of the Code, may only be used to carry out those minimum functions of the Exchange described in § 155.200; we believe this language addresses these concerns and establishes appropriate safeguards.

Regarding comments asking that coverage not be delayed, denied, reduced or terminated, pending verification of citizenship and immigration status, we addressed these concerns in § 155.315(f), which allows an applicant to enroll in coverage with financial assistance pending such verification. We also amend § 155.315(c) in order to be consistent throughout this subpart and clarify that an applicant and not an application filer receives the notice of inconsistency.

Comment: A number of comments addressed the process for resolving inconsistencies between applicant information and data obtained by the Exchange, as proposed in § 155.315(e). Commenters requested that we provide details on the types of documentation that the Exchange may use to verify applicant information; specifically, commenters asked for details on documents that the Exchange will be permitted to use in verifying citizenship and immigration status. Other commenters asked that we clarify the ways in which individuals will be able to submit documentation to the Exchange when attempting to resolve such inconsistencies. Furthermore, in response to the Medicaid eligibility proposed rule, HHS received a number of comments requesting adoption of an exception for agencies administering insurance affordability programs to accept attestations alone from certain applicants, who are part of at-risk populations and who may not have access to necessary documentation to resolve inconsistencies.

Response: While we acknowledge commenters' requests for details regarding documentation used during the inconsistency process, we believe that this level of specificity is most appropriate for guidance. Therefore, we maintain that the applicant may "present satisfactory evidence" in ***18359** § 155.315(f)(2)(ii) of the final rule. We intend to issue future guidance with details on documents which may be used to support verification, in coordination with Medicaid and CHIP and in accordance with the statutory standard for the Exchange to follow the procedures specified in section 1902(ee) of the Act.

We accept commenters' suggestions that we specify the ways in which an applicant will be able to submit documentation to the Exchange; accordingly, we adopt language in the final rule at § 155.315(f)(2)(ii) that the Exchange must provide the applicant with the opportunity to present satisfactory documentary evidence via the channels available for the submission of an application, as described in § 155.405, except for by telephone.

We also proposed a provision in § 155.315(g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available. We proposed this language to account for situations which documentation cannot be obtained, and to achieve consistency with the Medicaid program; examples of individuals for whom this provision may apply include homeless individuals, victims of domestic violence or natural disasters, and sporadic earners. We believe that adding

this provision is permissible within the Secretary's statutory authority to change verification methods as provided under sections 1411(c)(4) and 1321(a)(1) of the Affordable Care Act. We note also that if at the conclusion of the 90 day period, the Exchange is unable to verify the applicant's attestation and the data from the data sources specified in § 155.315 are unavailable, the Exchange must notify that applicant that the Exchange finds the applicant ineligible for the eligibility standard in question. In § 155.320(c)(3)(vi)(F), we also describe the procedures for the Exchange to discontinue advance payments and cost-sharing reductions in the event that the applicant's attestation is not verified by the conclusion of the 90 day period.

We also make several changes throughout verification provisions of the final rule at § 155.315 and § 155.320 where information is found by the Exchange to be not reasonably compatible with an applicant's attestation and where the inconsistency process is triggered; we change the language in a number of places to state that the Exchange "must," rather than "may," examine electronic data sources or supporting documentation, when applicable. The proposed rule did not consistently require that the Exchange examine other data sources or documentary evidence for all verification processes.

Comment: We received several comments regarding our use throughout § 155.315 of the term "reasonably compatible." Many commenters asked that we define the term and provided a number of suggested definitions; one common approach to clarifying the term was to provide the Exchange must only consider material differences between an attestation and available electronic data as not reasonably compatible.

Response: We believe that the common approach suggested by commenters is a sensible one, and in § 155.300(d) of this final rule, provide that the Exchange must consider information to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not have an impact on the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. This provision would provide, for example, that if an individual attested to one address within an Exchange service area, but Exchange-obtained data demonstrated a different address within the same Exchange service area, he or she must be considered to meet the residency eligibility standard. We note that while we provide this clarification in the final rule, Exchanges may still 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. We intend to provide future guidance on this issue. We also clarify that to the extent that income information provided by an application filer and income information obtained through electronic data sources both indicate that the applicant is eligible for Medicaid or CHIP, such information must be considered reasonably compatible; this provision aligns with the provision of the Medicaid eligibility final rule at 42 CFR 435.952(c)(1). We also clarify that this rule does not mean that an applicant's attestation regarding annual household income must be identical to that of the tax return information in order to be considered reasonably compatible. The standard for household income is discussed in more detail in § 155.320.

Comment: We received a few comments which asked that we explicitly state that an applicant has the ability to access and amend the data used to determine his or her eligibility.

Response: Section 155.330 of the proposed rule allowed an enrollee to report changes affecting his or her eligibility to the Exchange, which must then be verified by the Exchange. We maintain this provision in this final rule. We anticipate that the Exchange will make the information used in an eligibility determination available to the applicant and enrollee, including through a web-based self-service tool with appropriate safeguards. In addition, we direct the commenter to the final rule at § 155.260(b)(3)(i), which provides the Exchange must incorporate a principle of individual access to personally identifiable information as part of the Exchange's privacy and security policies and procedures.

Comment: We received comments asking that we specify the content of the eligibility determination notice provided to applicants, which is described in proposed § 155.315(e)(2)(i). Commenters also suggested certain content standards for such a notice, including clear procedures for the inconsistency process.

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Response: As noted in the notice of proposed rulemaking, we intend to provide content and timing standards for notices in future rulemaking and guidance. We have made a minor edit to the final rule at § 155.315(f)(2)(i) to clarify that this notice is sent to the applicant by the Exchange.

Comment: We received a number of comments regarding the process to resolve inconsistencies, as described in proposed § 155.315(b)(3) and (e). A few comments asked that the inconsistency periods described in proposed § 155.315(b)(3) and (e) begin when the application is submitted, not when the notice of inconsistency is sent or received by the applicant. Other commenters asked that we align inconsistency periods for the Exchange with the inconsistency period described in section 1902(ee) of the Act.

Response: Section 1411(e)(3) of the Affordable Care Act states that for inconsistencies related to citizenship and immigration status, the Exchange must follow procedures described in section 1902(ee) of the Act. Section 1902(ee) provides that the applicant must be given a period of 90 days from the date of the receipt of the notice to present satisfactory documentation. Because such a receipt date is difficult to pinpoint, we have adopted language specifying that the date on which the notice is received is 5 days from the date the notice is sent, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period. This standard is also utilized by the SSA. Alternatively, for ***18360** inconsistencies not related to citizenship and immigration status, section 1411(e)(4)(A)(ii)(II) of the Affordable Care Act provides that the 90 day period must begin on the date on which the notice is sent to the applicant. Due to these statutory standards, we are unable to change the point at which the inconsistency period is triggered, and unable to further align the provision in proposed § 155.315(e) with the process described in section 1902(ee) of the Act. Therefore, we maintain the provisions in § 155.315(c)(3) and (f) in the final rule.

We neglected to include the statutory language found in section 1411(e)(4)(A)(i) of the Affordable Care Act which provides that the Exchange must address “typographical or clerical errors” in order to address causes of inconsistencies, prior to accepting documentation or other evidence from the applicant; we adopt this language in the final rule at § 155.315(f)(1).

Comment: We received a number of comments which expressed concern over the potential for increased liability for QHP issuers as applicants are provided coverage during the inconsistency period described in proposed § 155.315(e). We also received comments suggesting that issuers should not be required to enroll, nor continue enrollment of, individuals for whom the Exchange is still verifying eligibility during the resolution period.

Response: The standard to determine eligibility based on the information on the application (that is, an individual's attestation) during the inconsistency period is specified in section 1411(e)(3) and (e)(4) of the Affordable Care Act. We note that this final rule does not prohibit QHPs from requiring premium payment prior to providing coverage. We also expect that the Exchange and an applicant's selected QHP issuer will provide notice to an applicant to ensure that the enrollee is aware of liability for premium payment.

Comment: One commenter suggested that the Exchange be given more flexibility to decrease the length of the inconsistency period.

Response: The period of time during which an applicant is permitted to provide documentation in order to resolve an inconsistency is specified in sections 1411(e)(3) and 1411(e)(4)(A)(ii)(II) of the Affordable Care Act; therefore, we maintain provisions § 155.315(c)(3) and (f)(2)(ii) the final rule.

Comment: A few commenters asked that we explicitly allow certain application assisters, Navigators, and application filers to help applicants navigate the inconsistency process, described in proposed § 155.315(e).

Response: As described in § 155.210, part of the duties of a Navigator will be to educate the consumer, facilitate enrollment, and assist with any part of the application process. We also anticipate that agents and brokers will provide such assistance. In addition, we expect that application assisters who are not Navigators, agents, or brokers will provide support for consumers

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during the application process, and we anticipate providing additional guidance regarding this role, including on appropriate privacy and security protections.

Comment: We received a number of comments on proposed § 155.315(e)(3), in which we proposed that the Exchange may extend the inconsistency period if the applicant demonstrates a good faith effort to obtain the documentation. Commenters asked that the Exchange must provide such an extension.

Response: We adopted the provision regarding the extension of the inconsistency period in order to align with Medicaid guidance, which provides States the flexibility to allow a good faith extension. Therefore, we are maintaining the proposed text in the final rule.

Comment: We received a comment asking that we include timeliness standards for processing inconsistencies.

Response: We adopt a timeliness standard of "promptly and without undue delay" for eligibility determinations made by the Exchange in the final rule at § 155.310(e), but intend to provide future guidance about best practices for an Exchange to make the best use of the 90 day inconsistency period.

Comment: We received a number of comments on proposed § 155.315(g), in which we proposed that the Exchange may not require the applicant to provide information beyond the minimum necessary to support the eligibility and enrollment process. Commenters asked us to define "minimum necessary"; others suggested that we include language describing how HHS will conduct oversight to ensure compliance with this provision.

Response: We acknowledge the importance of oversight to ensure compliance with the provision described in § 155.315(g) of the proposed rule, which is finalized in § 155.315(i), and intend to provide additional detail regarding oversight in future rulemaking and guidance. HHS will also consider this in the context of evaluating alternate applications developed by States, as described in § 155.405(b), and will continue to work with States on the issue of information collection.

Comment: We received a number of comments related to the proposed process for verification of citizenship and immigration status, described in proposed § 155.315(b). A few commenters found the process unclear, and asked for more information regarding the verification process for other individuals listed on the application, such as spouses and tax dependents.

We also received a number of comments related to the services that will be provided by a Federally-managed data services hub to support verification of citizenship and immigration status. Several comments recommended that we utilize the DHS Systematic Alien Verification for Entitlements (SAVE) system to verify immigration status. Comments on the proposed rule asked for information on the impact of services available through the Federally-managed data services hub on existing State agency connections with Federal data sources used for verification of citizenship and immigration status. Commenters recommended that Exchanges not use "E-verify" to verify immigration status and others asked that we provide details on the format of data provided to the State agency or Exchange. We also received comments asking whether it would be legally permissible for the Exchange to transmit information to DHS, via HHS, when an individual has attested to being a citizen. Another commenter asked how the Exchange will know whether an individual has documentation at the point of application that can be verified through DHS, as described in the provision proposed at § 155.315(b)(2).

Response: Section 1312(f)(3) of the Affordable Care Act, as codified in § 155.305(a)(1) in this final rule, states that an individual may only enroll in a QHP through the Exchange if he or she is a citizen, national, or a non-citizen who is lawfully present, and is reasonably expected to be so for the entire period for which enrollment is sought. Because citizenship, status as a national, or lawful presence is an eligibility standard for any applicant seeking coverage through the Exchange for him or herself, the verification process described in § 155.315(c) applies to each applicant, regardless of whether he or she is a tax filer or dependent.

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While we do not specify a level of operational detail in the final rule that includes the specific services or data ***18361** formats which will be used in supporting verification, we are working closely with our Federal partners to develop and provide details on the verification services provided by the Federally-managed data services hub; we expect to provide such details in guidance. However, we believe that the final rule supports the use of SAVE. We also note that we do not intend to use the E-verify service, as it is designed for employers to check the work authorization of employees, rather than to verify eligibility for benefits. Regarding existing State connections used in verification, we anticipate that Medicaid agencies, CHIP agencies, and Exchanges will leverage the Federally-managed data services hub for connections to SSA and DHS to support verification of citizenship and immigration status.

With regard to the Exchange transmitting information to DHS via HHS, when an individual has attested to being a citizen, section 1411(c)(2) of the Affordable Care Act specifies that in such cases when an individual who attests that he or she is a citizen but for whom citizenship cannot be verified through SSA, the Secretary of HHS shall submit to DHS the applicant's information and other identifying information for verification of immigration status. Based on this statutory standard, we maintain § 155.315(b)(2) in the final rule as § 155.315(c)(2).

Lastly, we intend to work with DHS to provide Exchanges with the information needed to identify whether an applicant can likely be matched through DHS. DHS has existing verification relationships with many State Medicaid and CHIP agencies, as well as other Federal, State, and Local government entities, which means that many States will already be familiar with this information.

Comment: We received several comments recommending the inclusion of language in proposed § 155.315(b) describing the verification process as to whether an applicant is "reasonably expected" to be lawfully present for the entire period for which enrollment is sought. The "reasonably expected" standard is part of the standard for determining whether an applicant is a citizen, national or non-citizen who is lawfully present, which is described in § 155.305(a)(1). Commenters' specific recommendations for such a verification process varied. One requested that as long as an applicant's residency is verified, that he or she be considered reasonably expected to be lawfully present for the entire period for which enrollment is sought. Others suggested that self-attestation alone be used in verification.

Response: In the final rule, we address our interpretation of the term "reasonably expected" in § 155.305. We intend to provide additional interpretation of this standard, including how it applies in specific scenarios, in future guidance.

Comment: We received a few comments asking that we specify in regulation that an applicant is permitted to provide his or her A-number for verification of immigration status through the records of DHS.

Response: In § 155.315(b), we proposed that for purposes of verifying citizenship and immigration status through the records of DHS, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS. We intend the phrase "information from the applicant's documentation and other identifying information" to encompass information such as A-numbers; therefore, we maintain the provision in the final rule. This approach incorporates other types of identifying information (for example, I-94 numbers) that are used by DHS, as well as preserves the intent and applicable of this regulation if DHS changes its process in the future.

Comment: We received a number of comments regarding the connections between the Exchange and Federal data sources needed to support verification of applicant information. Comments expressed concern that each Exchange would need to develop separate data sharing arrangements and interfaces with Federal agencies maintaining information for use in verification. Comments responding to the proposed rule, which identified HHS as a conduit for information transmitted between the Exchange and Federal agencies, asked that we specifically refer to the Federally-managed data services hub, or electronic service, throughout § 155.315, rather than refer to HHS as the entity through which data will be transmitted.

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Response: Acknowledging comments to the RFC and specific direction from section 1411(c) of the Affordable Care Act, we proposed that HHS would be the entity through which information would be transmitted to and from Exchanges and Federal data sources to support the verification process. In the final rule, we maintain HHS' role in supporting verification. However, in order to remain flexible to the technology used to transmit such data, we do not specifically mention in the final rule the “electronic service” or “data services hub”. Instead, the final rule focuses on HHS' role as the entity which will facilitate the transfer of information, rather than how such information will be transferred. We anticipate that as technological advances are made, there may be changes in the procedures used by HHS to receive information from the Exchange and to communicate with other Federal agencies involved in the verification process.

Comment: We received a number of comments on the process for verification of residency, proposed in § 155.315(c). A significant number of commenters asked that self-attestation of residency be accepted without further verification. A smaller number of commenters recommended always allowing the Exchange to verify residency through electronic data sources, not only when the State Medicaid or CHIP agency operating in the State of the Exchange opts to examine such data sources.

Response: We are redesignating proposed § 155.315(c) as § 155.315(d), and amending it to state that an Exchange may accept an attestation of residency from an applicant or examine electronic data sources which have been approved by HHS. This flexibility would allow an Exchange, should it choose, to align with the verification procedures of the State Medicaid or CHIP agency. Such alignment may facilitate integration across insurance affordability programs and result in a more streamlined process. We amend § 155.315(d)(3), as well as equivalent provisions throughout this subpart, to specify that if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through other electronic data sources. The proposed rule was inconsistent, and used, “may,” instead of, “must,” in this paragraph and in several other areas. This change was made to create consistency throughout the subpart, and because the rationale for the reasonably compatible concept, as described in the proposed rule, is that it is a threshold for when additional verification (for example, examining other electronic data sources) is necessary to complete the verification process. For example, in the event the Exchange accepts self-attestation without further verification, in accordance with paragraph (d)(1), and such attestation is found to be not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange would continue the verification process by examining available electronic data sources in order to verify the attestation. If the Exchange is still unable to complete the ***18362** verification after examining information in electronic data sources, the Exchange would then follow procedures to resolve the inconsistency, in accordance with § 155.315(f). As discussed in the proposed rule, examining data sources, when available, prior to moving through the inconsistency process will help minimize the need to request paper documentation from applicants, and the burden for Exchanges to process such documentation.

Comment: We received a few comments regarding the provision in proposed § 155.315(c)(4) in which we propose that a document that provides evidence of immigration status may not be used alone to determine State residency. A commenter requested that we remove the word “alone” from this phrase. Another asked that we allow the Exchange to use documentation of immigration status to positively verify residency.

Response: We are removing the word “alone” from § 155.315(d)(4) in the final rule because we do not intend for documents that provide evidence of immigration status to be used to determine State residency either alone or together with other documentation. We have also amended the phrase to allow the Exchange to positively verify residency using immigration documentation, which aligns with Medicaid regulations.

Comment: We received a number of comments regarding the verification of incarceration status, as proposed in § 155.315(d). Several commenters recommended that self-attestation of incarceration be accepted without further verification. Others believed that information or an attestation regarding incarceration should never be requested of an applicant, since such a request may be a deterrent to consumers applying for coverage through the Exchange. A smaller number of commenters questioned the availability of recent, accurate data with which Exchanges may verify incarceration status. One commenter stated that by not defining “release date,” incarceration status will be difficult to verify.

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Response: We acknowledge that there are challenges regarding the availability of electronic data on incarceration. However, we believe it is important for the Exchange to utilize any such data sources that are available and have been approved by HHS for this purpose, and, at the very least, accept self-attestations of incarceration status since such status is a statutory standard for eligibility to enroll in a QHP. In addition, we believe that this attestation can be collected with minimal burden on an applicant, and we expect that it will be paired with a clear explanation as to why the information is being requested. We believe that allowing for verification of incarceration status through paper documentation would increase administrative burden on the Exchange and applicants, and for these reasons, allow for the examination of paper documentation only in the event that the applicant's self-attestation is not reasonably compatible with other information provided by the individual or information in the records of the Exchange. For greater detail about the definition of incarceration, please see comment response for § 155.300.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.315 of the proposed rule, with the following modifications. We added paragraph (b), which clarifies that the Exchange will validate SSNs that are provided by individuals. In paragraph (c)(3), we changed the word "shows" to "demonstrates" in referring to what the applicant must do if the if he or she did not receive the notice within the 5 day period; this change was made to more accurately describe the obligation of the applicant. In paragraph (d)(1) and (2), we allowed the Exchange may choose whether it accepts an attestation from applicants regarding residency without further verification or examines electronic data sources for all applicants, and we clarify that the standard for approval of electronic data sources for verification of residency will be based on whether such sources are sufficiently current and accurate, and minimize administrative costs and burdens.

In paragraph (d)(3), we clarify that by referring to data sources, we mean those data sources that are available to the Exchange and that have been approved by HHS for this purpose. In paragraph (d)(3), we remove the reference to "a document that provides" before "evidence" so as not to limit the acceptable types of such evidence. We also remove the word "alone" in order to clarify that the Exchange may not use evidence of immigration status alone or together with other evidence to determine State residency. In paragraph (d)(3), we also change the term "may" to "must" to specify that if the applicant's attestation is not reasonably compatible with information in the records of the Exchange, the Exchange must examine available, approved data sources in order to verify the attestation. We also change the phrase in paragraph (d)(4) to state that evidence of immigration status may not be used to determine that an applicant is not resident of the Exchange service area.

We clarified in paragraph (f) that an inconsistency may result when electronic data is necessary for verification but is not available. We also included in paragraph (f)(1), "including through typographical or other clerical errors" to describe the causes of inconsistency. In paragraph (f)(2)(i), we changed "notify" to "provide notice to the applicant regarding" in order to clarify the Exchange's notice standard. Also, we added language to paragraph (f)(2)(ii) to specify that all channels described in § 155.405(c) of this part are acceptable for the submission of documentation to resolve inconsistencies, except for by telephone. In paragraph (f)(5)(i), we specify that the Exchange must determine the applicant's eligibility based on the information available unless such applicant qualifies for the exception provided under paragraph (g). We also add, on an interim final basis, paragraph (g), which provides a case-by-case approach to resolving inconsistencies for applicants for whom documentation does not exist or is not reasonably available.

We also made technical corrections. We redesignated paragraphs (b) through (g) as paragraphs (c) through (i). In paragraph (a), we changed the reference to paragraph (e) to paragraph (g). In paragraph (d), we changed "by" to "as follows," and changed verb tenses in (d)(1) and (d)(2). In paragraph (f)(3), we corrected the reference to paragraph (f)(3) and changed it to (f)(2)(ii). In paragraph (f)(5)(ii), we changed the word "implement" to "effectuate." We also add, on an interim final basis, paragraph (g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available.

In paragraph (h), we changed the word "plan" to "Blueprint." Throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in § 155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

f. Verification process related to eligibility for insurance affordability programs (§ 155.320)

In § 155.320, we proposed that the Exchange verify information in accordance with this section only for an applicant who is requesting an eligibility determination for insurance affordability programs.

***18363** We proposed standards related to the verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.

We also proposed standards for the verification of household income and family and family/household size and solicited comments regarding how best to ensure a streamlined eligibility process given underlying differences between the Treasury proposed rule and the Medicaid proposed rule. We proposed standards for the Exchange to obtain tax return data for individuals whose income is counted in calculating a tax filer's household income, and to obtain MAGI-based income for all individuals whose income is counted in calculating a tax filer's household income, in accordance with 26 CFR 1.36B-1(e), or an applicant's household income, in accordance with 42 CFR 435.603(d).

We proposed the verification process for income and household size for Medicaid and CHIP and solicited comments as to how this process could work most smoothly for both electronic and paper applications. We proposed that the Exchange must verify household size by obtaining an attestation from the application filer and accepting the attestation without further verification unless the attestation is not reasonably compatible with other information in the records of the Exchange. We also proposed the process for the Exchange to verify MAGI-based household income by referring to the procedures described in Medicaid proposed regulations at 42 CFR 435.948 and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380. We solicited comments as to how the Exchange process and the Medicaid and CHIP processes can be streamlined to ensure consistency and maximize the portion of eligibility determinations that can be completed in a single session.

Similar to Medicaid and CHIP, we proposed that for advance payments of the premium tax credit and cost-sharing reductions, the Exchange direct an application filer to attest to the specific individuals who comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions, and that the Exchange accept an application filer's attestation of family size without further verification, unless the attestation and any other information in the records of the Exchange are not reasonably compatible. We further proposed the basic verification process for annual household income. We proposed that the Exchange compute, in accordance with specific rules for Medicaid and CHIP and specific rules for eligibility for advance payments of premium tax credits and cost-sharing reductions, annual household income for the family defined by the application filer and that the application filer validate this information by attesting whether it represents an accurate projection of the family's household income for the benefit year for which coverage is requested. We proposed that if tax data are unavailable, or if an application filer attests that the Exchange's computation based on available tax data does not represent an accurate projection of the family's household income for the benefit year for which coverage is requested, the Exchange direct the application filer to attest to the family's projected household income. We proposed that if such an attestation is not reasonably compatible with the data obtained by the Exchange or if the data is unavailable, the Exchange must follow procedures for the alternate verification process. We also proposed that the Exchange use an alternate process for determining income for purposes of advance payments of the premium tax credit and cost-sharing reductions for tax filers in certain situations. We proposed that in situations in which an application filer attests that a tax filer's annual household income has increased or is reasonably expected to increase from the information obtained from his or her tax return, the Exchange accept the application filer's attestation without further verification, with limited exceptions. We also proposed to codify the minimum standards for circumstances under which an application filer who is attesting to a decrease in income for a tax filer, or is attesting to income because tax return data is unavailable, may utilize an alternate income verification process that includes annualized data from MAGI-based income sources and other electronic data sources approved by HHS. We solicited comment on what situations should justify use of the alternate process.

We also proposed the verification process the Exchange must follow for a tax filer whose annual household income decreases by a certain amount. We proposed that if the Exchange requests additional documentation to resolve an inconsistency and the application filer has not responded to a request for additional information from the Exchange within a 90 day period and data sources indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange may not provide the

applicant with eligibility for advance payments of the premium tax credit or cost-sharing reductions. We proposed that if at the end of the 90 day period the Exchange is unable to verify the application filer's attestation, the Exchange must determine the applicant's eligibility based on available data, in accordance with the process proposed in § 155.310(g) and § 155.330(f). In addition to the above standards, we proposed that the Exchange provide education and assistance to an application filer regarding the verification process for income and family/household size and solicited comments on strategies that the Exchange can employ to ensure that application filers understand the validation process and provide well-informed validations and attestations.

For other situations in which the Exchange remains unable to verify an application filer's attestation, we proposed that the Exchange determine eligibility for advance payments of the premium tax credit and cost-sharing reductions for tax filers who do not meet the criteria for the alternate income verification process based on the tax filer's tax data. We also proposed that if an application filer does not respond to a request for additional information from the Exchange and data sources described in paragraph (c)(1) indicate that an applicant in the primary tax filer's family is eligible for Medicaid or CHIP, the Exchange will not provide the applicant with eligibility for advance payments of the premium tax credit or cost-sharing reductions based on the application.

We proposed that the Exchange verify whether an applicant who requested an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions is enrolled in an eligible employer-sponsored plan by accepting his or her attestation without further verification, except in cases in which information is not reasonably compatible with other data provided by the applicant or in the records of the Exchange. We solicited comments as to whether the Exchange could assume that an applicant would understand whether or not he or she is enrolled in an eligible employer-sponsored plan, and therefore rely upon applicant attestation in this area. We proposed that the Exchange may request additional information regarding whether an applicant is enrolled in an eligible employer-sponsored plan if an applicant's attestation is where an applicant's information is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. We solicited comments regarding the best ***18364** data sources for this element of the process.

In addition, we proposed that the Exchange must request from an applicant who requests an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan. We further proposed that the Exchange verify this information. We solicited comments regarding how the Exchange may handle a situation in which it is unable to gain access to authoritative information regarding an applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan. We invited comment on the timing and reporting of information needed to verify whether an employed applicant is eligible for qualifying coverage in an eligible employer-sponsored plan, and the best methods for facilitating interaction among Exchanges for this purpose. Specifically, we solicited comment regarding two specific methods for the submission and collection of information regarding eligibility for qualifying coverage in an eligible employer-sponsored plan—the employee template and the employer central database.

Comment: Many commenters questioned the criteria for using the alternative verification process to verify household income; in particular, commenters argued against the standard proposed § 155.320(c)(3)(iv) that limits the ability of the Exchange to follow the alternative verification process to situations in which tax data is not available, family size or filing status has changed or is reasonably expected to change, an applicant has filed for unemployment benefits, or when an application filer attests that the tax filer's annual household income has decreased or is reasonably expected to decrease from tax data obtained by the Exchange by 20 percent or more. Comments focused on the 20 percent threshold, which commenters believed was too high, particularly given the relatively low incomes of the population likely to request an eligibility determination for financial assistance, and would thus result in a substantial group of tax filers being unable to obtain advance payments of the premium tax credit commensurate with their household income, regardless of whether they were able to substantiate a lower income. Commenters supported a percentage threshold lower than 20 percent or a different measure altogether.

Response: We recognize that utilizing the 20 percent minimum would result in a substantial number of tax filers who are unable to afford coverage due to significant changes in income and that we should modify our proposed rule so that an eligibility determination matches, as closely as possible, a tax filer's true circumstances. We note that section 1412(b)(2) of the Affordable

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Care Act describes that the Secretary must provide procedures for making eligibility determinations for advance payments of the premium tax credit, "in cases where information included with an application demonstrates substantial changes in income * * * or other significant changes affecting eligibility". The statute outlines a minimum set of circumstances that meet this standard; we interpret the statutory 20 percent or more decrease as congressional direction that any decrease of that magnitude must trigger an alternate verification process, but not to limit the Secretary's discretion to identify other significant changes in income that trigger an alternate verification process. We codified this provision in the proposed rule at § 155.320(c)(3)(iv), along with the other minimum standards, and solicited comments as to whether this was an appropriate standard, or whether we should establish a different threshold.

Based on an analysis performed by the Secretary,[FN5] a family of four with household income of 200 percent of the FPL ($47,018 using projected 2014 figures) is projected to have a total premium, after advance payments, of $247 per month. A five percent decrease in income from $47,018 is $44,667 (190 percent of the FPL), would correspond to a total premium, after advance payments, of $217 per month, for a total difference in premium of around $360 per year. In addition, while advance payments are sensitive to every dollar of income, cost-sharing reductions are not; consequently, even very small changes that move a person across a threshold (150 percent FPL, 200 percent FPL, or 250 percent FPL) can be very significant. For example, based on the same figures cited above, the difference in cost-sharing between a family at 190 percent FPL and a family at 200 percent FPL is $1,000 per year, due to the change in eligibility for cost-sharing reductions at 200 percent FPL. The difference is $2,000 around 250 percent FPL, which is the upper limit for cost-sharing reductions based solely on household income. We believe that these are significant changes, which will be critical to recognize in order to ensure that eligible individuals can afford coverage.

Therefore, in this final rule, we specify that the Exchange must use information other than tax data to verify income in cases in which an applicant attests that a change has occurred or is reasonably expected to occur, and as such, a tax filer's annual household income has decreased or is reasonably expected to decrease from his or her tax data. As noted above, we believe that any change in household income constitutes a change in circumstances that meets the "significant changes affecting eligibility" standard identified in section 1412(b)(2) of the Affordable Care Act, given the sensitivity of the advance payment formula and the potential for large variations in cost-sharing reductions with small shifts in income. This approach to implementing section 1412(b)(2) is further reinforced by the fact that requiring the Exchange to conduct an individualized analysis as to whether each tax filer's circumstances constitute a "significant change" in accordance with the statute would place a substantial administrative burden on the Exchange; to conduct such case-by-case analyses, the Exchange would need to apply different procedures to subgroups of tax filers, specifically around cost-sharing reduction thresholds. Overall, we believe that using this standard will increase the accuracy of income verification, the accuracy of eligibility determinations, and the equity of the process for tax filers without significantly increasing the administrative burden on the Exchange.

We also make a change to another criterion for the alternate verification process described in § 155.320(c)(3)(iv)(B); we include that when an applicant attests that members of the tax filer's family have changed or are reasonably expected to change, he or she qualifies for an alternate verification process. We add this provision in order to account for a situation in which the family members are different but the number of family members remains the same.

In § 155.320(c)(3)(v), we describe the alternate verification process for decreases in household income or situations in which tax data are unavailable. We move the language from § 155.320(c)(3)(ii)(C) of the proposed rule, which specified that the Exchange accept an applicant's attestation of projected annual household income, unless it was not reasonably compatible with tax data, to this section, and replace "reasonably compatible" with a standard of a decrease of ten percent or less from the tax data. We redesignate ***18365** § 155.320(c)(3)(v) of the proposed rule as § 155.320(c)(3)(vi), which specifies the verification process for larger decreases and situations in which tax data are unavailable. Taken together, these revisions address commenters' concerns regarding inequities in the proposed verification process by ensuring that there are procedures under which a tax filer can obtain advance payments of the premium tax credit commensurate with their household income when changes have occurred or are reasonably expected to occur, regardless of the size of any such changes.

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Comment: We received many comments recommending that HHS further define the term “reasonably compatible”, as used throughout proposed § 155.320(c) as the standard for assessing whether verification can be considered complete, or if additional information is necessary. Commenters suggested various approaches to establishing a more detailed standard, including, in the case of income, the use of an acceptable percentage of deviation between the amount reflected by the data and an application filer's attestation. Others recommended that the Exchange should consider an application filer's attestation to income reasonably compatible with electronic data even if there is a difference in the data and an application filer's attestation, as long as the difference does not significantly impact eligibility. Some commenters recommended that Exchanges maximize the use of self-attestation without further verification, which would speak to setting the “reasonably compatible” threshold at a higher level. Other commenters requested that HHS establish a standard that allows for flexibility in implementation, and a few commenters recommended removing the “reasonably compatible” standard altogether. A few commenters recommended providing that the Exchange must always request additional evidence with the goal of achieving a more accurate projection of income or family size.

Response: When assessing comments recommending that HHS define the “reasonably compatible” standard proposed in § 155.320(c), we weighed our desire for Exchange flexibility with the goal of providing greater consistency in income verification for applicants across Exchanges and a more streamlined process, in order to reduce burden for applicants and Exchanges. However, based on the comments received, we recognize that there is a need to define a specific threshold within which the Exchange would accept an applicant's attestation regarding projected annual household income, as opposed to engaging in a more burdensome process. Accordingly, as discussed in the previous response, the final rule specifies that the Exchange will accept an applicant's attestation to projected annual household income without further verification if it is no more than ten percent below his or her tax data. We believe that using this threshold will result in eligibility determinations that are accurate while limiting the administrative burden associated with completing additional verification processes for smaller decreases in income. We believe that this is particularly important given the age of available tax return information at the point of open enrollment, as well as the volatility in income among households that are likely to request an eligibility determination for insurance affordability programs. In particular, we believe that it is critical to focus the limited resources of Exchanges on ensuring that larger changes are subjected to additional scrutiny.

In addition, we clarify that the process proposed in § 155.320(c)(3)(i) for verification of family size for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions follows the process specified in section 1411 of the Affordable Care Act, which specifies that the Secretary verify family size with the Secretary of the Treasury, and then implement alternative procedures to the extent that a change has occurred or tax data are unavailable.

First, in paragraph (c)(1)(i)(A), the Exchange will request tax return data including data regarding family size. In paragraph (c)(3)(i)(A), we specify that an applicant will attest to the individuals that comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions. We add paragraph (c)(3)(i)(B) to clarify that if an applicant attests that tax data represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested (that is, that no change has occurred or is reasonably expected to occur), the Exchange must use the family size information from the tax data to determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions. And in paragraph (c)(3)(i)(C), we specify that if tax data are unavailable, or an applicant attests that a change has occurred or is reasonably expected to occur, and as such, it does not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must accept his or her attestation to family size without further verification, unless it is not reasonably compatible with other information provided by the applicant or in the records of the Exchange.

In paragraph (c)(3)(i)(C), we clarify that the assessment of reasonable compatibility is not with respect to the tax data, as paragraph (c)(3)(i)(C) is designed to address situations in which it is already clear that tax data are unavailable or not representative. We then maintain the provisions from the proposed rule specifying that if information regarding family size is not reasonably compatible, the Exchange must first utilize data obtained through other electronic data sources, and if that is unsuccessful, follow the inconsistency process in § 155.315(f).

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Comment: We received comments suggesting that HHS clarify aspects of the income verification process in proposed § 155.320; in particular, commenters asked that the final rule specify the sequencing of the process, so that a clear order for the execution of steps for Medicaid, CHIP, and advance payments of the premium tax credit and cost-sharing reductions is established. Commenters also asked that HHS allow Exchanges greater flexibility around the use of electronic data to verify household income. For example, one commenter recommended that in the event an applicant's current income data places them well below the income level for eligibility for advance payments of the premium tax credit or cost-sharing reductions, the Exchange not be required to also obtain the applicant's tax return data. Others questioned the overall usefulness of available tax return data given its age, and asked that Exchanges be permitted to look only at available current income data sources to verify household income for all insurance affordability programs.

Response: We acknowledge commenters' desire to further streamline and simplify the eligibility and enrollment process by avoiding unnecessary steps to verify applicant information. Sections 1402(f)(3), 1411(b)(3) and 1412(b)(1) of the Affordable Care Act provide that data from the most recent tax return information available must be the basis for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions to the extent such tax data is available. HHS is working closely with Treasury and IRS to ensure that such data is readily accessible by the Exchange, to assist in facilitating the completion of an eligibility determination in a single, online session. We believe that the regulation is not the place to lay out ***18366** detailed, sequenced steps for verifying household income. As such, in § 155.320(c)(3)(ii), we have made changes to allow the Exchange flexibility when sequencing the verification of annual household income; we altered the text such that the Exchange may present the applicant with his or her projected annual household income computed from the tax return information prior to requiring an attestation from the applicant or, in the alternative, to allow the Exchange to take an attestation from the applicant regarding a tax filer's projected annual household income and then verify whether the attestation is supported by the tax return information described in § 155.320(c)(3)(i). Overall, we intend for the regulation to be neutral with regard to the sequencing of operations, and will provide such operational details through guidance.

Comment: Commenters asked HHS to clarify whether, when verifying annual household income as described in proposed § 155.320, the Exchange must rely on a tax filer's attestation to make a final determination of household income when the attestation and tax data are reasonably compatible, or whether the Exchange must rely on tax data.

Response: We acknowledge commenters' concerns that the proposed regulation text at § 155.320(c)(3)(ii) does not clearly describe the process the Exchange must follow in the event that the applicant attests that the income in the tax data represents an accurate projection of the household's projected annual household income. In this final rule, we include a provision in § 155.320(c)(3)(ii)(B) which describes that, in this situation, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the income data from his or her tax return.

Comment: A few commenters asked for clarification as to when it is appropriate to accept self-attestation of income. We also received comments asking for clarification on our use of self-attestations throughout the verification processes described in § 155.315 and § 155.320.

Response: The Exchange may accept an applicant's attestation of her or her projected annual household income in a number of instances during the income verification process; however, it is important to note, that for purposes of verification of income for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, the Exchange will never accept such an attestation without attempting to acquire tax data. Those instances in which the Exchange may accept an attestation without further verification when an application attests that as a result of a change or an expected change, a tax filer's income has increased, by any amount, above the projected annual household income calculated by the Exchange based on tax data, as described in § 155.320(c)(3)(iii); and when an applicant attests that as a result of a change or an expected change, a tax filer's projected annual household income has decreased or is reasonably expected to decrease from the projected annual household income calculated based on tax data by ten percent or less, as described in § 155.320(c)(3)(v).

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In response to comments regarding the use of self-attestation in the verification process, the processes described are designed to confirm information to the extent necessary to provide eligibility. In situations in which the Exchange uses self-attestation without further verification as the basis of eligibility, we have determined that this approach yields valid data and does not pose unacceptable levels of risk. We believe that this approach is particularly important in order to promote a seamless, real-time experience for as many applicants as possible. It is also important to note that strong program integrity protections will be in place and that all attestations will be provided under penalty of perjury.

Comment: We received comments asking which procedures the Exchange must follow when an individual's unverified income meets the Medicaid or CHIP income threshold.

Response: As indicated in § 155.320(c)(2)(ii) of the proposed rule, if an individual's unverified current income meets the Medicaid or CHIP income threshold, the Exchange would verify his or her household income in accordance with Medicaid or CHIP rules specified in 42 CFR 435.948 and 42 CFR 435.952. Similarly, if an individual attests to income in the Medicaid or CHIP eligibility range, the Exchange would need to follow the procedures outlined in 42 CFR 435.948 and 42 CFR 435.952, since such individual would not be eligible for the alternative verification process, as indicated in § 155.320(c)(3)(iv). We maintain these provisions in this final rule.

Comment: We received several comments requesting greater integration and alignment in standards and processes for verifying family/household size and household income across insurance affordability programs. Some asked for States to be given flexibility to align standards across insurance affordability programs. Commenters also recommended specific changes facilitating a closer alignment of the rules for determining family/household size and household income between Medicaid, CHIP and advance payments of the premium tax credit and cost-sharing reductions. Some recommended full integration, utilizing identical standards across insurance affordability programs.

Response: Throughout § 155.320(c), the standards for verification of family size and income for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions closely follow the rules set forth in sections 1411 and 1412 of the Affordable Care Act and section 36B of the Code. We sought to align as closely as possible with the standards established for Medicaid and CHIP, but given statutory standards, we were limited in the degree of alignment we could achieve.

With respect to family/household income and household size, we note that Medicaid/CHIP and advance payments both start with the family size and income counting rules in section 36B of the Code. From there, there are three key differences in how income must be measured in Medicaid/CHIP and for advance payments and cost-sharing reductions. First, as noted in the proposed rule, section 1902(e)(14)(H) of the Social Security Act, as added by section 2002 of the Affordable Care Act, specifies that Medicaid eligibility will continue to be based on “point-in-time”, or current monthly income, while eligibility for advance payments of the premium tax credit and cost-sharing reductions is based on annual income. This is reflected in 42 CFR 435.603(h)(1). Second, 42 CFR 435.603(b) and (f) specifies that in certain situations, Medicaid and CHIP follow different household composition rules from those in section 36B of the Code, which then lead to counting income for a different group than would be counted for advance payments of the premium tax credit and cost-sharing reductions. These situations are discussed in detail in the preamble associated with 42 CFR 435.603.

Third, 42 CFR 435.603(e) specifies that there are some exceptions to the use of the income counting rules of section 36B of the Code for purposes of eligibility for Medicaid and CHIP. These include special treatment for lump sum payments, scholarships, awards, or fellowship grants used for educational purposes and not for living expenses, and certain types of American Indian and Alaska Native income.

***18367** Aside from the different time standard, in the majority of cases, the rules for counting household income and household/family size are the same across insurance affordability programs. In addition, we note that 42 CFR 435.603(i) specifies that in a situation in which an applicant is over the income threshold for Medicaid, but is under the income threshold for advance payments of the premium tax credit, the Medicaid agency will determine Medicaid eligibility using section 36B rules, which

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would likely result in Medicaid eligibility in most situations. We have also added an additional provision in § 155.345(e), which is discussed in the comment and response associated with that section.

Lastly, we note that throughout subpart D, we use "household size" for purposes of Medicaid and CHIP, in order to align with Medicaid and CHIP regulations, and "family size" for purposes of advance payments of the premium tax credit and cost-sharing reductions, in order to align with Treasury regulations. To clarify this, we added § 155.320(c)(3)(viii), which specifies that for purposes of advance payments of the premium tax credit and cost-sharing reductions, "family size" means family size as defined in section 36B(d)(1) of the Code.

Comment: We received a number of comments related to current income sources to be used by the Exchange in verifying household income. Commenters asked us to define those current income sources that the Exchange will use in the process proposed in § 155.320(c)(1)(ii). Others asked whether current income information would be available via the Federally-managed data services hub.

Response: Under § 155.320(c)(1)(ii) of the proposed and this final rule, the Exchange must obtain the most current income data from those data sources described in existing Medicaid regulations at 42 CFR 435.948(a). In order to access this current income data, we anticipate that the Exchange will leverage State Medicaid and CHIP agencies' existing relationships with current income sources, but we are also exploring the potential for supporting connections to sources of current income data through the data services hub.

Comment: Several commenters had specific questions related to services available to support the income verification process through the data services hub. Specifically, commenters asked which data elements from the tax return would be available from the IRS via the data services hub, and recommended that individual data elements (for example, wages, profit and loss from business, deductions) would be more useful in verifying household income than a single MAGI data element.

Response: We are working to identify those services which will be available to Exchanges to support the income verification process and will provide further detail in future guidance. We note that the section 6103(l)(21) of the Code identifies general categories of tax data that will be available for purposes of determining eligibility in insurance affordability programs. In addition, these categories are discussed in the response to question 8 in HHS' November 29, 2011 document titled "State Exchange Implementation Questions and Answers".[FN6]

Comment: We received comments related to the treatment of American Indian and Alaska Native income. Some asked whether current State arrangements around the treatment of such income will be allowed to stand under the Exchange; others asked that the exemption for American Indian and Alaska Native income be referenced in the Exchange final rule and that materials be available to consumers so they can understand the availability of such exemptions.

Response: In § 155.320(c)(1)(ii) of the proposed rule, we reference 42 CFR 435.603(d) for purposes of income eligibility for Medicaid, which incorporates the applicable income exemptions for American Indians and Alaska Natives described under 42 CFR 435.603(e)(3). This regulatory reference addresses the treatment of these exemptions and the future of existing arrangements with regard to American Indian and Alaska Native income with respect to Medicaid. We note that these income exemptions do not apply when verifying annual household income for advance payments of the premium tax credit and cost-sharing reductions, because the Affordable Care Act establishes specific definitions of "household income" and "MAGI" to use for determining eligibility for these benefits. Because of the statutory limits on the definition of household income for advance payment of premium tax credits and cost-sharing reductions, this final rule maintains the proposal to follow the rules described in section 36B of the Code.

Comment: We received a comment recommending that HHS clarify that, for purposes of obtaining data regarding MAGI-based income for purposes of Medicaid and CHIP eligibility, the Exchange will initially request data from data sources described in 42 CFR 435.948(a), not from the applicant.

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Response: The specific sequencing of the process for collecting and verifying relevant information is subject to future operational analysis, and that we anticipate providing future guidance on this topic, including through the model electronic application.

Comment: We received a number of comments related to proposed § 155.320(c)(4), which provides that the Exchange must provide education and assistance to an application filer regarding the family/household size and household income verification process. Several commenters suggested specific standards for the format and content of consumer education and assistance materials. Some commenters asked that a Federal standard for such materials be developed for Exchanges, and others advised that HHS encourage Exchanges to provide information specific to the alternative income verification process to ensure a smooth verification process.

Response: There are several provisions throughout this final rule which provides that the Exchange must provide consumer tools and education related to the eligibility and enrollment process, in addition to the standard described in § 155.320(c)(4), including a calculator and other tools, described in § 155.205, and information regarding advance payments of the premium tax credit, described in § 155.310(d)(2)(iii). We expect to issue future guidance on this topic.

Comment: We received comments asking if the Exchange would have access to all child support data; and if so, suggesting that the Exchange must abide by specific data safeguards.

Response: The Exchange would not be required to have access to child support data for purposes of verifying annual household income. Regardless, for data collected by the Exchange, privacy and security protections, described in § 155.260 of this final rule, and standards for electronic transactions, described in § 155.270 of this final rule, would also apply.

Comment: Several commenters supported the proposal in § 155.320(d) for the Exchange to utilize self-attestation by the employee to verify enrollment in an eligible employer-sponsored plan. One commenter stated that HHS should give States the flexibility to use self-attestation or to use other methods of verification.

Response: We accept these comments and maintain this provision in the final rule. Section 1411(d) gives authority to the Secretary to determine the appropriate means to verify certain ***18368** information that the applicant must submit in accordance with section 1411(b)(4). We note that § 155.315(h) of this subpart allows State flexibility, subject to approval by HHS, based on a finding that the alternative approach meets certain standards described in that section.

Comment: Several commenters asserted that individuals enrolled in continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or in an eligible employer-sponsored plan should have the opportunity to be conditionally determined eligible for advance payments of the premium tax credit and cost-sharing reductions, subject to termination prior to enrollment in a QHP. These commenters reasoned that individuals should not be forced into uninsured status in order to obtain a determination of eligibility for tax credits and risk remaining uninsured if they are found ineligible and the enrollment period for electing COBRA or coverage in an eligible employer-sponsored plan passes.

Response: Section 36B(c)(2)(C)(iii) of the Code states that an individual who is enrolled in an eligible employer-sponsored plan is not eligible for advance payments of the premium tax credit; because of the statutory prohibition on providing cost-sharing reductions for any month that is not a month for which the enrollee is eligible for premium tax credits, this bar also applies to eligibility for cost-sharing reductions. However, while an individual must terminate coverage in his or her employer-sponsored plan prior to the period for which he or she actually receives advance payments of the premium tax credit and/or cost-sharing reductions, we clarify that the individual need not terminate coverage to receive an eligibility determination that he or she is eligible to receive these payments and reductions. Accordingly, we have amended the language in § 155.320(d)(1) of this final rule to clarify that an attestation regarding enrollment in qualifying coverage in an eligible employer-sponsored plan should be based on the applicant's reasonable expectation of enrollment in the benefit year for which coverage is requested.

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Comment: One commenter noted that the language in proposed § 155.320(d) seems to indicate that the decision whether or not the Exchange must verify beyond an applicant's attestation regarding enrollment in an eligible employer-sponsored plan is within the discretion of an Exchange, and requested clarification regarding whether this was an intentional wording.

Response: We have amended the regulatory text to reflect the standard that an Exchange must verify an applicant's attestation using electronic data sources to the extent that an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange.

This change is consistent with equivalent amendments made in this subpart, and provides that, if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through electronic data sources. As discussed in the proposed rule, examining data sources, when available, will help minimize the need to request paper documentation from applicants, and the burden for Exchanges to process such documentation. A more detailed explanation of the change from “may” to “must” can be found in the comment and response to § 155.315. We also plan to release guidance for States regarding electronic data sources to support this verification.

Comment: Commenters suggested a variety of operational solutions for carrying out the verification of an applicant's eligibility for and/or enrollment in an eligible employer-sponsored plan. These comments were largely in response to the accompanying preamble discussion regarding the two potential data sources an Exchange may use to support this verification—the employer/employee template and the central database. Several commenters expressed support for or against the template and central database options. A large group consisting of consumer advocacy groups, a labor union and a think tank expressed support for the standard template option. Each of these commenters added that employees should not be required to provide information regarding minimum value because this information is not readily accessible to employees. One commenter requested that HHS provide that employers must submit information regarding eligibility for and enrollment in employer-sponsored plans to Exchanges on an annual basis. One commenter said HHS should provide States with the option to develop algorithms to determine who can be expected to have access to qualifying coverage in an eligible employer-sponsored plan using the size of the applicant's employer and industry type instead of creating a new database. Commenters also supported the goal of leveraging existing data sources for the purposes of verifying eligibility for qualifying coverage in an eligible employer-sponsored plan. One commenter said that HHS should give States the flexibility to verify eligibility for qualifying coverage in an eligible employer-sponsored plan using already-existing data. One commenter stated that HHS should have employee W-2 forms available as a verification source.

Response: We continue to consult with the Departments of Labor and Treasury regarding the optimal solution for gathering information for the purposes of verification of eligibility for qualifying coverage in an eligible employer-sponsored plan and will issue guidance on this topic. Both the template and database options we described in the proposed rule are being considered as operational solutions. We are also considering ways in which an individual could gather information from his or her employer for the purposes of this verification. A combination of these methods could provide the most accurate and reliable results, while gathering information from both of the relevant information sources—employees and employers. We are also considering additional options in which employees seeking coverage could provide other sources of documentation from his or her employer that could verify eligibility. We plan to issue guidance outlining one or more possible methods for comment that will help guide the collection of information necessary to verify eligibility for qualifying coverage in an eligible employer-sponsored plan. However, it should be noted that any database option may rely on voluntary submission of information regarding employee eligibility for qualifying employer-sponsored coverage by employers. Further, HHS acknowledges that building the functionality required to collect and retain information regarding employer-sponsored insurance coverage will be time and resource-intensive, and is therefore is considering options for an interim approach for verification of eligibility for qualifying coverage in an eligible employer-sponsored plan. We plan to describe these interim options in forthcoming guidance. We also note that it is anticipated that initial guidance under 6103(l)(21) of the Code will not provide for sharing the contents of an applicant's Form W-2 with the Exchange.

Comment: Some commenters said the Federal government should perform verification of eligibility for qualifying coverage in an eligible employer-sponsored plan as a service to States. These commenters cited limitations on ***18369** the ability of States to perform this verification. One commenter said that States with no individual income tax, specifically, would have difficulty making affordability determinations.

Response: In the State Exchange Implementation Questions and Answers released on November 29, 2011, we indicated that we are exploring how the Federal government could manage services for verification of employer-sponsored minimum essential coverage. We note, though, that we do not believe that the absence of an individual State income tax return poses an obstacle to computing affordability, since the income verification process in § 155.320(c)(3) of this final rule does not require the use of State income tax information.

Comment: One commenter stated that, in the case of an inconsistency between an applicant's attestation and internal Exchange records, the burden to produce further documentation should be on the employee, not the employer.

Response: We believe our proposed regulation followed the commenter's recommendation because the employee is the applicant. Section 155.315(f)(2)(ii) of this final rule describes that an applicant must provide further documentation if the applicant's attestation is inconsistent with other information sources.

Comment: One commenter requested that HHS must establish two distinct processes for the determination of eligibility for advance payments of the premium tax credit by Exchanges under proposed § 155.320 and for the assessment of employer penalties by the Treasury.

Response: The statute makes clear that the two processes are distinct. Under sections 1411 and 1412 of the Affordable Care Act, the Exchange will make eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, notify employers that a payment may be assessed and that the employer has a right to appeal to the Exchange, and provide information to the Treasury. The assessment of shared responsibility payments under section 4980H of the Code is within the jurisdiction of the Treasury.

Comment: One commenter concurred with the language of § 155.320 of the Exchange Eligibility proposed rule, which provides that the Exchange must verify information for only those applicants seeking eligibility determinations for insurance affordability programs in order to minimize multiple employer interactions with the Exchange.

Response: Verification of eligibility for qualifying coverage in an eligible employer-sponsored plan is necessary only when indicated as necessary in accordance with the statute. An Exchange is not required to verify eligibility for qualifying coverage in an eligible employer-sponsored plan for an applicant who did not request an eligibility determination for all insurance affordability programs.

Comment: One commenter asserted that HHS should declare that all employer-sponsored insurance offered to American Indians and Alaska Natives fails the affordability and minimum value standards. The commenter reasoned that information regarding affordability and minimum value will be difficult for this type of applicant to provide. In addition, the commenter stated that if an individual is eligible to receive services through the Indian Health Service (IHS), including eligibility for services from an IHS facility, or for services from a tribe or tribal organization, or Urban Indian Organization, the Exchange should not attempt to verify an attestation regarding eligibility for qualifying coverage in an eligible employer-sponsored plan because this population is exempt from the standard to maintain minimum essential coverage.

Response: While we recognize that certain data elements requested from applicants for the purposes of this verification may be challenging to obtain, we believe that a wholesale exception for American Indians and Alaska Natives is not warranted or permissible under the statute, and are not providing for such an exception in this final rule.

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Comment: One commenter requested clarification on the issue of full-time employment and its relationship to eligibility for qualifying coverage in an eligible employer-sponsored plan. Specifically, the commenter asked whether full-time status will be requested during the verification process, whether the Exchange will consider it when making eligibility determinations for advance payments of the premium tax credit, and whether the affordability test depends on whether the applicant is a full-time employee. In addition, the commenter requested clarification regarding notification and how an Exchange should manage eligibility determinations for applicants with multiple employers.

Response: Section 1411(b)(4)(B) of the Affordable Care Act specifies that an applicant must provide information including, “whether the enrollee or individual is a full-time employee.” With that said, the affordability test and the determination of whether an applicant is eligible to receive advance payments of the premium tax credit and/or cost-sharing reductions is not dependent on the full-time status of the employee. Rather, this information is relevant for Treasury's determination as to whether a shared responsibility payment under section 4980H of the Code applies to an employer. Also, we note that in the case of an applicant who has more than one employer, the Exchange will evaluate information from existing data sources regarding all of the applicant's employers to determine eligibility for qualifying coverage in an eligible employer-sponsored plan.

Comment: One commenter requested clarification regarding whether the Exchange will use tax data to ensure affordability of coverage for employees under proposed § 155.320. The commenters asked whether the employer may use wage data, instead of household income data, in its affordability determination.

Response: The Exchange will use the projected annual household income verified through the process described in § 155.320(c)(3) of this final rule to compute the affordability of available coverage through an eligible employer-sponsored plan. The question of whether an employer may use wage data in determining whether its offered coverage meets affordability criteria is beyond the scope of this rule, and is within the authority of the Department of the Treasury. In September 2011, the Department of the Treasury released IRS Notice 2011-73 (2011-40 I.R.B. 474) requesting comments on a potential safe harbor permitting employers to use an employee's W-2 wages in determining the affordability of employer-sponsored minimum essential coverage for purpose of the employer shared responsibility provisions under Code section 4980H. In February 2012, the Department of the Treasury released Notice 2012-17 (issued jointly with HHS and the Department of Labor) confirming that it intends to issue proposed regulations or other guidance providing for this safe harbor.[FN7]

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.320 of the proposed rule, with the following modifications. In paragraph (c)(2)(i)(A), we adopted new language to describe the verification of household size for ***18370** Medicaid and CHIP, in order to align with the Medicaid Eligibility final rule. We redesignated paragraph (c)(3)(i)(B) as paragraph (c)(3)(i)(C), and added paragraph (c)(3)(i)(B), which clarifies that if an applicant attests that tax data represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must use the family size information from the tax data to determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions. We also added paragraphs (c)(3)(i)(C) and (D), which clarifies that this paragraph applies when tax data are unavailable or when a change has occurred or is reasonably expected to occur such that the data does not represent an accurate projection of family size; and clarifies that the assessment of reasonable compatibility is with respect to data other than that from the tax return.

We also make a technical change to § 155.320(c)(2)(i)(B) to state that the Exchange “must,” rather than “may,” examine electronic data sources if information is found to be not reasonably compatible. This change was made in order to align with verification of other applicant information, and so that in the event the Exchange accepts an applicant's attestation without further verification but such attestation is not reasonably compatible with other information provided by the application filer or contained in the records of the Exchange, the Exchange must examine available data sources to verify the attestation. If the information in the data sources cannot be used to verify the attestation, the Exchange must request additional documentation in accordance with Medicaid regulations at 42 CFR 435.952. This change was also made in order to align with changes made to the Medicaid regulations regarding verification of household size.

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We redesignated paragraph (c)(3)(ii)(B) as paragraph (c)(3)(ii)(C), and removed the phrase "is requested and accept the application filer's attestation without further verification, except as provided in paragraph (c)(3)(ii)(C) of this section" in order to clarify that the Exchange must proceed in accordance with the procedures in paragraph (c)(3)(ii)(C) after receiving such an attestation.

We also added paragraph (c)(3)(ii)(B), which provides that the Exchange must request the applicant to attest regarding his or her projected annual household income. We have also added paragraph (c)(3)(ii)(C) which clarifies that if an applicant's attestation indicates that the tax data represents an accurate projection of a family's household income for the benefit year for which coverage is requested, the Exchange must use the household income information from the tax data to determine his or her eligibility for advance payments of the premium tax credit and cost-sharing reductions. In paragraph (c)(3)(iii)(B), we changed the term "may" to "must" to specify that if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through other electronic data sources. In paragraph (c)(3)(iv)(A), we replaced the phrase "this is as a result of an individual not being required to file" with "an individual was not required to file." In paragraph (c)(3)(iv)(B), we added that the alternate verification process is also available for a tax filer whose family composition has changed or is reasonably expected to change; we also added the phrase "or members of the tax filer's family have changed or are reasonably expected to change." In paragraph (c)(3)(iv)(C), we removed, "by more than 20 percent," and clarified that this criterion is based on an applicant's attestation that a change has occurred or is reasonably expected to occur. We added a paragraph (c)(3)(iv)(D) to allow a tax filer to qualify for the alternative verification process if the applicant attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage. Omitting this provision from the proposed rule was an oversight; this basis for use of an alternate income determination process is authorized in section 1412(b)(2) of the Affordable Care Act.

We removed proposed paragraph (c)(3)(vi); given changes made to this section of the regulation, this paragraph was no longer necessary. We redesignated proposed paragraph (c)(3)(v) as paragraph (c)(3)(vi), and added a new paragraph (c)(3)(v). In paragraph (c)(3)(v) of the final rule, we specified that if a tax filer qualifies for an alternate verification process and the applicant's attestation to projected annual household income is no more than ten percent below the annual household income computed from tax data, the Exchange must accept his or her attestation without further verification. In revised paragraph (c)(3)(vi), we specified that the process in proposed paragraph (c)(3)(vi) applies if a tax filer qualifies for an alternate verification process and the applicant's attestation to projected annual household income is greater than ten percent below the annual household income computed from tax data, or if tax data are unavailable.

In paragraph (c)(3)(vi)(C), we clarified a reference to § 155.315(f) to include paragraphs (f)(1)-(4), which includes the 90 day period during which an individual may either present satisfactory documentary evidence or otherwise resolve the inconsistency. We also added paragraph (c)(3)(vi)(F), to describe that if, at the end of the 90 day period the Exchange is unable to verify the applicant's attestation and the tax data described in (c)(3)(ii)(A) is unavailable, the Exchange must notify that applicant and discontinue the advance payments and cost-sharing reductions. We added this paragraph in order to explicitly describe the procedures the Exchange must follow when there is no data on which to rely at the conclusion of the 90 day period.

We also added paragraphs (c)(3)(vii) and (c)(3)(viii), which clarify that the terms "household income" and "family size" in paragraph (c)(3) mean household income as specified in section 36B(d)(2) of the Code, and family size as specified in section 36B(d)(1) of the Code, respectively. To clarify the process for verifying eligibility for qualifying coverage in an eligible employer-sponsored plan tracks, we amended paragraph (d)(1) to state that the Exchange must also verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We amended paragraph (d)(2) by changing "may" to "must", which provides that an Exchange must obtain data from electronic data sources to verify an applicant's attestation that he or she is not enrolled in an eligible employer-sponsored plan when an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. We also added the word "electronic" in paragraph (d)(2) to create consistency with equivalent provisions in the subpart.

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We made several technical corrections. In paragraph (a)(2), we also changed the reference in § 155.315 from paragraph (e) to (h). In paragraphs (c)(3)(i)(C) and (c)(3)(ii)(C), we clarified that when an applicant attests that tax return data is not representative of family size or household income for the benefit year for which coverage is requested, it is as a result of a change in circumstances, which aligns with section 1412 of the Affordable Care Act. In paragraph (c)(3)(iii)(A), we added "in accordance with paragraph (c)(3)(ii)(B). Proposed paragraph (c)(3)(iv)(D) was ***18371** redesignated as paragraph (c)(3)(iv)(E). In paragraph (c)(3)(vi)(E), we renumbered the reference to § 155.310(f) to § 155.310(g), and the reference to § 155.330(e)(1) through (e)(2) to § 155.330(f). Throughout paragraph (c)(3), we changed references to ensure that the paragraph consistently referred to the tax filer for verification of household income for purposes of advance payments of the premium tax credit and cost-sharing reductions, in order to align with the eligibility standards. We made several changes to paragraph (f) to align with the Medicaid final rule. In paragraph (c)(2)(i)(A), we changed references to the Medicaid Eligibility final rule to account for renumbering. We also added the reference to 42 CFR 435.945 to paragraph (c)(2)(ii). Throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in § 155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

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

In § 155.330, we outlined procedures for redeterminations during a benefit year. We proposed to rely primarily on the enrollee to provide the Exchange with updated information during the benefit year, and solicited comments as to whether there should be an ongoing role for Exchange-initiated data matching beyond what was proposed in the proposed rule. We also solicited comments on whether the Exchange should offer an enrollee an option to be periodically reminded to report any changes that have occurred.

We proposed that the Exchange redetermine the eligibility of an enrollee in a QHP during the benefit year in two situations: first, if an enrollee reports updated information and the Exchange verifies it; and second, if the Exchange identifies updated information through limited data matching to identify individuals who have died or gained eligibility for a public health insurance program.

We also proposed that an individual who enrolls in a QHP with or without advance payments of the premium tax credit or cost-sharing reductions must report any changes to the Exchange with respect to the eligibility standards specified in § 155.305 within 30 days of such change. Additionally, we proposed that the Exchange use the verification procedures at the point of initial application for any changes reported by an individual prior to using the self-reported data in an eligibility determination. We solicited comments on whether to allow the Exchange to limit those changes on which an individual must report, to changes in income of a certain magnitude. We noted that this provision would have no effect on whether an individual was liable for repayment of excess advance payments of the premium tax credit at reconciliation.

We also proposed that the Exchange periodically examine certain data sources that are used to support the initial eligibility process to identify death and eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if applicable. We proposed to generally limit proactive examination to these pieces of information because of the reliability of these data sources and because the identified information provides clear-cut indications of ineligibility for enrollment in a QHP and advance payments of the premium tax credit and cost-sharing reductions.

We further proposed to allow the Exchange to make additional efforts to identify and act on changes that may affect an enrollee's eligibility to enroll in a QHP to the extent that HHS approves a plan to modify the process.[FN8] We indicated that such approval would be granted if HHS finds that a modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that such changes would not undermine coordination with Medicaid and CHIP, and that any applicable provisions related to the confidentiality, disclosure, maintenance, or use of information will be met.

We solicited comments regarding whether and how we should approach additional data matching, whether the Exchange should modify an enrollee's eligibility based on electronic data in the event that he or she did not respond to a notice regarding the

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updated information, and whether there are other procedures that could support the goals of the redetermination process for changes during the benefit year.

To the extent that the Exchange verifies updated information reported by an enrollee or identifies updated information through data matching, we proposed that the Exchange determine the enrollee's eligibility and provide an eligibility notice in accordance with the process described in § 155.305 and § 155.310, respectively. Additionally, we proposed that changes resulting from a redetermination during the benefit year be effective for the first day of the month following the notice of eligibility determination, and proposed to allow for an exception, subject to the authorization of HHS, in which the Exchange could establish a “cut-off date” for changes resulting from a redetermination during the coverage year. We solicited comment as to whether this should or should not necessitate an authorization from HHS, and if there should be a uniform timeframe across all Exchanges. In addition, we solicited comment as to whether this is the appropriate policy for the effective date for changes.

Finally, we proposed that if the eligibility determination results in an individual being ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange maintain his or her eligibility for enrollment in a QHP through the Exchange for a full month after the month in which the determination notice is sent. However, as soon as eligibility for insurance affordability materially changes, we proposed that the Exchange discontinue advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in paragraphs (e)(1) and (e)(2). We solicited comment on this topic, as well as on approaches to ensuring that transitions between insurance affordability programs do not create coverage gaps for individuals.

Comment: We received a number of comments regarding redeterminations conducted during the benefit year, as proposed in § 155.330. While several commenters were supportive of the opportunity for an enrollee to have his or her eligibility redetermined prior to the annual redetermination, other commenters suggested that we limit or eliminate eligibility redeterminations during the benefit year in order to limit movement for enrollees between different insurance affordability programs and QHPs.

Response: We feel it is important for the Exchange to accept and identify changes to help ensure that an enrollee's eligibility reflects his or her true circumstances, which will help minimize repayment of excess advance payments at reconciliation when income increases, increase the affordability of coverage when income decreases, and improve program integrity. Therefore, we maintain in the final rule the opportunity for eligibility redeterminations during the benefit year.

Comment: Of those entities that commented on the process for handling ***18372** changes during the benefit year described in proposed § 155.330, a number suggested limiting the scope of changes on which enrollees must report; these commenters stated that requiring reporting of any and all changes potentially impacting eligibility would substantially increase the administrative burden on both the Exchange and on enrollees. Many commenters recommended clarifying that an enrollee in a QHP who is not receiving advance payments of the premium tax credit or cost-sharing reductions would not be required to report changes in their household income or access to minimum essential coverage, as these are not considered when financial assistance is not present. Other commenters suggested limiting the reporting of changes in income; some recommended that enrollees be allowed and encouraged, but never required, to report changes in income, while others were in favor of a establishing a threshold for the reporting of income changes. Generally, those commenters who suggested limiting the changes that individuals must report also suggested that enrollees should be encouraged but not required to report all other changes impacting eligibility, such as changes in income and family size.

Response: In response to commenters' suggestions, we have altered § 155.330 in this final rule regarding the policy of reporting of changes during the benefit year. First, we clarify that the Exchange may not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes related to eligibility for insurance affordability programs, including changes in income or access to minimum essential coverage. We clarify that we mean an enrollee who, as of his or her most recent interaction with the Exchange, has not requested an eligibility determination for insurance affordability programs. In response to comments regarding which changes an enrollee must report, we amended the regulation text in the final rule to reflect different standards for changes related to income. As a result, we maintain that an individual must report

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a change related to eligibility for enrollment in a QHP through the Exchange (that is a change in residence, incarceration or citizenship and lawful presence) within 30 days of such change; however, we allow the Exchange to establish a reasonable threshold below which an individual is not required to report a change in income. We believe that allowing the Exchange to limit the changes the enrollee must report will reduce confusion for enrollees and administrative burden on the Exchange, while still ensuring that significant changes are captured. With that said, we clarify that this provision does not allow the Exchange to not process changes in income that are reported by enrollees, regardless of whether they meet the threshold.

Comment: In response to our request for comment in this area, we received comments asking that Exchanges periodically remind individuals to report changes impacting their eligibility. We also received comments recommending that the Exchange provide education regarding what changes must be reported and how the reporting of changes may impact reconciliation.

Response: We have added a provision at paragraph § 155.330(c)(2) of this final rule specifying that the Exchange must provide periodic electronic notifications regarding the standards for reporting changes to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive such periodic electronic notifications. We believe this will complement the provision allowing Exchanges to limit those changes in income an enrollee must report, by helping ensure that consumers are informed of the impact and importance of reporting any change to the Exchange during the benefit year. In addition, we believe that electronic communications will be minimally burdensome for the Exchange and for enrollees. Exchanges can determine the timing and frequency of such notices.

Comment: A large number of commenters supported our policy proposed at § 155.330(c) directing Exchanges to periodically initiate limited data matches to identify changes in enrollees' eligibility. A few commenters asked that we preserve Exchange flexibility to expand the scope of data matches and others asked that we provide that Exchanges must expand data matches to include income and other data; these commenters noted that such an expansion would help decrease the burden on enrollees to report changes and to decrease inaccuracy when enrollees fail to report. However, some commenters were against any Exchange-initiated data matches, including the proposal to allow Exchanges flexibility to expand the scope of data matches with HHS approval. These commenters stated that such data matches would increase movement between programs for enrollees; they also believe that enrollees are in the best position to report changes impacting their eligibility.

Response: While we acknowledge commenters' calls for Exchange flexibility to expand data matching, we believe that allowing for unlimited data matching without the application of specific standards would be undesirable. Therefore, in the final rule, we maintain the flexibility provision we proposed in the paragraph redesignated in this final rule as § 155.330(d)(2), with one change: we do not require HHS approval to expand data matching, but provide that the Exchange must adhere to specific standards. We also adopt new procedures in this final rule around the verification of data obtained through such expanded data matches, which is explained in more detail in comment response below. Together, these changes will reduce burden for the Exchange and allow the Exchange to take steps to increase the accuracy of eligibility determinations as technology and data sources evolve; furthermore, the Exchange must ensure that such data matches would reduce administrative costs and burdens on individuals, maintain accuracy, minimize delay and would not undermine coordination with Medicaid and CHIP.

Comment: We received a number of comments on the provision proposed in § 155.330(d), related to the verification process and enrollee notification following the Exchange identifying a change that affects eligibility. As noted previously, some commenters objected to any Exchange-initiated data matching; these concerns were based in part on discomfort with the Exchange making changes to an enrollee's eligibility in cases in which the enrollee did not respond to a notice regarding the change. Some suggested that the Exchange verify changes reported or identified through data matching in accordance with the standards proposed in § 155.315 and § 155.320. Several commenters suggested that enrollees be given advance notice of changes identified through data matching and that they be able to affirm all changes prior to the Exchange using the new information. A number of commenters recommended that the notice proposed in § 155.330(d) contain a right to appeal.

Response: For changes in eligibility identified by the Exchange through data matching, the procedures for notifying the enrollee should be more clearly outlined in the final rule. Therefore, in § 155.330(e)(2) of this final rule we provide that for changes

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identified through data-matching that do not impact household income, family size, or family composition, the Exchange must notify the enrollee of the new data and his or her projected eligibility determination, and allow the enrollee ***18373** 30 days to notify the Exchange if the information is inaccurate. If the enrollee responds that the information is inaccurate, the Exchange must proceed with the inconsistency process described in § 155.315(f); if the enrollee responds that the information is accurate or does not respond, the Exchange must redetermine the enrollee's eligibility based on the verified data obtained through the data matching process.

For changes to household income, family size and family composition identified through data matching, we provide in § 155.330(e)(3) of this final rule that the Exchange must notify the enrollee of the new data and his or her projected eligibility determination (including the amount of advance payments of the premium tax credit and the level of cost-sharing reductions), and allow the enrollee 30 days to respond to the notice. If the enrollee does respond confirming the information obtained by the Exchange or responds by providing more up to date information, the Exchange must redetermine the enrollee's eligibility based on the data obtained through the data matching process or by verifying the updated information provided by the enrollee. However, if the enrollee does not respond, the Exchange must maintain the enrollee's eligibility without considering the new information. Because data related to income, family size and family composition has the potential to impact both the amount of financial assistance received by the enrollee and his or her tax liability at reconciliation, we believe the procedures for acting on such information should be different from the procedures for acting on data that do not have an impact on income and family size, and that enrollees must actively confirm such changes. We also note that the Exchange must notify the enrollee of the determination made as a result of a redetermination conducted during the benefit year, as indicated in (e)(1)(ii), and that such notice will include the right to appeal, in accordance with § 155.355(a).

Comment: Several commenters suggested clarification of our policies related to effective dates, as proposed in § 155.330(d). A number of commenters suggested that we align effective dates across part 155; among those suggestions was one to align the effective dates for redeterminations with effective dates for coverage under special enrollment periods, as described in § 155.420. Further, we received comments which suggested that we establish a uniform cut-off date.

Response: We recognize the need for greater alignment between the effective dates for redeterminations of eligibility with effective dates for coverage, as described in § 155.420 of this final rule. As such, in the final rule, we provide in § 155.330(f) of this final rule that changes resulting from redeterminations during the benefit year must be implemented for the first day of the month following the date of the redetermination notice; however, we allow the Exchange to establish a cut-off date after which redeterminations would be implemented in the following month, as long as the cut-off date is no earlier than the date established under § 155.420(b)(1), (which is the 15th of the month) in order to effectuate coverage on the first of the following month. We believe that allowing the Exchange to establish such a cut-off date aligning with the cut-off date for coverage effective dates will facilitate administrative efficiency for the Exchange, if it chooses to align. Regarding comments requesting a uniform cut-off date, we wish to maintain Exchange flexibility to establish such a cut-off date, which is the same approach taken in subpart E, and so do not change the policy reflected in § 155.330(f)(2) in this final rule. In the paragraph newly designated as § 155.310(f) in this final rule, we also include the effective dates of eligibility for redeterminations, since these were inadvertently not included in the proposed rule. We also clarify that when we state that the effective date is the date on which the Exchange must implement an eligibility determination, we mean the date on which the applicant's eligibility, for example his or her advance payments of the premium tax credit or cost-sharing reduction, is or can be applied to the cost of his or her coverage.

Comment: We received a number of comments regarding the policy proposed in § 155.330(e)(3), which provides that the Exchange must extend an enrollee's eligibility for enrollment in a QHP for a full month, without advance payments of the premium tax credit or cost-sharing reductions, following a notice of redetermination terminating his or her eligibility for enrollment. Several commenters expressed concern regarding this provision citing a potential for liability to issuers when enrollees neglected to or were unable to pay premiums without financial assistance. Some commenters suggested that individuals must pay premiums in order to receive such coverage, or that the redetermination notice clearly indicate when coverage will be terminated and that the enrollee will be liable for premiums not paid. Others asked that we make clear that an enrollee may always choose to terminate his or her enrollment in a QHP sooner than the termination date included in paragraph (e)(3).

Response: We acknowledge commenters concerns regarding the potential for QHP liability during the available extension of coverage described in proposed § 155.330(e)(3), redesignated as § 155.330(f)(3). We will take into consideration such comments when developing the notice of eligibility determination sent to an enrollee when he or she loses advance payments of the premium tax credit after redetermination and ensure that an enrollee is aware of their responsibility to pay for his or her premium. Furthermore, the provision § 155.430(d)(3) of this final rule, which allows the enrollee to maintain eligibility for enrollment in a QHP without advance payments or cost-sharing reductions until the last day of the month following the notice of termination of coverage is sent, also makes clear that an enrollee may terminate his or her enrollment sooner than such date. We also clarify that the final rule does not provide that an enrollee must pay a premium if he or she does terminate coverage sooner than the date described in § 155.430(d)(3), but we acknowledge that this provision would not prevent an issuer from seeking out premiums owed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.330 of the proposed rule, with several modifications: we specified in paragraph (b)(1), that an enrollee must report any change with respect to the eligibility standard specified in § 155.305 within 30 days of such change; however, we added in paragraph (b)(1) exceptions to this standard as described in new paragraphs (b)(2) and (b)(3). In new paragraph (b)(2), we provide that individuals who did request an eligibility determination for all insurance affordability programs must not be required to report changes related to eligibility for insurance affordability programs. In new paragraph (b)(3), we specified that for changes in income, the Exchange may establish a reasonable threshold for such changes below which enrollees are not required to report. Also, in new paragraph (b)(4), we added that the Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report a change via all channels available for the ***18374** submission of an application, which are described in § 155.405(c).

We also created new paragraph (c), which describes the standards for the Exchange to verify changes reported by enrollees. We moved proposed paragraph (b)(2) and redesignated it as paragraph (c)(1) and added paragraph (c)(2), which describes that the Exchange must provide enrollees with periodic notifications regarding standards for reporting changes and the opportunity to report any change, to the extent the enrollee has elected to receive electronic notifications and has not opted out of periodic notifications regarding change reporting.

In new paragraph (d)(2), we added the opportunity for the Exchange to make additional efforts to identify and act on changes related to eligibility for insurance affordability programs, in addition to eligibility for enrollment in a QHP as previously proposed. We also removed the language that provided the Exchange with flexibility to conduct data matching during the benefit year, contingent upon HHS approval of a change to the Exchange Blueprint and instead included that this flexibility is subject to compliance with specific standards, including that such efforts would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable standards under § 155.260, § 155.270, § 155.315(i) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met. We also add that such efforts must comply with the newly designated paragraphs (e)(2) and (3).

In newly designated paragraph (e), we added paragraphs (e)(2) and (e)(3) to describe the procedures for redeterminations that Exchanges must follow upon identifying new information through data matching. In newly designated paragraph (e)(2), we specified that for all changes identified by the Exchange that are not related to income, family size and family composition, the Exchange must notify the enrollee of his or her projected eligibility determination and allow the enrollee 30 days from the date of the notice to inform the Exchange that such information is inaccurate. If the information is inaccurate, the Exchange must follow procedures related to resolving inconsistencies described in § 155.315(f). If the enrollee does not respond within the 30 day period, the Exchange must redetermine his or her eligibility using the new information. In newly designated paragraph (e)(3), we specify that for changes identified by the Exchange that are related to income, family size and family composition, the Exchange must notify the enrollee of his or her projected eligibility determination and allow the enrollee 30 days from the date of the notice to respond to the notice. If the enrollee responds within the 30 day period, the Exchange must redetermine his

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or her eligibility in accordance with the procedures for redetermining enrollee-reported data. If the enrollee does not respond within the 30 day period, we specified that the Exchange must maintain the enrollee's eligibility determination without the updated information.

In newly designated paragraph (f), we amended the provisions related to effective dates for redeterminations made in accordance with this section. In newly designated paragraph (f)(1), we clarified the exceptions to the provision regarding effective dates for implementing changes resulting from a redetermination. In newly designated paragraph (f)(2), we added that while an Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month specified in newly designated paragraph (f)(1). We clarify that such reasonable point must be no earlier than the cut-off date described in § 155.420(b)(1) of this part. In newly designated paragraph (f)(3), we also added a new reference to the effective dates described in subpart E to accommodate for renumbering.

We renumbered several paragraphs in this section to accommodate changes to the final rule. Also, in paragraph (d), which was previously designated as paragraph (c), we changed the title to "periodic examination of data sources."

h. Annual Eligibility Redetermination (§ 155.335)

In § 155.330, we proposed that the Exchange redetermine the eligibility of an enrollee in a QHP during a benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through data matching. We solicited comments on whether the redetermination based on changes reported or identified during the year should satisfy the annual redetermination as well, and if so, whether this should be a Federal standard or an Exchange option. We also solicited comment on how the interaction between Exchange eligibility and updated tax data can be streamlined, and at what point annual redeterminations should occur. Finally, we solicited comment regarding whether and how we should approach data matching related to redeterminations, and whether there were alternatives that could support the goals of this process.

We also proposed that the Exchange provide an enrollee with an annual redetermination notice and identified specific data elements that should be contained in the notice and solicited comment regarding the contents of the notice. In addition, we proposed that the Exchange direct an individual to report any changes relative to the information listed on the redetermination notice within 30 days of the date of the notice, and specified that the Exchange must verify any changes reported by the individual in response to the notice using the same verification procedures used at the point of initial application, including the provisions regarding inconsistencies.

We also proposed that an enrollee must sign and return the redetermination notice. We solicited comment on policy and operational strategies to improve the accuracy of redeterminations. We also solicited comment as to what steps the Exchange could take to ensure that redetermination minimizes burden on individuals, QHPs, and the Exchange without increasing inaccuracies.

After the conclusion of the 30 day notice period, we proposed that the Exchange determine an enrollee's eligibility based on the information provided to the enrollee in the redetermination notice, along with any information that an enrollee has provided in response to such notice that the Exchange has verified; notify the enrollee; and, if applicable, notify the enrollee's employer. If an enrollee does not sign and return the notice, we proposed that the Exchange redetermine an enrollee's eligibility based on the information provided in the notice. In addition, we proposed that to the extent that the Exchange is unable to verify a change reported by an enrollee as of the close of the 30 day period, the Exchange redetermine the enrollee's eligibility as soon as possible after completing verification.

We solicited comment as to whether the effective dates for changes made as a result of an annual redetermination should be different from the effective dates for changes made as a result of a redetermination that occurs during the coverage year.

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Finally, we proposed that if an enrollee remains eligible for coverage in a QHP upon annual redetermination, the enrollee will remain in the QHP selected the previous year unless the ***18375** enrollee takes action to select a new QHP or terminate coverage.

Comment: A number of commenters supported the provision in proposed § 155.335(a) to conduct eligibility redeterminations on an annual basis. Many commenters highlighted that this would avoid administrative burden, costs, and loss of eligibility. Several commenters suggested that HHS not provide for more frequent redeterminations.

Response: In the final rule, we maintain the standard in § 155.335(a) to redetermine eligibility on an annual basis. We address redeterminations during the coverage year in our responses to § 155.330.

Comment: The majority of commenters recommended that the timing of annual redetermination as described in proposed § 155.335 align with the annual open enrollment period as specified in § 155.410. Some commenters suggested combining the annual open enrollment notice with the annual redetermination notice. Many commenters recommended that the annual redetermination notice be distributed prior to the start of the annual open enrollment period. One commenter suggested sending the annual redetermination notice no later than 45 days prior to annual open enrollment. Another commenter recommended that HHS provide that Exchanges must send annual redetermination notices to enrollees no later than June 15th of each year. Commenters also suggested giving Exchanges flexibility to determine the best way to conduct redeterminations.

Response: In response to the large number of comments we received on this topic, we have set a timing standard in § 155.335(d) of this final rule for annual redetermination to align with annual open enrollment. In § 155.335(d)(1), we provide that the Exchange must provide the annual redetermination notice and the notice of annual open enrollment in a single, coordinated notice for the 2015 and 2016 benefit year. We believe this will reduce confusion among consumers and reduce administrative burden. In § 155.410(d), we specify that the notice of annual open enrollment will be provided no earlier than September 1 and no later than September 30. We expect that as the program matures, States may have a better understanding of the best time to release the annual redetermination notice, and therefore in § 155.335(d)(2) of this final rule, starting with annual redeterminations for coverage effective on January 1, 2017, we provide flexibility for Exchanges to adjust the timing and coordination of the redetermination notice in future years. The Exchange may exercise this flexibility to provide separate notices, provided that the timing of the redetermination notice is no earlier than the date of the notice of annual open enrollment specified in 155.410(d) and allows a reasonable amount of time for the enrollee to review the notice, provide a timely response, and for the Exchange to implement any changes in coverage elected during the annual open enrollment period; this is to ensure that the enrollee has adequate time to review available plans and change plans, if applicable.

Comment: We solicited comment regarding whether a redetermination during the benefit year should satisfy the annual redetermination standard. Several commenters opposed this concept. One commenter recommended that allowing a redetermination of eligibility during the coverage year to serve as a household's annual redetermination should be a State option. Several commenters recommended that HHS should not give Exchanges the flexibility to conduct redeterminations on a rolling basis. Commenters suggested that annual redetermination should occur at a consistent point in the year for all individuals when new tax data becomes available, regardless if eligibility was redetermined during the coverage year.

Response: We decided not to allow redeterminations during the benefit year to satisfy the annual redetermination for an enrollee. Due to the fixed coverage period and a set annual open enrollment period, we believe allowing for a rolling annual redetermination would create a situation where the Exchange may redetermine an enrollee's eligibility but the enrollee would not be able to switch plans because they would not qualify for an enrollment period. Additionally, we believe that because the annual redetermination relies on tax data which is updated at a specific time each year, rolling annual redetermination would add unnecessary complexity to the streamlined redetermination process. Finally, we also believe that this approach will increase the predictability of Exchange staffing and other resource needs.

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Comment: Some commenters suggested HHS clarify that enrollees do not have to submit a new application to complete the annual redetermination process. Several commenters recommended that an individual's information from initial enrollment should be retained and used during the redetermination process. Accordingly, commenters suggested that an enrollee should never have to re-enter any information during the annual redetermination process that has not changed. A few commenters specified that States should use an "ex parte" redetermination process, in which the Exchange attempts to redetermine the enrollee's eligibility using information from external data sources; under such a process, the Exchange only contacts the enrollee if additional information is needed. Commenters also suggested that Exchanges and States should use a "passive" redetermination process, through which an enrollee notifies the Exchange that he or she agrees with the information included in a redetermination notice by not responding. Several commenters suggested that pre-populated forms or applications be used for annual redeterminations. Many commenters expressed support for the proactive role of the Exchange in obtaining data from external data sources to assist in annual redetermination.

Response: We have maintained the provisions in § 155.335(c) of this final rule that outline information to be presented on the annual redetermination notice. We believe this will increase retention rates by helping to minimize the risk of individuals losing coverage when they remain eligible. We also believe this process will reduce administrative burden on the Exchange by reducing the steps necessary to redetermine eligibility. Furthermore, we add language to paragraph (c)(3) providing that the notice of annual redetermination must include eligibility for Medicaid, CHIP or BHP, if applicable, since the updated tax return information and data regarding MAGI-based income may indicate eligibility for Medicaid, CHIP or BHP, in addition to eligibility for advance payments of the premium tax credit and cost-sharing reductions.

Comment: Several commenters recommended specific information for the content of the annual redetermination notice as specified in proposed § 155.335(c). Items suggested include the date the redetermination will become effective, procedures to correct errors in data obtained or used in the enrollee's most recent eligibility determination, including the 30 day requirement to report changes specified in § 155.335(e), or where individuals may obtain additional information or assistance, including the Exchange Web site, call center, Navigators and other consumer assistance tools. One commenter felt that notices regarding annual redeterminations may be confusing to many consumers. Some commenters recommended that notices comply with standards in § 155.230 to ***18376** ensure meaningful access for limited English proficient enrollees. Others recommended that annual redetermination notices include information about rights to appeal.

Response: We provide general standards for all notices from the Exchange in § 155.230, which include accessibility and readability standards outlined in § 155.205(b)(2) and (b)(3). We intend to provide further interpretation regarding issuance of the annual redetermination notice in future guidance which may include a model of the annual redetermination notice and detail on content.

In response to comments, we would also like to clarify the differences between the notices outlined in § 155.335(c) and § 155.310(g) of this final rule. The redetermination notice in § 155.335(c) is the pre-populated form which includes the enrollee's updated information, including—in the case of an enrollee who allowed the Exchange to determine his or her eligibility for insurance affordability programs—updated tax return information and updated current income information. In accordance with § 155.335(e), this notice will be signed and returned by each enrollee to confirm information is up-to-date. After information on this notice has been verified and a final eligibility determination has been made, the Exchange will send a second notice described in § 155.310(g), as finalized in this rule, to notify the enrollee of the final eligibility determination for the upcoming benefit year.

Comment: Many commenters recommended that the final rule should specify that enrollees can report changes through the same channels available for the submission of an application (online, by phone, by mail, in person), as specified in proposed § 155.405.

Response: In 155.335(e)(2) of this final rule, we clarify that an enrollee or an application filer, on behalf of the enrollee, may report a change online, by phone, by mail, or in person. We identify these channels for an enrollee to provide additional

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information based on section 1413(b) of the Affordable Care Act and § 155.405, which identify how an applicant may submit an application. As the annual redetermination will be functionally the same as a new application for the next benefit year, the use of the same procedures is appropriate. We have also added this provision to § 155.330(b)(4), to allow an enrollee, or application filer on the enrollee's behalf, to report changes via the channels described in § 155.405.

Comment: Some commenters supported the standard set forth in the proposed rule that the verification processes related to changes reported as a part of the annual redetermination process specified in proposed § 155.335(e) be consistent with the processes specified in proposed § 155.315 and § 155.320. Many commenters suggested HHS specify timeframes by which the Exchange must verify changes reported by the enrollee in response to the annual redetermination notice. One commenter suggested a time period of 10 days by which to conduct the verification. Another commenter believed States should have the flexibility to be able to determine any time constraints or verification processes related to changes reported in response to the annual redeterminations.

Response: We support the standard to use the same verification processes for initial applications and for annual redeterminations. We believe that the timeliness standards for verification should be consistent with the standards § 155.310(e); we intend to provide more guidance on the interpretation of the timeliness standard.

Additionally, we would like to clarify that in order to conduct a redetermination as outlined in § 155.335, the Exchange must obtain an authorization from an enrollee to request his or her tax data. We anticipate that this authorization will be obtained during the initial application process, and that such authorization could be accomplished, for example, by allowing enrollees a chance to opt out of authorizing the use of tax data. An enrollee must provide an authorization for the Exchange to obtain tax data for annual redeterminations only if he or she chooses to allow the Exchange to determine his or her eligibility for insurance affordability programs. We also clarify that without such authorization, the Exchange will be unable to access tax return information and, subsequently, conduct an eligibility redetermination for insurance affordability programs.

The Secretary of Treasury will allow an individual to authorize the release of his or her tax data for use by the Exchange in verification of household income for a period of up to five years. In 155.335(k), we specify that the Exchange must have authorization from an enrollee in order to obtain his or her updated tax return information for purposes of conducting an annual redetermination. We specify that the Exchange may obtain this tax return information for a period of no more than five years, based on a single authorization. The Exchange must allow the individual to decline a five-year authorization or to authorize the Exchange to obtain tax return data for annual redetermination for a period of less than five years. We also specify that the Exchange must allow an individual to discontinue, change, or renew the authorization at any time. We expect that an enrollee will have an opportunity to reauthorize the Exchange to obtain tax return data whenever he or she reports changes, at annual redetermination, and in the course of other interactions with the Exchange. We believe this process will be minimally burdensome on the individual and on the Exchange.

In 155.335(l), we clarify that to the extent that an enrollee has requested an eligibility determination for all insurance affordability programs and has not authorized the request of tax data, the Exchange will redetermine the enrollee's eligibility for enrollment in a QHP, but must notify the enrollee that the Exchange will not proceed with the redetermination process until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability programs.

We also clarify that for purposes of providing updated data described in § 155.335(b), we expect that the Exchange will obtain the updated information for enrollees who, as of their most recent interaction with the Exchange, has requested an eligibility determination for all insurance affordability programs; as such, for an enrollee who requested an eligibility determination for insurance affordability programs but who was determined ineligible for advance payments of the premium tax credits or cost-sharing reductions, the Exchange would obtain updated information at annual redetermination, to the extent that the applicable authorization was in place.

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Comment: We received a large number of comments expressing concern over the requirement for enrollees to sign and return the annual redetermination notice when no changes have occurred, as specified in proposed § 155.335(f)(1). Commenters suggested the sign and return requirement was an unnecessary burden on consumers and Exchanges, since the Exchange is instructed to redetermine eligibility using the information on the notice even if the notice is not returned. A few commenters highlighted the current practice in Medicaid where annual redeterminations are completed without a signature required from the enrollee.

Response: While signing and returning the redetermination notice ***18377** will add an additional step in the redetermination process, due to the financial responsibility imposed on an individual accepting an advance payment of the premium tax credit as part of the reconciliation process, we believe it is important to collect a signature from an enrollee as a means of ensuring that he or she accepts this responsibility.

Comment: Several commenters supported proposed § 155.335(e), which provided that an enrollee correct any erroneous information on the redetermination notice and report changes to the information on the annual redetermination notice within 30 days. A few commenters urged HHS to consider extending the period enrollees are given to return the notice with reported changes consistent with the language in the Medicaid proposed rule, which provides States with the authority to increase this time period to more than 30 days.

Response: In the final rule, we maintain the standard of 30 days for an individual to report changes and believe this standard provides a reasonable amount of time for individuals to review the annual redetermination notice and submit changes as appropriate.

Comment: Commenters recommended adopting the effective dates outlined for the annual open enrollment periods in proposed § 155.410(f) as the effective dates for annual redeterminations, except for enrollees who become eligible for Medicaid as a result of an annual redetermination. In those cases, commenter recommended that Medicaid eligibility and coverage be effective on the first day of the month in which the eligibility determination is made.

Response: In § 155.335(i) of the final rule, we have modified the language in the regulation text to clarify that the effective date for the annual redetermination will be the first day of the coverage year following the year in which the Exchange provided the annual redetermination notice in § 155.335(c) or on the first day of the month following the eligibility notice to the enrollee in accordance with § 155.330(f), whichever is later. The latter part of this clarification addresses situations in which the eligibility determination is made by the Exchange in the benefit year for which the applicant is seeking coverage. The effective dates for annual redetermination should not be confused with the dates by which the Exchange must make a QHP selection effective during the annual open enrollment period as specified in § 155.410(f). Regarding commenters suggestions for the effective dates for individual determined eligible for Medicaid at annual redetermination, we clarify that coverage effective dates for Medicaid eligibility are governed by those standards found in Medicaid regulations at 42 CFR 435.915. In accordance with § 155.310(d)(3), the Exchange must transmit enrollee information promptly and without undue delay to the State Medicaid or CHIP agency so that he or she may be enrolled in Medicaid or CHIP. We note that in accordance with section 36B(c)(2) of the Code, eligibility for premium tax credits (including the advance payments) and cost-sharing reductions will terminate when an individual is eligible for minimum essential coverage, including Medicaid and CHIP coverage.

Comment: Several commenters supported the provision specified in proposed § 155.335(i) to allow an enrollee who remains eligible for enrollment in a QHP upon annual redetermination to remain in his or her QHP without the need to re-select it. One commenter suggested the provision aligns with the goal of a simple and consumer-friendly Exchange. Another commenter emphasized that no enrollee should be removed from coverage until the enrollee has been given notice of an eligibility determination and the right to appeal.

Response: We are finalizing without change the provision to allow an enrollee who remains eligible for enrollment in a QHP upon annual redetermination to remain in his or her QHP without the need to re-select it. We believe this provision will minimize disruptions in coverage for eligible enrollees and administrative burden for the Exchange, QHP issuers, and enrollees. We also

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clarify that references to termination in this provision only relate to termination initiated by the enrollee, which we believe addresses the commenter's concern about notices and appeals.

Summary of Regulatory Changes
We are finalizing the provisions proposed in § 155.335 of the proposed rule, with the following modifications: in paragraph (a), we noted that annual redeterminations are limited based on the new language in paragraph (l) of this section. In paragraph (b), we clarified that in the case of an enrollee who has requested an eligibility determination for all insurance affordability programs in accordance with § 155.310(b) of this subpart, the Exchange must request updated tax return information, if the enrollee has authorized the request of such tax return information. In paragraph (c), we added that the notice must also include an enrollee's projected eligibility determination, including eligibility for insurance affordability programs. In paragraph (d), we clarified the timing of the annual redetermination. For coverage effective January 1, 2015 and January 1, 2016, the Exchange must satisfy the notice provisions of paragraph (c) of this section and § 155.410(d) of this part through a single, coordinated notice. In paragraph (d)(2), we provided that for coverage effective January 1, 2017, the Exchange may send the annual redetermination notice separately from the notice of annual open enrollment, provided that certain restrictions on the timing of such notices are met.

In paragraph (e) of this section we clarified that the Exchange must allow an enrollee or an application filer, on the enrollee's behalf, to report changes via the channels available for the submission of an application, as described in § 155.405(c) of this part. We also added to paragraph (g)(1), that an application filer may sign and return the annual redetermination notice on an enrollee's behalf. In paragraph (i), we modified the standard for effective dates of annual redetermination to clarify that the Exchange must ensure that the annual redetermination is effective on the first day of the coverage year following the year in which the Exchange provided the notice in paragraph (c) of this section or in accordance with the rules specified in § 155.330(f), regarding effective dates, whichever is later. In new paragraph (k), we added language to specify that the Exchange must have authorization from an enrollee in order to obtain updated tax return information for purposes of conducting an annual redetermination. We also describe that any single authorization will extend for a period of no more than five years, and that an individual may authorize the Exchange to obtain tax data for a period of less than five years, or not at all. We also provide that the enrollee must be able to discontinue, change or renew an authorization at any time. In new paragraph (l), we added language to specify that to the extent that an enrollee who has requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) has not authorized the request of data described in paragraph (b), the Exchange must notify the enrollee in accordance with the timing described in paragraph (d), and not proceed with the redetermination process described in paragraphs (c) and (e) through (j) until such authorization has been obtained or the enrollee discontinues his or her request for an ***18378** eligibility determination for insurance affordability programs in accordance with § 155.310(b).

We also made a few technical corrections to this section including renumbering paragraphs (d) through (k) to account for additional regulation text and updated cross-references based on similar renumbering in other parts of this final rule. In paragraph (e)(1) we clarified that the reference to a notice is referring to the notice in paragraph (c) of this section. We also clarified that changes reported at annual redetermination must be verified according to the processes specified in § 155.315 and § 155.320. Finally, we clarified that the verification referred to in paragraph (h)(2) of this section is the same verification specified in paragraph (f) of this section.

i. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§ 155.340)
In § 155.340, we proposed reporting provisions for the Exchange related to advance payments of the premium tax credit and cost-sharing reductions. We proposed that in the event of a determination of an individual's eligibility or ineligibility for advance payments of the premium tax credit or cost-sharing reductions, including a change in the level of advance payments of the premium tax credit or cost-sharing reductions for which he or she is eligible, the Exchange provide information to the issuer of the QHP selected by the individual or in which the individual is enrolled.

We also proposed that the Exchange provide eligibility and enrollment information to HHS to enable HHS to begin, end, or adjust advance payments of the premium tax credit and cost-sharing reductions. We solicited comment on whether the information

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could be used by HHS to support any reporting necessary for monitoring, evaluation, and program integrity. We solicited comment as to how this interaction can work as smoothly as possible and the scope of information that should be transmitted among the relevant agencies.

We further proposed that the information transmitted to issuers include the information necessary to enable the issuer of the QHP to implement or discontinue the implementation, or modify the level of an individual's advance payment of the premium tax credit or cost-sharing reductions.

We proposed to codify the reporting rules in sections 1311(d)(4)(I)(ii) through (iii) and 1311 (d)(4)(J), which support the employer responsibility provisions of the Affordable Care Act. We proposed that when the Exchange determines that an applicant is eligible to receive advance payments of the premium tax credit based in part on a finding that his or her employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable as described in 26 CFR 1.36B-2(c)(3)(v) of the Treasury proposed rule, or does not meet the minimum value standard, as described in 26 CFR 1.36B-2(c)(3)(vi) of the Treasury proposed rule, the Exchange will provide this information to the Secretary of the Treasury. We proposed that the Exchange transmit such applicant's name and SSN to HHS, which will transmit it to the Secretary of the Treasury.

In the event that an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he or she has changed employers, we proposed that the Exchange transmit the enrollee's name and SSN to HHS, which will transmit it to the Treasury. We also proposed that in the event an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage in a QHP through the Exchange during a benefit year, the Exchange transmit his or her name and SSN and the effective date of the termination of coverage to HHS, which will transmit it to the Treasury. We proposed that the Exchange will also transmit his or her name and the effective date of the termination of coverage to his or her employer. Finally, we proposed that the Exchange must comply with the standards related to reconciliation of the advance payments of the premium tax credit specified in section 36B(f)(3) of the Code and 26 CFR 1.36B-5 regarding reporting to the IRS and to taxpayers.

Comment: We received a number of comments asking that we clarify how advance payments of the premium tax credit will be administered. Many comments suggested the use of electronic funds transfers, as well as electronic communications that are compatible with existing issuer infrastructure. Several commenters noted the importance of transparency and flexibility in establishing the standards regarding administration of the advance payment of the premium tax credit and cost-sharing reductions. Commenters suggested the need for further guidance on this topic.

Response: In § 155.340 of this final rule, we provide general standards for the exchange of information necessary for administration of advance payments of the premium tax credit and cost-sharing reductions, as well as to support the employer responsibility and reconciliation provisions of the Affordable Care Act. We anticipate providing more operational and procedural detail about these processes in future guidance.

Comment: Several commenters recommended that the proposed § 155.340(a) include a specific timeliness standard for the Exchange to transmit information to facilitate the administration of advance payments of the premium tax credit and cost-sharing reductions to the applicable QHP and HHS. Commenters recommended that the timeliness standard reflect the “real-time” expectation, but to provide for exceptions in instances when systems are not functioning properly. Some commenters suggested that the regulation specify that all transactions be completed within one business day from the initiating event (for example, the completion of an eligibility determination).

Response: In paragraph (d), we adopt, on an interim final basis, a timeliness standard that the Exchange must perform actions outlined in § 155.340(a) to enable advance payment of premium tax credits and cost-sharing reductions “promptly and without undue delay.” We also adopt this standard for transmission of information described in § 155.340(b). We intend to interpret this standard in future guidance.

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Comment: Several commenters raised various privacy concerns in response to proposed § 155.340(b)(2) and § 155.340(b)(3)(i) prescribing that the Exchange transmit information to HHS when an enrollee changes employers and in the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year. Some commenters raised concerns over the amount of burden placed on Exchanges to provide this information to HHS and the Secretary of Treasury. A large number of commenters suggested that the information provided be limited to a minimum amount of information, only name and taxpayer ID number. Many commenters recommended striking, “Social Security number,” and replacing it with, “taxpayer identification number.”

Response: We codified the transactions specified in § 155.340(b)(2) and § 155.340(b)(3)(i) from section 1311(d)(4)(I) of the Affordable Care Act, which specifies that they include name and taxpayer identification number. Accordingly, we have replaced, “Social ***18379** Security number,” with “taxpayer identification number.” We note that we have limited the information to be sent to HHS and to the Secretary of Treasury to be the information that is explicitly mentioned in section 1311(d)(4)(I). In addition, like all other activities related to personally identifiable information, the transactions specified in this section are subject to the privacy and security protections specified in § 155.260 of this final rule. Regarding concerns of burden on the Exchange, in addition to this being a statutory standard, we believe that this will largely be an automated process and that the submission of information to HHS and the Secretary of Treasury will not be overly burdensome.

Comment: A number of commenters sought more guidance on how cost-sharing reductions will be implemented and monitored. Commenters suggested HHS provide flexibility and transparency in establishing standards related to cost-sharing reductions.

Response: In § 155.340 of this final rule, we specify that the Exchange will transmit information about an enrollee's eligibility to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of cost-sharing reductions. We intend to provide future guidance on this issue and identify what we interpret to be the minimally necessary information for this purpose.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.340 of the proposed rule, with the following modifications: in § 155.340(a) we replaced 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; we have retained the use of the terms applicant and enrollee in connection with cost-sharing reductions because that statute does not limit eligibility for that benefit to tax filers or tax payers. In § 155.340(a)(2), we clarified that the Exchange must notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of an individual's advance payments of the premium tax credit or cost-sharing reductions, as applicable. In § 155.340(b)(2) and (b)(3)(i) of this section, we removed the standard that the Exchange transmit the enrollee's SSN and replaced it with taxpayer identification number. We also replaced the term “disenrolls” with “terminates coverage” to align with language used in § 155.430 of this part. We note that coverage terminations by the Exchange are limited to enrollment through the Exchange. For a more detailed discussion, please see the comment and response for § 155.430. We also add in paragraph (d) a timeliness standard for the transmissions of information described in paragraphs (a) and (b).

j. Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Plan (§ 155.345)

Based on comments and feedback to the proposed rule, we are revising the proposed rule to include paragraphs (a) and (g) of this section, and we are seeking comments on these provisions.

In § 155.345, we proposed standards for coordination across insurance affordability programs in order to implement a streamlined, simplified system for eligibility determinations and enrollment as part of the implementation of section 1413 of the Affordable Care Act. In this section, we also proposed standards for coordination between the Exchange and the Pre-Existing Condition Insurance Plan (PCIP), established in accordance with section 1101 of the Affordable Care Act.

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Specifically, we proposed that the Exchange enter into agreements with the State Medicaid or CHIP agencies as necessary to fulfill the Exchange responsibilities identified in this subpart. We proposed that as part of the eligibility determination process, the Exchange determine an applicant's eligibility for Medicaid and CHIP, in accordance with standards described in § 155.305 of this subpart, notify the State agency administering Medicaid or CHIP of that determination, and transmit relevant information necessary for the timely enrollment of the eligible individual into coverage. Upon making a determination of eligibility for Medicaid or CHIP, we indicated that the Exchange must also notify the applicant of the determination. We suggested that the Exchange may also facilitate delivery system and health plan selection for Medicaid and CHIP and solicited comments regarding whether and how this integration of delivery system selection could best work for the Exchange, Medicaid, and CHIP.

We also proposed that the Exchange perform a "screen and refer" function for those applicants who may be eligible for Medicaid in a MAGI-exempt category or an applicant that is potentially eligible for Medicaid based on factors not otherwise considered in this subpart. We proposed that the Exchange transmit eligibility information related to such application to the applicable State agencies promptly and without undue delay. In addition, we proposed that the Exchange provide advance payments of the premium tax credit and cost-sharing reductions to an individual who is found to be otherwise eligible while the agency administering Medicaid completes a more detailed determination.

We also noted, based on our interpretation of proposed Treasury § 1.36B-2(c)(2) published on the same day in the Federal Register, that an applicant who is referred to the Medicaid agency for additional screening and is enrolled in a QHP receiving advance payments of the premium tax credit in the interim would not be liable to repay advance payments if he or she is ultimately determined eligible for Medicaid and for any period of retroactive eligibility.

We proposed that the Exchange provide an opportunity for an applicant who is not automatically referred to the State Medicaid agency for an eligibility determination to request a full screening of eligibility for Medicaid by such agency. We proposed that to the extent that an applicant requests such a determination, the Exchange will transmit the applicant's information to the State Medicaid agency promptly and without undue delay.

We also proposed that the Exchange work with the agencies administering Medicaid and CHIP to establish procedures through which an application that is submitted directly to an agency administering Medicaid or CHIP initiates an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. In addition, we proposed that the Exchange utilize a secure, electronic interface for the exchange of data for the purpose of determining eligibility, including verifying whether an applicant requesting an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions has been determined eligible for Medicaid or CHIP, and other functions specified under this subpart. We also proposed that the Exchange utilize any model agreements established by HHS for the purpose of sharing data as described in this section. We solicited comment as to the content of these model agreements.

Finally, we proposed to develop procedures for the transition of PCIP enrollees to coverage in QHPs offered through the Exchanges to ensure that PCIP enrollees do not experience a lapse in coverage. We solicited comment on additional responsibilities that should be assigned to an Exchange as part of this process, such as providing ***18380** dedicated customer service staff for PCIP enrollees or actions that may accelerate or further streamline eligibility determinations for PCIP enrollees.

Comment: A large number of commenters supported a streamlined and coordinated eligibility determination process for all insurance affordability programs. A number of commenters also supported close alignment of policies between the Exchange and other insurance affordability programs to facilitate this streamlining and coordination. Commenters supported the standard specified in proposed § 155.345(a) that the Exchange enter into agreements with Medicaid and CHIP agencies. A few commenters suggested that language be added to regulation text to ensure that the Exchange eligibility determinations for Medicaid and CHIP comply with State plans and interpretive policies and procedures of the State agency or agencies administering the Medicaid or CHIP programs.

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Response: We believe that agreements between the Exchange and other insurance affordability programs are important for ensuring such alignment and coordination across programs. We also note that in § 155.300(b) of this final rule, we specify that, in general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with policies and procedures as applied by the State Medicaid or State CHIP agency or as approved by the State Medicaid or State CHIP agency. With that said, we have also added new § 155.302 in this final rule that describes in greater detail the options available for configuring responsibilities related to eligibility determinations, which clarifies that there is an option under which the Exchange does not make Medicaid or CHIP eligibility determinations but is considered to be compliant with this final rule; in such situations, the State Medicaid and CHIP agencies exercise final control over eligibility determinations for Medicaid and CHIP for applications submitted to the Exchange.

Additionally, we further clarify standards for coordination in § 155.345(a) of this final rule to align with those outlined in the Medicaid final rule. Such standards are set to provide a clear delineation of responsibilities of each program to minimize burden on individuals, ensure prompt determinations of eligibility, enroll eligible individuals into the program promptly and without undue delay, and ensure compliance with the standards set forth in subpart D. We encourage States to work closely across the Exchange, Medicaid, and CHIP to simplify and streamline eligibility processes to maximize efficiency and minimize administrative costs. In addition, in response to comments regarding coordinating policies across insurance affordability programs to avoid negative outcomes for consumers, we have added new 155.345(f), which provides a special rule for the limited number of situations in which a tax filer's household income, as defined in section 36B(d)(2) of the Code, is less than 100 percent of the FPL for the benefit year for which coverage is requested, the Exchange determines that the tax filer is not eligible for advance payments of the premium tax credit based on § 155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income. This provision describes that the Exchange must provide information and explanation to the applicant and tax filer in such situations; we clarify that this language is new text, but that it is a means to address gaps in eligibility rules and procedures. This provision will only have an impact after the Medicaid rule in 42 CFR 435.603(i) is applied, which specifies that the Medicaid agency will determine Medicaid eligibility using section 36B rules, which should result in Medicaid eligibility in most cases. As such, we believe that the provision in paragraph (f) will be used in a very limited set of cases, but will ensure individuals are not affected by gaps in eligibility rules.

Comment: Several commenters highlighted the importance of coordinating eligibility and enrollment for individuals who are determined eligible for Medicaid based on factors other than MAGI, for example those qualifying based on disability status. Many commenters to the proposed rule expressed concern that the Exchange standards in proposed § 155.345(b) through (d), which relate to those individuals potentially eligible for Medicaid based on factors not otherwise mentioned in this subpart were overly vague. Commenters requested that HHS provide further details and guidance on the “basic screening” standard specified in proposed paragraph § 155.345(b)(1). Several commenters urged HHS to strengthen the standard and others suggested the Exchange should ask a question or a set of questions to assess whether a person is eligible for Medicaid on a non-MAGI basis. Some commenters suggested striking a balance between gathering relevant information and not overburdening applicants with unnecessary questions. A few commenters suggested that States implement oversight mechanisms and protections to ensure that each applicant is directed to the most comprehensive benefits package to which he or she is entitled.

Response: We clarified that the Exchange must assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors not otherwise considered in this subpart. We believe the term “screening” may have been misleading as the intention of the provision was to simply check the application for an indication that an applicant may be potentially eligible for Medicaid based on factors not otherwise considered, such as disability or age. We appreciate commenters' concerns that the Exchange only gather relevant information and not overburden applicants, and we believe that this approach will meet these standards.

Comment: Many commenters raised concerns that individuals may be unaware of coverage that may be available to them and suggested that HHS clarify how an individual who is not found eligible for Medicaid based on MAGI will be notified of the opportunity to request a full eligibility determination for Medicaid. One commenter suggested that we provide example scenarios in the final rule to show when an applicant may be determined ineligible in a screening but eligible after a full

screening. Another commenter suggested the basic screening on factors other than MAGI could be confused as an eligibility determination. Some commenters suggested amending language in proposed § 155.345(c) such that the Exchange must notify applicants of the Medicaid programs that may be available to them so the applicant can request an appropriate determination of Medicaid eligibility from the State agency.

Response: To address this concern, in § 155.345(b) of this final rule, we specify that the Exchange will assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors other than MAGI. While not every individual who is potentially eligible for Medicaid based on non-MAGI factors will be identified through the assessment in § 155.345(b), we believe that this provision will help identify a substantial portion of those individuals.

***18381** We also clarify in § 155.345(c) of this final rule that the Exchange will notify an applicant of his or her opportunity to request a full determination of eligibility for Medicaid and provide the applicant such opportunity. We anticipate that Exchanges will work with State Medicaid agencies to craft notice text that reflects the options available in specific States for Medicaid eligibility based on factors other than MAGI. We have added to paragraph § 155.345(d) that the Exchange must notify the applicant during the application process that his or her application has been transmitted to the State Medicaid agency. We anticipate that such notices will be the subject of future guidance.

Comment: Many commenters highlighted the importance of seamless transmissions between coverage programs. Some commenters suggested clarifying, "promptly and without undue delay," and adding language providing that the Exchange must transmit the relevant information within 24 hours. A few commenters suggested that HHS establish standards for the State Medicaid agency to follow up on referrals it receives from the Exchange.

Response: We believe it would be more appropriate to interpret such a standard in guidance, which will allow it to evolve with technology and supporting business processes.

Comment: A few commenters also recommended aligning with Medicaid language to clarify that relevant information transmitted to Medicaid or CHIP agencies includes the electronic account containing the finding of Medicaid or CHIP eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such a finding.

Response: We adopt the following standard to implement such a standard: the Exchange must transmit all information provided on the application and any information obtained or verified by, the Exchange to the State Medicaid agency. As discussed in more detail above, this Exchange final rule does not use the term "electronic account" but we believe that the scope of our standard appropriately aligns with the language in the Medicaid final rule on this point.

Comment: The majority of commenters supported the standard to provide advance payments of the premium tax credit to individuals seeking a determination of Medicaid eligibility on a basis other than MAGI until the State Medicaid agency notifies the Exchange that the applicant is eligible for Medicaid. Commenters highlighted that this standard encourages applicants to obtain the most comprehensive coverage for which they are eligible. Commenters also noted this standard is vital to ensuring that consumers have access to continuous health coverage while they navigate the eligibility and enrollment process in their State. One commenter recommended that applicants be able to waive enrollment in a QHP while awaiting a Medicaid/CHIP determination.

Response: We maintain this provision in the final rule. We clarify that this provision applies both when an applicant has not been determined eligible for Medicaid based on MAGI and either is referred by the Exchange to the State Medicaid agency based on screening, or requests a full Medicaid eligibility determination. We also clarify that an applicant is never required to enroll in a QHP while a full Medicaid determination is underway; the Exchange must provide eligibility, but it is the choice of the applicant whether to actually select a QHP. We also clarify that this provision would apply only to the extent that the responsibility to

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conduct a determination for Medicaid eligibility on bases other than MAGI has not been delegated to the Exchange, through an agreement between the Exchange and the State Medicaid agency.

Comment: A few commenters said that the proposed process in § 155.345(d) for applications submitted directly to Medicaid, CHIP, or BHP was vague and should be clarified to specify that such agencies will screen applicants to determine whether they are eligible for enrollment in a QHP with or without advance payments of the premium tax credit and cost-sharing reductions, and then "enroll" eligible applicants. Many commenters supported the provisions in proposed § 155.345(d) that specified that an Exchange may not be required to duplicate any eligibility or verification findings that have already been made by agencies administering Medicaid, CHIP, or the BHP, where applicable. A few commenters suggested that language be added to clarify that Exchanges are not permitted, not simply "not required," to duplicate eligibility and verification findings made by the Medicaid or CHIP agency.

Response: In § 155.345(g) of this final rule, we clarify our intention to maintain a streamlined eligibility determination process for consumers. Consistent with the Medicaid final rule, we add standards for how agencies administering Medicaid, CHIP, and BHP will transmit an application to the Exchange and how the Exchange will take the necessary steps to process such applications. We note that the Medicaid final rule provides additional information regarding the responsibilities of the Medicaid agency with regards to applications submitted directly to Medicaid. In § 155.345(g)(2), we clarify that the Exchange must not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart and in § 155.345(g)(3). We also clarify that the Exchange must not request information or documentation from the individual already provided to Medicaid, CHIP, or BHP that was included in the transmission to the Exchange. Additionally, in § 155.345(g)(6) of this final rule, we specify that the Exchange must provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application. This provision is intended to ensure that an application that is submitted to a State Medicaid or CHIP agency follows the same processes for a complete MAGI-based determination of eligibility to enroll in a QHP, advance payments of the premium tax credit, and cost-sharing reductions.

Comment: Commenters supported the provisions in proposed § 155.345(e) to use of a secure electronic interface to transmit data among the various agencies responsible for determining eligibility for the insurance affordability programs.

Response: We maintain these provisions in the final rule. In addition to these standards, we have also further specified standards for data sharing in § 155.260 in this final rule. More information can be found in the responses to comments found in that section.

Comment: Several commenters requested guidance or standards in proposed § 155.345(i) regarding the transition of Pre-existing Condition Insurance Plan (PCIP) enrollees into the Exchange, and many commenters provided specific suggestions as to what this guidance should consider. Some specific recommendations provided include that the Exchange should develop an agreement with PCIP; the Exchange and PCIP should coordinate to develop a letter informing PCIP enrollees of what they need to do to transition to the Exchange; customer service resources should be dedicated and trained to assist these enrollees to transition smoothly; and others provided recommendations regarding outreach, education, and information that should be provided to PCIP enrollees, frequently citing provider ***18382** directories as an example of information that needs to be clearly provided to PCIP enrollees. Some commenters recommended that information be transferred between the PCIP and Exchange programs to reduce the need for the Exchange to request duplicative information from PCIP enrollees and to ease their transition into the Exchange.

Several commenters emphasized that flexibility be given to States to accommodate the transition of PCIP enrollees due to concerns related to the influx of large numbers of high-risk people. Some of these commenters recommended that HHS consider allowing the Exchange to transition PCIP enrollees into 2014 and years beyond. One commenter recommended that the Federal government should not assign specific responsibilities to State-operated Exchanges relating to transitioning PCIP enrollees into Exchanges, while another commenter suggested that HHS evaluate mechanisms to ensure that a distribution of enrollees is balanced among QHPs in the Exchange.

Response: We will consider these comments as we develop future guidance to support a smooth transition of PCIP enrollees into the Exchange that minimizes disruption in the insurance marketplace to the greatest extent possible, while also ensuring that this population has access to affordable, high-quality health insurance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.345 of the proposed rule, with several modifications: in § 155.345(a), we clarified that the Exchange must provide HHS with copies of any agreements made with other agencies administering insurance affordability programs upon request. We clarified that agreements must include a 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 paragraphs (c), (d), (e), and (g) of this section. We also modified language in § 155.345(b) to specify that for an applicant who is not eligible for Medicaid based on the standards specified in § 155.305 of this subpart, the Exchange must assess the information provided on the application to determine whether he or she is potentially eligible for Medicaid based on factors included in the streamlined application, but not otherwise considered in this subpart.

In § 155.345(c) of this final rule, we added that the Exchange must provide, and notify an applicant of, the opportunity to request a full determination of eligibility for Medicaid. We also add that the Exchange must provide notification and opportunity for a full determination of eligibility for Medicaid when making a determination in accordance with § 155.330 and § 155. 335. We modified language in § 155.345(d) to specify that if the Exchange identifies an applicant as potentially eligible for Medicaid or an applicant requests a full determination for Medicaid, the Exchange must transmit all information provided on the application and any information obtained or verified by the Exchange to the State Medicaid agency promptly and without undue delay.

In addition, we clarified language in § 155.345(e) to provide that if an applicant potentially eligible for Medicaid is otherwise eligible for advance payments of the premium tax credit and cost-sharing reductions, the Exchange must provide the applicant with such advance payments of the premium tax credit or cost-sharing reductions until Medicaid notifies the Exchange that the applicant is eligible for Medicaid. We amended § 155.345(f) to add a special rule to address situations in which a tax filer's household income is below 100 percent of the FPL for the benefit year for which coverage is requested, the tax filer is not eligible for advance payments of the premium tax credit based on § 155.305(f)(2), and one or more applicants in the tax filer's household is ineligible for Medicaid and CHIP based on income, in which case the Exchange must provide the income information used in the Medicaid and CHIP determination to the applicant, and then repeat the verification process. We modified § 155.345(g)(1) to include the standards set forth in the Medicaid final rule and outline that the Exchange 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, if a BHP is operating in the service area of the Exchange, for the individual, and not require submission of another application; (2) not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart; (3) not request information or documentation from the individual already provided to another insurance affordability program; (4) promptly and without undue delay determine eligibility of the individual for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions, in accordance with this subpart; and (5) provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application. Additionally, we renumbered paragraphs (c) through (i) to account for the changes described above.

We also made two technical corrections. First, we amended the phrase "providing advance payments of the premium tax credit" to "providing eligibility for advance payments of the premium tax credit". Second, we changed, "Pre-Existing Condition Insurance Program" to "Pre-Existing Condition Insurance Plan" to match the actual name of the plan.

k. Special Eligibility Standards and Process for Indians (§ 155.350)

In accordance with section 1402(d)(1) of the Affordable Care Act, in § 155.350(a), we proposed that the Exchange determine eligibility for cost-sharing reductions for an applicant who is an Indian if he or she meets the standards related to eligibility

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for enrollment in a QHP and has household income that does not exceed 300 percent of the FPL. We also proposed to clarify that the Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP. In addition, in § 155.350(b) we provided that the Exchange must determine an applicant eligible for the special Indian cost-sharing rule in accordance with section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination that provides for collection or verification of income.

We further proposed a two-phase process by which the Exchange must verify an individual's attestation that he or she is an Indian for purposes of determining whether he or she qualifies for these cost-sharing rules. In paragraph (c)(1), we proposed that the Exchange must verify an applicant's attestation that he or she is an Indian if an applicant submits satisfactory documentation to support their attestation of citizenship or lawful presence in accordance with § 155.315(e). In paragraph (c)(2), we proposed that the Exchange must rely on any available electronic data sources that have been authorized by HHS. Lastly, if the process under (c)(1) does not occur or data sources are unavailable, the individual is not represented in the source, or the source is not reasonably compatible with the applicant's attestation, we proposed that ***18383** the Exchange follow the standard inconsistency procedures under § 155.315(e). We solicited comment on the availability and usability of electronic data sources, as well as best practices for accepting and verifying documentation related to Indian status.

Comment: One commenter sought clarification about proposed § 155.350(b), which codifies section 1402(d)(2) of the Affordable Care Act. The commenter noted that this section appears to apply only to those services received at the IHS, and the commenter asked if it also applies to referrals to outside specialists, etc. The commenter further suggested that the proposed regulations appear to go beyond what the statute asks and recommends that the special cost-sharing provisions be limited to those services furnished through Indian Health Providers.

Response: Our intent is to adhere to the statute. In accordance with section 1402(d)(2) of the Affordable Care Act, the cost-sharing rule described in § 155.350(b) of this final rule is limited to only an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

Comment: Several commenters generally requested that all applicants and potential applicants be given notice that there may be benefits and protections that apply if the applicant is an Indian. One commenter recommended that determining Indian status should be a one-time occurrence, and the commenter further requested that any data matching system used to identify eligible American Indians or Alaska Natives should only provide information essential to establish whether an individual is an Indian in order to protect the privacy of the individual from unwarranted intrusions. The commenter acknowledged that there will be cases in which further verification is necessary or where there is a gap in information available through data matching, and that there should be other vehicles by which an individual can establish qualifications for benefits and protections as an American Indian or Alaska Native. Another commenter suggested that any reasonable documentation be accepted, and lists a number of potential documents that would satisfy this policy. One commenter recommended that Indians with tribal enrollment cards should be able to submit their tribal enrollment number on their application.

Response: We anticipate that verification of Indian status for purposes of determining eligibility for Exchange-related benefits will only be a one-time occurrence for applicants. Additionally, the utilization of any electronic data sources for purposes of verification of Indian status will be subject to the privacy and security standards outlined in § 155.260 and § 155.270 of this final rule, as is the case for all data acquired and used by the Exchange in the eligibility determination process. Lastly, under § 155.350(c)(3) of this final rule, we reference section 1903(x)(3)(B)(v) of the Act for standards for acceptable documentation, which includes documents issued by Federally-recognized tribes. These standards for acceptable documentation provide uniformity in process for applicants claiming Indian status.

Comment: A few commenters recommended that the Exchange accept self-attestation for verification of Indian status, stating that self-attestation should be sufficient if the application questions are framed in a way that can be used to determine eligibility. One commenter suggested that verification of Indian status only be conducted when there are inconsistencies that cannot be resolved through simple explanation and attestation by the individual, or if there is some indication of fraud on the part of the

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individual, and further recommended that if electronic data sources are utilized to verify Indian status, that the only appropriate data source is the registration database used by Indian Tribe, Tribal Organization, or Urban Indian Organization programs.

Response: We are maintaining the verification process described under § 155.350 in this final rule. This verification is tied to a full exemption from cost-sharing, which could involve a substantial expenditure for the Federal government; consequently, we are specifying a more stringent process for verification though we note that § 155.315(h) allows the Exchange flexibility to modify this and other verification processes with HHS approval. In addition, we note that the documentation process described under § 155.350(c)(3) is similar to the documentation process utilized by the IHS when determining eligibility for American Indians/Alaska Natives who seek services at IHS facilities. The standard for Exchanges is slightly different from the standard for such services, however, which means that the registration database for Indian Tribe, Tribal Organization, or Urban Indian Organization programs may not be a one-to-one match. With that in mind, we are working closely with the IHS and intend to work with States and tribes to determine whether and how electronic data can support this process.

Comment: Several commenters recommended that American Indians be determined eligible for advance payments of the premium tax credit and cost-sharing reductions through the Exchange even if they have access to qualifying coverage in an eligible employer-sponsored plan, notably because cost-sharing may be more costly for the employer-sponsored plan in comparison to that for a QHP through the Exchange given the special cost-sharing benefits provided for Indians under section 1402(d) of the Affordable Care Act. Other commenters recommended that American Indians under 300 percent of the FPL should be exempt from both cost-sharing and premiums for QHPs through the Exchange.

Response: The comment regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions based on eligibility for qualifying coverage in an eligible employer-sponsored plan is addressed in responses associated with § 155.320(e). Additionally, in accordance with section 1302(c)(3) of the Affordable Care Act, the definition of "cost-sharing" as provided does not include premiums; therefore, HHS does not interpret this statutory provision to say that the special cost-sharing benefits provided to Indians under section 1402 of the Affordable Care Act includes an exemption from premiums for a QHP through the Exchange. Nothing in this final rule impacts an Indian's ability to access IHS facilities at no cost-sharing.

Summary of Regulatory Changes

For the reasons described in the proposed rule and considering the comments received, we are finalizing the provisions proposed in § 155.350 of the proposed rule, with the following modifications: In paragraph (a)(1)(i), we clarify that in accordance with section 1402(f)(2) of the Affordable Care Act, an applicant must be eligible for advance payments of the premium tax credit in order to receive cost-sharing reductions based in part on household income. In paragraph (a)(1)(ii), we add a citation to clarify that for purposes of cost-sharing reductions under paragraph (a)(1), household income is defined in section 36B(d)(2) of the Code and FPL is defined in section 36B(d)(3) of the Code.

l. Right to Appeal (§ 155.355)

In § 155.355, we proposed that an individual may appeal any eligibility determination or redetermination made by the Exchange, including determinations of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost- ***18384** sharing reductions. We noted that we intend to propose the details of the individual eligibility appeals processes, including standards for the Federal appeals process, in future rulemaking.

Comment: We received a number of comments in support of our proposal that the Exchange must provide a notice of the right to appeal and instructions on how to file an appeal of any aspect of an eligibility determination in accordance with proposed § 155.310(g), § 155.330(d), or § 155.335(g). However, several commenters recommended that we provide greater detail around the appeals process in the final rule, including specific standards for the notice, coordination or integration with the Medicaid and CHIP appeals processes, and alignment of standards with Medicaid.

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Response: We acknowledge the importance of providing greater detail regarding the appeals process, and will do so in future rulemaking.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.355 of the proposed rule, with the following technical modifications: In paragraph (a), we added "eligibility" to describe the determination notice. We also edited the references to other sections of subpart D to account for renumbering.

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

In subpart E, we outline the initial, annual, and special enrollment periods as well as the enrollment process and the termination of coverage process.

a. Enrollment of Qualified Individuals into QHPs (§ 155.400)

In § 155.400, we proposed that the Exchange must: (1) Accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP; (2) notify the issuer of the applicant's selected QHP; and (3) transmit information necessary to enable the QHP issuer to enroll the applicant. We also proposed that the Exchange send QHP issuers enrollment information on a timely basis, and sought comment as to whether we should establish a specific frequency for enrollment transactions, such as in real time or daily, in our final rule. Finally, to ensure that the Exchange and QHP issuers have identical plan enrollment records, we proposed that the Exchange maintain records of enrollment, submit enrollment information to HHS, and reconcile the enrollment files with the QHP issuers no less than monthly.

Comment: With respect to proposed § 155.400(a), several commenters recommended adding the limitation that the Exchange transmit "only" information necessary to effectuate enrollment. Commenters further recommended HHS identify the information that Exchanges should transmit to QHP issuers.

Response: We outline the limitations for information the Exchange may collect, use or receive in § 155.260 of this final rule, which addresses privacy and security of information. Across all functions, the Exchange will only acquire, maintain, and disclose information that is necessary for Exchange operations. Specific data elements for transmission to QHP issuers will be identified at a later date.

Comment: One commenter recommended allowing Exchanges to contract with safety net providers to conduct enrollment activities, similar to the activities they perform for Medicaid.

Response: In general, the Exchange has discretion to contract with an eligible contracting entity to perform Exchange functions on its behalf, as outlined in § 155.110 of this final rule. Furthermore, § 155.210(c)(2)(viii) of this final rule allows for "other public or private entities that meet the standards of this section," to serve as Navigators, including "State or local human service agencies."

Comment: One commenter encouraged the Exchanges to initiate what it referred to as a preliminary "pipeline" reporting under proposed § 155.400(a), so that QHP issuers would have a sense of the enrollment volume they might expect over the next month, particularly during, and leading up to open enrollment periods.

Response: Exchanges have the flexibility to notify QHP issuers of the number of individuals who have received eligibility determinations for coverage through the Exchange, as well as to work with QHP issuers to define other operational communications that would streamline administration. We do not believe it is necessary or within statutory authority for Exchanges to share any personally identifiable information with QHPs about individuals who have not selected the QHP issuer's offering.

Comment: Several commenters noted that the success of health reform hinges on individuals' ability to easily enroll in, and retain coverage. They generally recommended instituting enrollment processes that do not overburden individuals with paperwork and documentation.

Response: We believe the streamlined application discussed in § 155.405 and the Internet Web site discussed in § 155.205 of this final rule will help to achieve a streamlined process for all applicants. In addition, in § 155.315(g) of this final rule, we codify a provision of the Affordable Care Act that specifies that an applicant does not have to provide information beyond the minimum necessary to support the eligibility and enrollment process.

Comment: One commenter recommended that QHP issuers be responsible for the enrollment of participants in the Exchange in accordance with proposed § 155.400(a), since they currently facilitate the enrollment process, and will continue to do so for products outside of the Exchange.

Response: Prior to enrollment by the QHP issuer, the Exchange will need to transmit enrollment information to the QHP issuer because the individual must have an eligibility determination for coverage, and, if interested, for advance payments of the premium tax credit and cost-sharing reductions. Furthermore, the Exchange must report enrollment information to HHS in order to initiate advance payments of the premium tax credit and cost-sharing reductions. Once enrollment information has been provided by the Exchange, the QHP issuer is ultimately responsible for effectuating enrollment.

Comment: One commenter noted that the proposed provision in § 155.400(a)(2) for the Exchange to transmit information necessary to enable the QHP issuer to enroll the applicant, appears to be inconsistent with the proposed § 155.205(b)(6), now redesignated in this final rule as § 155.205(b)(5), which established that the Exchange Web site must have the capacity to allow enrollment. The commenter asked HHS to clarify whether these are intended as alternatives.

Response: We have clarified language in this final rule at § 155.205(b)(5) to ensure that the Exchange Web site allows consumers to make a QHP selection, thereby initiating the enrollment process. Section 155.400(a)(2) of this final rule describes the subsequent step in the enrollment process, and establishes that Exchanges must transmit the QHP selection to the appropriate QHP issuer.

Comments: Many commenters requested clarification on the definition of a "timely" transmittal of enrollment information from the Exchange to QHP issuers, as discussed in proposed § 155.400(b)(1). Some suggested specifying "daily," "real-time," or leaving the definition to State flexibility.

***18385** Response: In this final rule, we have modified the regulatory text in § 155.400(b)(1) to be consistent with § 155.340(d), which states that Exchanges must send eligibility information to both QHP issuers and to HHS promptly and without undue delay. We expect Exchanges will send each QHP issuer an automated file of applicable eligibility and enrollment transactions, and simply include HHS on the transmission. HHS will issue future guidance outlining standards and timing for these transmissions. We further expect Exchanges to use the monthly reconciliation standards outlined in § 155.400(c) and § 155.400(d) to ensure consistency in enrollment records.

Comment: A few health insurance issuers cautioned that the QHP issuer's acknowledgement of the receipt of an enrollment transaction under proposed § 155.400(b)(2) is not a confirmation that the information is complete. The commenters stated that it should be the responsibility of the Exchange to ensure that the eligibility and enrollment information being sent to the QHP issuer is complete and accurate. One commenter recommended a strong file validation protocol, so that any incomplete or conflicting records were identified prior to submission.

Response: The intent of the acknowledgement standard in § 155.400(b)(2) is to ensure that QHP issuers accept responsibility for completing an individual's enrollment. We expect Exchanges will establish a process by which the QHP issuer signifies

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that it has received complete and accurate enrollment information, and if it does not, promptly notifies the Exchange that the information is insufficient to complete enrollment.

Comment: One commenter recommended that QHP issuers acknowledge the receipt of eligibility and enrollment information, as described in proposed § 155.400(b)(2), to both the Exchange and the applicant, while one health insurance issuer recommended that State laws govern communication between QHP issuers and enrollees.

Response: We clarify in part 156 the information that QHP issuers must provide to enrollees. As finalized in § 156.260(b), the QHP issuer must provide notice of the effective date of coverage and must provide new enrollees an enrollment information package as an acknowledgement of enrollment as described in § 156.265(e). However, we note that Exchanges may apply additional rules to ensure an optimal consumer experience, such as notifying the applicant that the Exchange has transmitted enrollment information to the QHP issuer.

Comments: Several commenters requested clarification on reporting standards under proposed § 155.400(c), including timing, format, and content. Some commenters requested that the HHS reporting standard be omitted. One State agency recommended that State regulators have unfettered access to all data sets used for and by Exchanges.

Response: As noted above, HHS plans to provide guidance on timing, format, and content of the enrollment information transmissions required under § 155.400 of this final rule. We have removed the standard in proposed § 155.400(c) for Exchanges to submit enrollment information to HHS on a monthly basis, because § 155.400(b)(2) of this final rule directs Exchanges to send eligibility and enrollment information to HHS “promptly and without undue delay.” With respect to the comment on the ability of State regulators to have access to all data collected and used by Exchanges, we note that data sets that contain personally identifiable information, and that are used by an Exchange while the Exchange is fulfilling its responsibilities in accordance with § 155.200(c), may only be disclosed if such disclosure is consistent with § 155.260. Disclosures for other purposes must be consistent with applicable Federal and State laws.

Comment: For the reporting and reconciliation standards outlined in proposed § 155.400(c) and § 155.400(d), one commenter requested clarification to ensure that Exchanges may collect monthly enrollment and termination data directly from insurers. The commenter sought to eliminate the need for the Exchange to collect this information on a case by case basis, compile it, and then reconcile it with issuers; all activities that the commenter stated are not feasible under a free market model where the Exchange Web site may not be tracking an individual's coverage choices.

Response: Per subpart D of both the proposed and final rules, the Exchange must make a determination of an individual's eligibility in order for a person to enroll in a QHP through the Exchange. In addition, per § 155.340(a), the Exchange must know which QHP a qualified individual has selected in order to make any advance payments of the premium tax credit. We do not believe that collection of enrollment data from issuers on a monthly basis would be sufficient to meet these standards, and therefore maintain the policy in § 155.400 of this final rule.

Comment: Most commenters supported a minimum monthly reconciliation under § 155.400(d), as long as Exchanges retained flexibility to reconcile more frequently. One health insurance issuer recommended reconciling only the cases with changes on a more frequent basis, while reconciling the full case load on a quarterly basis.

Response: In this final rule, we maintain the requirement in § 155.400(d) for monthly reconciliation, and require Exchanges to reconcile enrollment information with HHS in addition to QHP issuers. Exchanges have flexibility to reconcile some or all cases more frequently. We expect that Exchanges will work to minimize enrollment discrepancies, to automate reconciliation where possible, and to streamline any manual reconciliation activities that remain necessary.

Summary of Regulatory Changes

We are finalizing the standards proposed in § 155.400 of the proposed rule with the following modifications: In § 155.400(b) regarding the timing of data exchanges, we specify in the final rule that the Exchange must send enrollment information to both QHP issuers and HHS promptly and without undue delay. In § 155.400(c) we remove the standard that Exchanges submit enrollment information to HHS on a monthly basis. In § 155.400(d), we establish that Exchanges must reconcile enrollment information with both QHP issuers and HHS no less than on a monthly basis. We also made a few non-substantive edits to streamline the regulatory text.

b. Single Streamlined Application (§ 155.405)

In § 155.405, we proposed to codify that a QHP issuer must use the single streamlined application for qualified individuals and employers to enroll in QHPs through the Exchange. We also offered States the option to develop an alternative application, subject to approval by HHS. We sought comment regarding whether we should establish that applicants do not have to answer questions that are not pertinent to the eligibility and enrollment process.

We further proposed that the Exchange must accept applications from multiple sources including the applicant, an authorized representative (as defined by State law), or someone acting responsibly for the applicant; and that an individual must be able to file an application online, by telephone, by mail, or in person. We solicited comment on whether an individual must be able to file an application in person.

***18386** Comment: A handful of commenters urged that the application described in proposed § 155.405(a) enable eligibility determinations for other human services programs such as the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) in addition to Medicaid, CHIP, and BHP.

Response: In this final rule, we are only establishing that the application support eligibility for Exchange coverage and insurance affordability programs. With that said, States can decide to use HHS-approved alternative applications that include human services programs.

Comment: Some commenters suggested that all States should use the HHS-created application and requested that we strike proposed § 155.405(b) from this section, which pertains to alternative applications. Issuers were concerned that they could be subjected to too much variation in Exchange applications. Other commenters supported our proposal to give States flexibility to create an alternative application should they desire.

Response: Section 1413(b)(1)(B) of the Affordable Care Act directs HHS to allow a State to develop and use its application, subject to compliance with standards. We do not believe that variations in applications will place a burden on QHP issuers since the necessary enrollment information will be consistent across Exchanges. In addition, we reiterate our position in the proposed rule that the single streamlined application has been developed to meet the requirement for a uniform enrollment form, as set forth in section 1311(c)(1)(F) of the Affordable Care Act. We further clarify that the single streamlined application, or an HHS-approved Exchange alternative application, must be used for enrollment in a QHP through the Exchange only. Per § 156.265 of the final rule, a QHP can satisfy the standard regarding use of the single streamlined application by directing the individual to file the single streamlined application with the Exchange, or ensuring the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

Comment: Numerous commenters urged HHS to add language to proposed § 155.405 stating that the standard single streamlined application should not include questions that are not pertinent to the eligibility and enrollment process. Other commenters wanted to ensure that the application will collect demographic information beyond what is established in the statute.

Response: The Exchange eligibility proposed rule and this final rule at § 155.315(g) prohibit Exchanges from requiring information beyond the minimum necessary to support eligibility determinations for the Exchange and insurance affordability programs. This provision limits the application to information that is pertinent to the eligibility and enrollment process.

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Comment: Numerous commenters expressed support for allowing an applicant to file an application in person, as described in the preamble to § 155.405 in the proposed rule. A handful of commenters also urged HHS to go further and establish that Exchanges must allow individuals to submit, change, or renew coverage at numerous locations, including social service offices, welfare offices, community-based organizations, and any other pathway that accepts applications for government health benefit programs. Some commenters expressed concern that the proposed regulation did not ensure effective communication for individuals with disabilities because it did not provide for assistance when filing an application in person. Other commenters suggested that HHS establish that Exchanges must provide in-person assistance in a number of different locations throughout States.

Response: We are maintaining the standard that applicants should be able to file an application for an eligibility determination through the Exchange and other insurance affordability programs in person. We have added to regulation text in § 155.405(c)(2)(iv) to establish that the facilities where someone files an application in person comply with the Americans with Disabilities Act. However, Exchanges have the flexibility to determine the venues at which applicants may file in person, which will allow Exchanges to configure staffing to meet the specific characteristics of each State. We encourage Exchanges to consider allowing enrollees to submit changes or complete the annual redetermination process at an in-person location. We are not, however, amending this in the final rule.

Comment: A handful of commenters suggested that an Exchange could fulfill the standard to accept applications in person in accordance with proposed § 155.405(c)(2) through its Navigator program. These commenters stated that in-person assistance may be burdensome for the States, but Navigators are a natural venue for such assistance.

Response: An Exchange has flexibility in how it structures it Navigator program and may use such a program to meet the standard for in-person application filing and to provide assistance to individuals applying for coverage through the Exchange.

Comment: Some commenters requested that the application provide meaningful access for individuals who are LEP, provide effective communication for individuals with disabilities, and also that the application be translated into a number of different languages. Some commenters recommended the application be translated into no fewer than 15 languages.

Response: We address meaningful access issues and concerns in § 155.205(c) as well as in § 155.230(b) of this final rule. Additional guidance issued at a later date will coordinate our accessibility standards with insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services, and access standards.

Comment: A significant number of commenters asked for clarification on who can qualify as an authorized representative to file an application on behalf of an applicant under proposed § 155.405(c)(1) and, in particular, on what HHS meant by "someone acting responsibly for the applicant" and how this role is different from an authorized representative. Other commenters asked for more details on the privacy standards that will be applied to authorized representatives and others assisting with the application process. Additionally, commenters thought that the final rule should specify that a Navigator cannot apply on behalf of the individual without the signed consent of an individual or an individual's parent, guardian, court-designated representative, or legally-approved family member.

Response: We expect to provide future guidance regarding who may serve as an authorized representative; we intend for this to track against who can serve as an authorized representative under Medicaid. We also note that a single application may have both an application filer and an authorized representative. In paragraph § 155.405(c) of this final rule, we state that an "application filer" may file the application, and we have added a corresponding definition in § 155.20 in this final rule that notes that an application filer includes authorized representatives as well as someone acting responsibly for the applicant, if ***18387** the applicant is a minor or incapacitated. This change clarifies situations when someone acting responsibly for the applicant might file an application. In addition, the privacy and security standards addressed in § 155.260 apply to any person or entity that views or receives personally identifiable information from or on behalf of an applicant through the Exchange. Therefore, we believe that these standards will ensure appropriate privacy standards for authorized representatives and others assisting

applicants. Further, the application process will include an authentication process. HHS expects to issue future guidance on the authentication process to verify an individual's identity. In addition, we expect that application assisters who are not Navigators, agents, or brokers will provide support for consumers during the application process, and we anticipate providing additional guidance regarding this role, including on appropriate privacy and security protections.

Comment: Several commenters asked for clarification regarding whether mobile devices could be used to apply for coverage under proposed § 155.405(c)(2). Many of these commenters recommended that the final rule establish that the single streamlined application must be available through mobile devices or mobile applications.

Response: In this final rule, Exchanges must only provide an online application at this time (see § 155.405(c)(2)(i)). Although it may be beneficial for applicants to be able to complete the application and the plan selection process using a mobile device, Exchanges do not have to provide this functionality given the short implementation timeframe.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.405 of the proposed rule, with a few small modifications: We changed the final rule in § 155.405(b) from "request" to "collect" for consistency with other parts of the final rule. We replaced (c)(1)(i) through (c)(1)(iii) of the proposed rule with (c)(1) "application filer," which incorporates the previous categories included in the proposed rule. In paragraph (c)(2), we have made minor clarifying edits. We codified the standard that an individual may file an application for coverage in person and clarified that reasonable accommodations must be made for individuals with disabilities.

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

In § 155.410, we proposed that the Exchange adhere to specified initial and annual open enrollment periods and indicated that qualified individuals and enrollees may begin or change coverage in a QHP at such times. We sought comment on the duration of the initial open enrollment period, which we proposed to be from October 1, 2013 to February 28, 2014. We also requested comment on the proposed annual open enrollment period (October 15 to December 7 of each year) and whether we should consider an alternative annual enrollment period from November 1 through December 15 of each year.

We also proposed standards for effective dates based on the date when an individual's QHP selection is received. To coordinate coverage in a QHP with the advance payments of the premium tax credit, we proposed that coverage in a QHP may only begin on the first of the month. We sought comment as to whether we should consider twice monthly or flexible effective dates of coverage for individuals who forgo advance payment of the premium tax credit for the first partial month or who are not eligible for advance payments of the premium tax credit.

We also proposed that the Exchange must send written notification to enrollees about the annual open enrollment period and sought comment on whether we should codify specific elements that must be included in the notification and timing of the notification. We further proposed that the Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

Finally, we sought comment on whether Exchanges should automatically enroll individuals who received advance payments of the premium tax credit and then have coverage terminated from a QHP because the QHP is no longer offered, if such individual does not make a new QHP selection. We also sought comment on whether we should allow for automatic enrollment of individuals in specific circumstances, such as mergers between issuers or when one QHP offered through a specific issuer is no longer offered, but there are other options available to the individual through the same issuer. Lastly, we sought comment as to how far such automatic enrollment should extend if we were to allow it.

Comment: Several commenters expressed concern about adverse selection with respect to the enrollment periods in proposed § 155.410 and § 155.420. The commenters supported limited enrollment periods and opposed any flexibility for States to implement longer or more frequent enrollment periods.

Response: In both the proposed and final rules, we have attempted to balance the risk of adverse selection with the need to ensure that consumers have adequate opportunity to enroll in QHPs through an Exchange. We believe that the enrollment periods described in § 155.410 and § 155.420 of this final rule achieve that balance. As we describe later in this section, we believe that additional time is needed for the initial enrollment period, given that Exchanges are a new coverage option under the Affordable Care Act, and significant education and outreach will be needed to make individuals aware of this coverage opportunity.

Comment: Several commenters requested more State flexibility with respect to the enrollment periods identified under proposed § 155.410 and § 155.420. The commenters recommended States have flexibility to set their own enrollment periods and effective dates, especially those States already operating Exchanges. A few commenters requested State flexibility to extend enrollment periods, particularly for vulnerable populations.

Response: Section 1311(c)(6) of the Affordable Care Act specifically directs the Secretary to provide for initial, annual and special enrollment periods. In both the proposed and final rule, we have tried to provide State flexibility while adhering to our responsibility under the statute to establish the enrollment periods identified under section 1311(c). Therefore, we have proposed and finalized in this rule the minimum uniform enrollment periods across all Exchanges, including a special enrollment period for individuals experiencing an exceptional circumstance.

Comment: Almost all commenters supported the proposed start date of October 1, 2013 under proposed § 155.410(b) for the initial open enrollment period. One State agency believed it was unrealistic to expect Exchanges to be operational prior to January 1, 2014, given the systems development challenges ahead. A few commenters requested flexibility to begin enrollment, or a “pre-qualification” period before October 1, 2013. Commenters recommended an ***18388** initial open enrollment period lasting as few as two months and as long as three years. The majority of commenters recommended a six-month initial open enrollment period, ending on March 31, 2014, one month later than in the proposed rule. Most commenters suggested that the longer initial open enrollment period would allow more time for individuals and families to learn about their coverage options, and more time for them to select a QHP. Finally, commenters recommended that individuals who enroll during the initial open enrollment period be permitted to change plans at least once without penalty during the Exchanges' first year of operation.

Response: In this final rule, we maintain the start date of October 1, 2013 for the start of the initial open enrollment period. Although coverage will not be effective until January 1, 2014, we believe that individuals and families need time to explore their coverage options and QHPs need time to process plan selections. We have extended the initial open enrollment period by one month—from February 28, 2014 to March 31, 2014. HHS's experience with the initial open enrollment period for Medicare's Prescription Drug Benefit Program supports an extended period. We have not extended the initial open enrollment period past March 31 in order to limit the risk of adverse selection, as expressed by commenters.

Comment: Several commenters recommended a robust outreach campaign prior to the initial open enrollment period. One group recommended that health insurance issuers notify all individual market subscribers about their potential eligibility for financial assistance through an Exchange under this section.

Response: We encourage Exchanges to leverage existing resources in their marketing efforts, including working with issuers to determine how they can participate most effectively. Section 155.205(e) of this final rule directs Exchanges to conduct outreach and education activities to educate consumers about the Exchange and to encourage participation.

Comments: Several commenters representing State agencies and health insurance issuers expressed concern about effective dates proposed in § 155.410(c). The commenters asserted that the specified minimum of eight days between plan selection and coverage effective date was too short, and that they needed as many as 30 days to make coverage effective. Commenters recommended that we ensure there is sufficient lag time between QHP selection and effective dates.

Response: Based on the commenters' recommendation to allow more time between QHP selection and effective dates, we have modified the proposed QHP selection cutoff date in this final rule from the 22nd to the 15th of the month. As described in more detail below, we have also provided flexibility for Exchanges to work with QHP issuers to make coverage effective more quickly.

Comment: Many commenters, namely consumer and patient advocates, were concerned that the proposed effective dates under § 155.410(c) and § 155.410(f) would lead to coverage gaps for individuals losing coverage mid-month. The commenters offered alternative effective dates, including twice monthly, continuous, and retroactive. Many commenters responded positively to our solicitation for comments on whether to allow mid-month or flexible effective dates for qualified individuals willing to forgo advance payments of the premium tax credit until the 1st of the following month, or who are ineligible for such payments. Others requested that coverage be guaranteed for the 1st of the month for all qualified individuals, even when they select a QHP on the last day of the previous month. Finally, a few commenters recommended printable, temporary insurance cards that individuals could use until the enrollment process was completed.

Response: We recognize the need to minimize coverage gaps, especially for vulnerable populations. However, the suggested alternatives could have negative consequences for Exchanges and QHP issuers, by increasing costs and administrative burden. Because the initial open enrollment period will be the Exchanges' first experience with enrollment, and many newly-eligible individuals will be seeking to enroll at the same time, we believe it is important to maintain administrative processes consistent with health insurance issuers' experience, while at the same time including flexibility for improvement as Exchanges and QHP issuers enhance their capabilities.

In response to commenters' concerns, we have added two new options for earlier initial open enrollment period effective dates in § 155.410(c)(2) of this final rule. We have also added the same options for special enrollment period effective dates in § 155.420(b)(3) of this final rule. An Exchange may adopt one or both options, provided that it demonstrate to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in § 155.410(c)(1)(ii) through § 155.410(c)(1)(iii). We include this qualification because QHP issuers may need to implement administrative changes to accommodate the modified effective dates. We note that individuals seeking the earlier effective date described in § 155.410(c)(2)(i)(B) must waive the benefit of advance payments of the premium tax credit and cost-sharing reductions if coverage is effectuated mid-month. However, individuals do not have to accept this earlier effective date. As an example, if all QHP issuers in State X agree that they can effectuate coverage eight days after QHP selection, and individual A makes a QHP selection on January 17th, 2014, the issuer may effectuate the coverage on January 25th, provided that the individual is willing to forgo advance payment of the premium tax credit for the seven days of coverage in January.

Comment: In response to our request for comment in the preamble of proposed § 155.410(d) on whether we should set a standard for the timing of the annual open enrollment notice, most commenters supported a standard for the Exchange to send a notice of annual open enrollment 30 days prior to the start of enrollment, though one patient advocacy organization recommended 60 days' notice.

Response: We have added a standard in this final rule in § 155.410(d) that the Exchange send the notice no earlier than September 1st, and no later than September 30th of each year, in preparation for an October 15th annual open enrollment. Because subpart D of this final rule directs the annual redetermination notice to be combined with the annual open enrollment notice, we have allowed a 30 day window for States to produce and mail the combined notice. We believe that 60 days is too far in advance of annual open enrollment for enrollees to remember to take action.

Comment: Many commenters representing patient and consumer advocacy groups recommended that proposed § 155.410(d) establish an additional notice to be sent 30 days before the end of the annual open enrollment period to enrollees who had not yet selected a QHP. Some commenters recommended the use of social media and mass media to increase awareness of annual open enrollment.

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Response: We note that Exchanges may send additional notices and conduct outreach to assist consumers with enrollment, but we do not establish such notices as a minimum standard.

Comment: A few commenters recommended that HHS provide a ***18389** model annual open enrollment notice and a process for deviating from that notice. Suggestions for the notice's content included: meaningful access standards, information about how to access brokers and application assisters, an explanation of the once-a-year nature of an annual enrollment period, the implications of going uninsured, and the criteria for qualifying for a special enrollment period. Several commenters recommended that the notice of annual eligibility redetermination described in proposed § 155.335(c) be combined with the notice of annual open enrollment described in § 155.410(d), into a single, streamlined notice.

Response: HHS intends to provide Exchanges with a model notice in future guidance. The model will consider the content recommended above. In response to commenters' recommendation to combine and streamline notices, we have added timing standards to the notice of annual redetermination notice in § 155.335(d) of this final rule.

Comment: One commenter noted that health insurance issuers already send a notice of annual open enrollment. The commenter stated that if Exchanges did the same, as described in proposed § 155.410(d), it would be duplicative and unnecessarily burdensome for Exchanges.

Response: While it is possible that an Exchange or a State insurance regulator might direct health insurance issuers to send a notice of annual open enrollment, HHS is not imposing such a standard. We therefore do not believe § 155.410(d) is duplicative, and we maintain it in the final rule. Issuers may continue to send such notices at their discretion.

Comment: Several commenters, namely health insurance issuers, recommended a shorter annual open enrollment period under proposed § 155.410(e), lasting between 30 and 45 days, to discourage adverse selection. Conversely, several other commenters recommend extending the annual open enrollment period until at least December 15th (for a total of at least 60 days), to give individuals and families more time to explore their coverage options. One commenter recommended quarterly instead of annual open enrollment periods, to increase opportunities for consumers to enroll. Commenters recommended annual open enrollment periods lasting between 30 and 90 days, with several recommending continuous open enrollment.

Response: As noted above, the rule seeks to balance flexibility for consumers with the need to limit adverse selection. The 53-day length of the annual open enrollment period balances these competing interests, and gives individuals and families ample time to explore coverage options. Therefore we maintain the annual open enrollment start and end dates in § 155.410(e) of this final rule.

Comment: One health insurance issuer suggested limiting an enrollee's QHP selection during annual open enrollment in proposed § 155.410(e) to only one metal level higher. For example, the commenter believed that enrollees should not be permitted to move from a bronze level QHP to a gold or platinum level QHP. In response to a similar proposal in § 155.420(f) of the proposed rule to limit movement between QHPs during special enrollment periods, most commenters, with the exception of a few health insurance issuers, either objected to the provision outright, or recommended additional exceptions to allow movement between QHPs. One commenter noted that because the special enrollment periods were generally not tied to changes in an individual's health status, they did not pose a risk of adverse selection.

Response: We have removed § 155.420(f) from the final rule. We do not believe it is appropriate to limit enrollee movement between QHPs during the annual open enrollment period in § 155.410(e), and we have not added the restriction requested by the commenter.

Comment: With respect to the proposed annual open enrollment period under § 155.410(e), many commenters were concerned that its overlap with the open enrollment periods for SHOP, Medicare and other Federal programs would create an unmanageable administrative workload at the end of each year. Some commenters suggested moving the Exchange's open enrollment until

after the first of the year to better align it with tax filing season and with many employers' annual open enrollment periods. Others recommended staggered, individual-specific open enrollment periods. For example, periods could be linked to birthdays, to spread out enrollment over the course of the year. Others recommended that the annual open enrollment period reflect the current enrollment practices in the individual and small-group market, and at the least, align inside and outside the Exchange. Some commenters representing senior citizens supported the alignment with Medicare.

Response: We recognize that the annual open enrollment period overlaps with that of other Federal programs. However, we believe that the alternatives suggested by commenters would lead to undesirable outcomes. For instance, aligning the annual open enrollment period with the tax season would mean that the coverage year and the tax year no longer align, and in the first year consumers could have more than 12 months of coverage before receiving an opportunity to change QHPs. Further, the updated tax return information may not yet be available via the data services hub. We believe that a rolling open enrollment period, with individual-specific dates would add complexity for families and increase risk selection. It would also eliminate the ability to conduct a single enrollment campaign when consumers could take action. We therefore maintain the proposed open enrollment period in § 155.410(e) of this final rule. With respect to the comment on aligning the enrollment period inside and outside the Exchange, we clarify that this rule only sets standards for Exchanges.

Comment: In response to our request for comment on the issue of auto-enrollment, several State agencies supported the rule's lack of auto-enrollment standards, because they perceived it as permitting flexibility. A few commenters explicitly opposed auto-enrollment. The remainder of the commenters supported the option for Exchanges to auto-enroll individuals who become unintentionally uninsured, but they expressed concerns over limiting an individual's right to choose his or her own QHP. Most commenters recommended that an Exchange send multiple notices to individuals facing potential auto-enrollment, and provide a 30- to 90-day period for individuals to change QHPs after being auto-enrolled.

Response: We have established flexibility for the Exchange to auto-enroll qualified individuals when the Exchange demonstrates to HHS that it has good cause to do so under § 155.410(g) of this final rule. We expect to issue guidance outlining generally the circumstances under which HHS will approve Exchange auto-enrollment. HHS will also monitor auto-enrollment practices across Exchanges for appropriateness and effectiveness.

Comment: A few commenters stressed that any QHP into which qualified individuals are auto-enrolled must meet women's reproductive needs, as well as the need for local providers. The commenters recommended that the QHP in which an individual is auto-enrolled resemble any previous QHP coverage the qualified individual had.

Response: All QHPs must offer the essential health benefits established ***18390** under section 1302(b) of the Affordable Care Act, which includes coverage of maternity and newborn care. Also, all QHPs must comply with Exchange network adequacy standards that ensure a sufficient number and type of providers to assure that all services will be accessible without unreasonable delay, per § 156.230. HHS will consider other commenter suggestions in developing guidance for § 155.410(g) of this final rule.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.410 of the proposed rule, with the following modifications: in § 155.410(b), we extended the end date of the initial enrollment period from February 28, 2014 to March 31, 2014. In § 155.410(c)(2), we modified the initial enrollment period effective date such that a QHP selection must be received by the Exchange by the 15th of the month to secure an effective date of the first day of the following month. We also provided Exchanges flexibility to effectuate coverage more quickly if all QHP issuers offering coverage through the Exchange agree with the earlier dates, but noted that advance payments of the premium tax credit and cost-sharing reductions cannot begin until the first of the month. We further specified in § 155.410(d) that the Exchange must send the notice of annual open enrollment no earlier than September 1st, and no later than September 30th of each year. Finally, in § 155.410(g) we added an option for Exchanges to automatically enroll qualified individuals at such time and in such manner as HHS may specify, and subject to the Exchange demonstrating to HHS that it has good cause to perform such automatic enrollments.

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d. Special Enrollment Periods (§ 155.420)

In § 155.420, we proposed that the Exchange must allow a qualified individual or enrollee to enroll in a QHP or change from one QHP to another outside of the annual open enrollment period if such individual qualifies for a special enrollment period. We proposed special enrollment period effective dates that generally followed the proposed initial enrollment period effective dates in § 155.410.

For each special enrollment period we proposed a standard length of 60 days from the date of the triggering event, unless the regulation specified otherwise. We requested comment on whether special enrollment periods, particularly those described in paragraphs § 155.420(d)(4), § 155.420(d)(6), and § 155.420(d)(7), should have an alternate trigger or start date. The special enrollment periods we proposed were triggered by the following events:

• A qualified individual and any dependents losing other minimum essential coverage. We provided several examples of loss of coverage, and we sought comment on our proposal to limit this special enrollment period to the loss of minimum essential coverage, rather than loss of any coverage.

• A qualified individual gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption. We solicited comment on whether States might consider expanding the special enrollment period to include gaining dependents through other life events.

• An individual, not previously lawfully present, gaining status as a citizen, national, or lawfully present individual in the U.S.

• Consistent with the Medicare Prescription Drug Program, a qualified individual experiencing an error in enrollment.

• An individual enrolled in a QHP adequately demonstrating to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract.

• An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions.

• New QHPs offered through the Exchange becoming available to a qualified individual or enrollee as a result of a permanent move.

• The individual is an Indian, as defined by the Indian Health Care Improvement Act. We solicited comment on the potential implications on the process for verifying Indian status for purposes of this special enrollment period.

• A qualified individual or enrollee meeting other exceptional circumstances, as determined by the Exchange or HHS. Similar to section 9801 of the Code, we proposed that loss of coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage. We also proposed that loss of coverage not include situations allowing for a rescission as specified in 45 CFR 147.128.

We proposed that the Exchange allow an existing enrollee who qualifies for a special enrollment period to only change plans within the same metal level of coverage, as defined by section 1302(d) of the Affordable Care Act. We proposed a single exception for new eligibility for advance payments of the premium tax credit or change in eligibility for cost-sharing reductions. We requested comment as to whether we should provide an exception for catastrophic plan enrollees who become pregnant.

Comment: Several commenters sought clarification on the types of documents needed to qualify for a special enrollment period, as described in proposed § 155.420(a). Some requested that the same verifications used for determining eligibility for coverage also be used to verify eligibility for a special enrollment period. Others, namely State agencies, requested State flexibility for determining special enrollment period eligibility.

Response: Exchanges must verify information outlined in § 155.315 of the rule in order to make an eligibility determination, which includes a determination of eligibility for enrollment periods, per § 155.305(b). Exchanges will be able to determine eligibility for most special enrollment periods using the information available through verifications outlined in § 155.315. However, given that the eligibility criteria for some of the special enrollment periods in § 155.420 do not directly align with the criteria to establish eligibility for coverage through the Exchange or insurance affordability programs in § 155.315, we expect Exchanges will use other verification standards and processes to determine eligibility for those particular special enrollment periods.

Comment: Several commenters recommended adding standards for Exchanges, QHP issuers and employers to notify an individual about his or her potential eligibility for a special enrollment period under proposed § 155.420(a). For example, commenters recommended that employers include a notice about employees' potential eligibility for a special enrollment period with any health benefit change materials, or that QHP issuers notify enrollees who report a change in address.

Response: HHS will issue guidance pertaining to notices that may include information on special enrollment periods. We expect that Exchanges will include information about all enrollment periods both on their Web site and other informational resources.

Comment: Many commenters expressed general concerns about adverse selection. The commenters requested that individuals be limited to only one special enrollment period per month, and recommended limiting individuals' movement between QHPs ***18391** during some or all special enrollment periods.

Response: While we recognize the need to limit the risk of adverse selection, we do not believe it is necessary to limit special enrollment periods, given the nature of the types of special enrollment periods. We received similar comments on the issue of limiting enrollees' movement between QHPs during open and special enrollment periods, and have responded to them in preamble for § 155.410(e) and § 155.420(f), respectively.

Comment: A few commenters suggested that the special enrollment periods described in this section be aligned more closely with HIPAA rules for consistency inside and outside the Exchange. A few other commenters instead recommended aligning the special enrollment periods more closely with Medicare's special enrollment periods.

Response: Section 1311(c)(6) of the Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code (the HIPAA special enrollment periods) and reflect those available under part D of title XVIII of the Act. The final rule balances these two parameters by adopting relevant provisions from each. In response to comments requesting closer alignment with HIPAA rules, we have added regulatory text to § 155.420(b)(2) to ensure first-of-the-month effective dates for qualified individuals who gain or become dependents through marriage, and for qualified individuals who lose minimum essential coverage. We have also aligned more closely with HIPAA rules by clarifying what is included under loss of minimum essential coverage in § 155.420(e).

Comment: Many commenters made suggestions for effective dates under § 155.420(b) similar to those made for the proposed § 155.410(c) and § 155.410(f) on effective dates during the initial and annual open enrollment periods.

Response: With the exception of the cases noted above in § 155.420(b)(2), we have modified the special enrollment period effective dates in proposed § 155.420(b) to align with initial enrollment period effective dates in § 155.410(c) of this final rule. Our reasoning follows the same logic for both sections of the rule.

Comment: Several commenters recommended 30-day special enrollment periods, under proposed § 155.420(c), consistent with the HIPAA standard, while several others supported the proposed 60-day periods, consistent with several special enrollment periods under the Medicare Prescription Drug Benefit Program. Several commenters recommended extending the periods for as long as 120 days, particularly for vulnerable populations.

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Response: Regarding the length of Exchange special enrollment periods outlined in § 155.420(c) of the final rule, our experience with the Medicare Prescription Drug Benefit Program informs our decision to adopt the 60-day window, which generally conforms with several special enrollment periods in the Medicare Prescription Drug Benefit Manual that extend for two months beyond the month of a triggering event. We believe that this approach will give consumers the time they need to explore their coverage options through the Exchange, following a change in life circumstances. We have not extended the length of the enrollment period due to concerns about adverse selection. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: Several commenters, namely health insurance issuers, asked HHS not to add any additional special enrollment periods to those listed in proposed § 155.420(d). Several other commenters recommended additions to the rule, including special enrollment periods for certain changes in plan provider networks, exhaustion of the COBRA disability extension, denial of services due to a provider's moral or religious opposition, and pregnancy.

Response: The Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code and part D of title XVIII of the Act. The additional special enrollment periods suggested by commenters are not specified in the Code, nor are they similar enough to those available under the Act for HHS to include them in the final rule. Therefore the final rule implements the statute without additions. We note, however, that the special enrollment period for exceptional circumstances in § 155.420(d)(9) of this final rule provides an additional opportunity for enrollment when unforeseen circumstances arise.

Comment: Regarding proposed § 155.420(d)(1), for individuals losing minimum essential coverage, many commenters sought clarification about what coverage it included. Several commenters questioned whether an individual would be eligible for this special enrollment period if offered COBRA, and how the policy related to proposed § 155.420(e) and the Treasury proposed rule. Many commenters also sought assurance that loss of coverage included loss of coverage through Medicaid, CHIP and the BHP. One health insurance issuer recommended that loss of Medicaid or CHIP only be included if it is the result of a reported change in household income to an Exchange that disqualifies the individual or family from Medicaid or CHIP. A few health insurance issuers supported the language in proposed § 155.420(d)(1) specifying loss of “minimum essential coverage,” as opposed to any coverage, because it limits adverse selection by prohibiting individuals from dropping their substandard coverage when they became sick or injured. A few other commenters recommended Exchange flexibility to offer special enrollment periods to individuals losing non-minimum essential coverage.

Response: The Exchange establishment proposed rule preamble provides several examples of loss of coverage, including loss of Medicaid and CHIP, in accordance with section 9801(f)(3) of the Code. The examples remain accurate for this final rule. We have further clarified § 155.420(e) in this final rule by specifying that loss of coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). This clarification aligns the special enrollment more closely with section 9801 of the Code. An individual could lose eligibility for Medicaid or CHIP as a result of a reported change in household income, or as a result of other circumstances.

Qualified individuals are eligible for the loss of minimum essential coverage special enrollment period described in § 155.420(d)(1), even if offered COBRA. The Treasury proposed rule defines COBRA coverage as minimum essential coverage only if the individual enrolls in such coverage. Therefore, if an individual elects and enrolls in COBRA, he or she cannot qualify for this special enrollment period until exhausting COBRA, as described in § 155.420(e), but if the individual does not elect COBRA, he or she may take advantage of the Exchange special enrollment period. Regarding the recommendation to allow Exchanges to offer this special enrollment period to individuals losing non-minimum essential coverage, we have not adopted this policy in ***18392** deference to the status the statute gives to minimum essential coverage.

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Comment: Regarding the special enrollment period for individuals gaining or becoming a dependent as described in proposed § 155.420(d)(2), many commenters made arguments for either limiting or for expanding the list of life events through which an individual becomes or gains a dependent. Several commenters recommended adding domestic partners, partners joined in civil unions, or dependents gained through guardianship. Several other commenters recommended that State law determine the types of dependents allowed.

Response: For the same reasons as described above, we do not find legal grounds for expanding the definition of dependents for the purpose of the special enrollment period described in § 155.420(d)(2). Therefore, we retain this provision in this final rule without modification.

Comment: Regarding the special enrollment period for individuals becoming lawfully present, outlined in proposed § 155.420(d)(3), several commenters questioned whether an individual moving from one lawfully present category to another would be granted this special enrollment period if it affected his or her eligibility for certain types of coverage.

Response: To qualify for coverage without advance payments of the premium tax credit or cost-sharing reductions through an Exchange under the special enrollment period described in both the proposed and final rule at § 155.420(d)(3), the individual cannot have been previously lawfully present.

Comment: Regarding the special enrollment periods for errors in enrollment, and for contract violations, outlined in proposed § 155.420(d)(4) and § 155.420(d)(5) respectively, several commenters sought clarification on the kinds of events that would trigger them, and how individuals would demonstrate such events. A few health insurance issuers recommended appeals processes, either in conjunction with, or instead of these special enrollment periods. They recommended various limitations on the special enrollment period for errors in enrollment, and one commenter recommended that it be removed from the rule all together. Several other commenters sought clarification as to which entities are considered "agents of the Exchange or HHS," and recommended that at least QHPs be included as such agents.

Response: The special enrollment periods in § 155.420(d)(4) and § 155.420(d)(5) of this final rule are generally consistent with those offered under the Medicare Prescription Drug Program, as noted above. We expect Exchanges to develop guidance and standard operating procedures for considering requests for this special enrollment period. We encourage Exchanges to do so in consultation with health insurance issuers and other stakeholders. HHS may also provide future guidance to help Exchanges in operationalizing this special enrollment period.

Comment: Regarding the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed § 155.420(d)(6), a couple of commenters sought clarification as to whether an individual newly released from incarceration would qualify for the special enrollment period, even if he or she did not qualify for advance payments of the premium tax credit or did not experience a change in cost-sharing reductions.

Response: Qualified individuals newly released from incarceration are eligible for the special enrollment period afforded to individuals who gain access to a new QHP as a result of a permanent move, as outlined in § 155.420(d)(7) of this final rule and as described further below.

Comment: A couple of commenters recommended that the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed § 155.420(d)(6), clarify that individuals may not qualify for this special enrollment period if they become eligible for an increase or decrease in their existing advance payments of the premium tax credit. Conversely, one commenter responding to HHS' request for comment recommended that this kind of special enrollment period be offered to all individuals who experience a change in income resulting in recalculation of their advance payments of the premium tax credit.

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Response: The final rule specifies that individuals may only qualify for this special enrollment period in § 155.420(d)(6) if they are newly eligible or ineligible for advance payments of the premium tax credit, and we do not believe clarification is necessary, as requested by the commenter. That said, if an individual experiences a change in his or her existing payments of the premium tax credit in tandem with a change in level of cost-sharing reductions, the individual could qualify for this special enrollment period.

Comment: One commenter recommended dividing the special enrollment period in proposed § 155.420(d)(6) into two distinct periods—one for individuals gaining eligibility for advance payments of the premium tax credit or experiencing a change in cost-sharing reductions, and a second for individuals whose employer-sponsored coverage ceases to meet affordability or minimum value standards.

Response: While we have not added a special enrollment period specifically for individuals whose employer-sponsored coverage ceases to meet affordability or minimum value standards, as recommended by the commenter, we clarify in § 155.420(e) that loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). We believe that between the special enrollment periods offered for loss of minimum essential coverage in § 155.420(d)(1) and for employer-sponsored coverage becoming unaffordable in § 155.420(d)(6), individuals will have ample opportunities to enroll in coverage through the Exchange.

Comment: Regarding the special enrollment period for permanent moves, outlined in proposed § 155.420(d)(7), one health insurance issuer recommended that the provision be revised so that it would only be a triggering event if an enrollee moves permanently outside the service area of his or her existing QHP. Several health insurance issuers also recommended that individuals who move across State lines receive an eligibility determination from the Exchange in their new State.

Response: The special enrollment period in § 155.420(d)(7) is similar to the special enrollment period under part D of title XVIII of the Act, as directed by section 1311(c)(6) of the Affordable Care Act. Both are intended to afford individuals the full range of plan options when they relocate. Individuals moving to a new State should receive an eligibility determination from their new State's Exchange. Qualified individuals are responsible for reporting a permanent move.

Comment: Several commenters recommended that a special enrollment period be triggered by the date of a permanent move described in § 155.420(d)(7), while others recommended it be triggered by the date the individual reports the move to the Exchange, with a time-limited time window in which to report it. In cases where an individual's eligibility for employer-sponsored coverage terminates or changes, in response to proposed § 155.420(d)(1) and (d)(6) respectively, several commenters recommended that the period be ***18393** triggered by the date the employee learns of the termination or change. Other commenters recommended that it be triggered by the actual date of the termination of or change in coverage. In cases where an individual becomes newly eligible for advance payments of the premium tax credit or experiences a change in cost-sharing reductions, in response to proposed § 155.420(d)(6), several commenters recommended that the period be triggered by the date the individual experienced a change in circumstances, while others recommended it be triggered by the date of the Exchange's official eligibility determination. Several other commenters recommended less structured approaches, such as leaving the trigger up to the consumer with the change in circumstances, or allowing the particular circumstances to dictate the trigger. Many commenters also recommended that individuals be permitted to seek special enrollment periods in advance of a known triggering event.

Response: We expect to issue guidance to help Exchanges determine how to define the triggering events and consider the recommendations received. We believe it is critical to establish a balance between minimizing gaps in coverage and the need to avoid coverage overlaps when premium tax credits are involved. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: Regarding the special enrollment period for Indians, outlined in proposed § 155.420(d)(8), some commenters expressed support, while others either opposed it or recommended that States have flexibility to adopt their own special Indian provisions. Many commenters sought further clarification on how the Exchange would verify an individual's status as an Indian. Some disagreed with the definition of Indian outlined by HHS in proposed § 155.420(d)(8), and some provided a detailed legal analysis to support their position. Others recommended allowing special enrollment periods more frequently than once per month in cases where any QHP network excludes Indian Health Service, tribal, or urban Indian providers or when a QHP drops such providers from its network.

Response: Consistent with the proposed rule, HHS is codifying the special monthly enrollment period for Indians in accordance with section 1311(c)(6)(D) of the Affordable Care Act. Sections 155.300 and 155.350(c) of this final rule address comments submitted regarding the definition of Indian and verification of an individual's status as an Indian as it relates to eligibility for cost-sharing reductions. The same verification rules apply to eligibility for this special enrollment period. As stated above, we do not believe that there is legal flexibility to include additional special enrollment periods.

Comment: Regarding the special enrollment period for individuals with exceptional circumstances, outlined in proposed § 155.420(d)(9), many commenters supported the broad language, while several others recommended more specificity. A few commenters recommended that States, not HHS, determine the exceptional circumstances.

Response: We have modified the language in § 155.420(d)(9) to permit individuals to request a special enrollment period by demonstrating to their Exchange that they meet exceptional circumstances. The modified language establishes that individuals must demonstrate such circumstances in accordance with guidelines issued by HHS. Consistent with examples outlined in the proposed rule preamble, HHS's guidance for this special enrollment period will outline circumstances when HHS may grant special enrollment periods directly, such as in cases of natural disasters.

Comment: A few commenters supported the exclusion from special enrollment periods when individuals failed to pay their premiums on a timely basis, outlined in proposed § 155.420(e), while several other commenters explicitly opposed this provision. Several commenters only opposed the exclusion for individuals who failed to pay their COBRA premium on a timely basis, noting that many people are likely to elect COBRA without realizing that there are more affordable coverage options through the Exchange.

Response: The limitation described in § 155.420(e) reflects similar limitations in both section 9801 of the Code, and part D of title XVIII, as directed by section 1311(c)(6) of the Affordable Care Act. As stated in the response to comments on § 155.420(d)(1) (for individuals losing minimum essential coverage) individuals are free to decline COBRA and instead enroll in a QHP through the Exchange. We have also added clarification to § 155.420(e) to indicate which circumstances are included under loss of minimum essential coverage.

Comment: While a few health insurance issuers supported the limits on special enrollment periods outlined in proposed § 155.420(f), most commenters either opposed the provision outright, or recommended additional exceptions, such as exceptions for pregnant women, or for the special enrollment periods described in proposed § 155.420(d)(2), § 155.420(d)(4), § 155.420(d)(5), and § 155.420(d)(8). One commenter noted that because the special enrollment periods were generally not tied to changes in an individual's health status, they did not pose a risk of adverse selection.

Response: We have removed § 155.420(f) from the final rule because special enrollment periods are generally not tied to changes in an individual's health status, and are unlikely to increase the potential for adverse selection. Just as qualified individuals are free to move between metal levels during the initial and annual open enrollment periods, they are also free to do so during special enrollment periods.

Summary of Regulatory Changes

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We are finalizing the standards proposed in § 155.420 of the proposed rule, with several modifications: in § 155.420(b) related to effective dates, we modified the special enrollment period effective dates such that a QHP selection must be received by the Exchange by the 15th of the month to secure an effective date of the first day of the following month. We provided Exchanges flexibility to effectuate coverage more quickly by demonstrating to HHS that all QHP issuers offering coverage through the Exchange agree with the earlier dates, but noted that advance payments of the premium tax credit and cost-sharing reductions cannot begin until the first of the month. This limitation on advance payments of the premium tax credit and cost-sharing reductions also applies to individuals enrolling mid-month as a result of birth, adoption or placement for adoption. As an exception to the effective dates above, we specified in § 155.420(b)(2)(ii) that in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the Exchange must always ensure coverage is effective on the first day of the following month, consistent with HIPAA rules. We clarify that to qualify for the special enrollment period under § 155.420(d)(9) individuals must demonstrate their exceptional circumstances to the Exchange, in accordance with guidelines issued by HHS. In § 155.420(e) we clarify that loss of coverage includes those ***18394** circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Finally, we remove the restrictions in § 155.420(f) that had previously prohibited individuals from moving between metal levels during special enrollment periods.

e. Termination of Coverage (§ 155.430)

We proposed that the Exchange must permit an enrollee to terminate his or her coverage in a QHP with appropriate notice to the Exchange or the QHP. We proposed that the Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage under a specific list of circumstances: the enrollee is no longer eligible for coverage; the enrollee obtains other minimum essential coverage; payment of premiums cease; the enrollee's coverage is rescinded in accordance with § 147.128 of this title; the enrollee's QHP is terminated or decertified; or the enrollee changes from one plan to another during the annual open enrollment or a special enrollment period in accordance with sections § 155.410 and § 155.420.

We also proposed that the Exchange establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS promptly and without undue delay, establish terms for reasonable accommodations for individuals with mental or cognitive conditions, and retain records in order to facilitate audit functions.

Additionally, we proposed that in the case of a termination requested by an enrollee, the last day of coverage for an enrollee is the termination date specified by the enrollee, provided that the Exchange and QHP receive reasonable notice. We proposed that if the Exchange or the QHP do not receive reasonable notice, the last day of coverage is the first day after a reasonable amount of time has passed. We proposed that in the case of a termination by the Exchange or a QHP as a result of an enrollee obtaining new minimum essential coverage, the last day of coverage is the day before the effective date of the new coverage. We solicited comments regarding how Exchanges can work with QHP issuers to implement this proposal. We also proposed standards for termination effective dates in the case of a termination by the Exchange or a QHP as a result of an enrollee changing QHPs. Finally, we proposed that for individuals not covered by the previous termination effective dates, the last day of coverage would be either the fourteenth or the last day of the month, depending on when termination of coverage was initiated.

Comment: A handful of commenters asked us to clarify what length of time would qualify as “reasonable notice,” as referenced in the proposed rule in § 155.430(b)(1). Some commenters suggested 24 hours while others suggested 30 days. The most common suggestion was 14 days. Other commenters requested that the final rule specify the methods consumers may use to notify their intent to terminate coverage.

Response: In this final rule, we clarify in § 155.430(d)(1) that “reasonable notice” is defined as 14 days from the requested date of termination. We want to ensure that individuals who have access to other coverage sources do not need to maintain Exchange coverage longer than necessary. In § 155.430(d)(2)(ii) of the final rule, we further state that the date of termination of coverage is 14 days from the request if the enrollee does not give reasonable notice to terminate coverage. We also note in § 155.430(d)(2)(iii) that coverage may be terminated in fewer than 14 days, per the request of the individual, if his or her

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QHP issuer is able to effectuate terminations more quickly. We do not specify how an individual will notify the Exchange that they wish to terminate coverage; rather, we leave this up to States to define how such transmissions may be received. This is in part because a request for termination may be received through either the Exchange or the QHP, and also because we wish to allow maximum flexibility to Exchanges.

Comment: Several commenters requested clarification regarding how the grace period for non-payment of premiums would work for individuals receiving advance payments of the premium tax credit and whether these policies differ for those who are not.

Response: We clarify in § 155.430(b)(2)(ii)(A) and (B) of this final rule that the grace periods for non-payment of premiums are not the same for individuals receiving advance payments of the premium tax credit and other enrollees. The 90-day grace period for non-payment of premiums for individuals receiving advance payments of the premium tax credit is addressed in § 156.270(d). In § 155.430(d)(5) of the final rule, we clarify that the last day of coverage for individuals not receiving advance payments of the premium tax credit should be consistent with existing State laws regarding grace periods for non-payment.

Comment: One commenter suggested that Exchanges be allowed to designate either the Exchange or the QHP to receive termination notifications in order to reduce duplication. A few commenters did not support the proposed standard in § 155.430(c) that QHP issuers report termination of coverage data to HHS because of privacy concerns.

Response: We did not accept the commenter's recommendation. Regardless of which entity the enrollee contacts to terminate coverage, the Exchange and QHP issuers will need to notify the other entity of the enrollee's coverage status to keep updated enrollment records. In addition, HHS needs to know when coverage is terminated to stop advance payments of the premium tax credit. As such, we maintain the reporting standards in § 155.430(c) in this final rule.

Comment: A few commenters asked that language in proposed § 155.430(c)(3), which directs QHP issuers to make reasonable accommodations when terminating coverage for individuals with mental or cognitive conditions, be broadened to include all individuals with disabilities, not just individuals with mental or cognitive disabilities.

Response: We broaden the final rule in § 155.430(c)(3) to state that reasonable accommodations must be undertaken when terminating coverage for individuals with disabilities as defined by the Americans with Disabilities Act.

Comment: A handful of commenters thought that provisions of section 2703 of the PHS Act were in conflict with the termination provisions contained in the Exchange establishment proposed rule in § 155.430(d)(2) because the proposed rule outlined dates of termination when an enrollee gains other minimum essential coverage. Commenters interpreted this to mean that an individual must terminate his or her Exchange coverage and said that issuers cannot terminate an individual's coverage because they gain access to other minimum essential coverage.

Response: We removed language indicating that a QHP must terminate an enrollee's coverage should they gain access to other minimum essential coverage in the final rule. Therefore, we do not believe there is a conflict with section 2703 of the PHS Act. We note, however, that the enrollee would no longer be eligible for advance payments of the premium tax credit or cost-sharing reductions if they have access to other minimum essential coverage.

Comment: Several commenters requested that CMS put in place ***18395** "safeguards" so as to minimize or eliminate coverage gaps for individuals who become newly eligible for Medicaid, CHIP, or the BHP. Other commenters requested that individuals not have their Exchange coverage terminated when they become eligible but do not enroll in Medicare. Many other commenters recommended that the final rule state that individuals cannot be automatically terminated from Exchange coverage should they be found eligible for Medicaid, CHIP, or the BHP.

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Response: In order to address these concerns, we have added § 155.430(d)(2)(iv) to the final rule to specify that if an individual enrolls in Medicaid, CHIP, or the BHP and wishes to terminate his or her Exchange coverage, then the last day of Exchange coverage is the day before such other coverage begins. We note that neither the proposed nor the final rule state that individuals will automatically be terminated from Exchange coverage should they be found eligible for Medicare. We also note that we remove proposed § 155.430(d)(4) from this final rule because the provisions are no longer necessary given the termination dates outlined in § 155.430(d)(1-6) of the final rule.

Comment: Some commenters requested that the Exchange establish a broad definition of "minimum essential coverage," as well as flexibility in terms of when coverage is terminated because an enrollee gains access to other minimum essential coverage.

Response: We do not define minimum essential coverage in this final rule as this definition is included in section 5000A(f) of the Code. Individuals do not have to terminate coverage and QHP issuers must not terminate coverage when an individual becomes enrolled in other minimum essential coverage unless such individual requests a termination. In § 155.430(d)(2) of this final rule, we clarify that the last day of coverage when an enrollee gains access to other minimum essential coverage is the date requested by the enrollee, should they give reasonable notice unless the QHP issuer can effectuate the termination earlier, or, the day before new coverage begins if the enrollee becomes eligible for Medicaid, CHIP, or the Basic Health Program. Individuals and QHP issuers do not have to terminate coverage when an individual becomes enrolled in other minimum essential coverage. However, if an individual is eligible for or enrolled in other minimum essential coverage, such individual may no longer be included in the coverage family, as indicated in § 155.305(f)(1)(B) and can no longer receive advance payments of the premium tax credit or cost-sharing reductions.

Comment: A few commenters asked that HHS track reasons for termination of coverage.

Response: Additional details regarding data that must be submitted to HHS will be addressed in future guidance.

Comment: Several commenters noted that the proposed termination effective date in § 155.430(d)(3) was inaccurate as it was prospective, when rescission is by definition retrospective.

Response: We removed § 155.430(d)(3) in the final rule to eliminate a date of termination for a rescission in accordance with § 147.128. The termination of coverage date will vary based on the situation.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.430 of the proposed rule, with the following modifications: we clarified paragraph (b)(1) to specify that an enrollee must be permitted to terminate his or her coverage, including as a result of obtaining other minimum essential coverage. In new paragraph (b)(2)(A), we clarified that enrollees receiving advance payments of the premium tax credit will be terminated from coverage when the grace period described in § 156.270 is exhausted. In § 155.430(c)(2) we clarified that the Exchange must transmit data on terminations to QHP issuers and HHS promptly and without undue delay. We also broadened the regulation text in § 155.430(c)(3) regarding individuals with disabilities to state that QHP issuers must create standards to accommodate all individuals with disabilities when terminating such individuals' coverage, and defined individuals with disabilities as those groups identified under the Americans with Disabilities Act. In addition, in paragraph § 155.430(d)(1) we defined "reasonable notice" given by the enrollee to the Exchange or QHP issuer to terminate coverage as 14 days.

In paragraph § 155.430(d)(2), we described the last day of coverage as the date specified by the enrollee; fourteen days after the termination date requested by the enrollee, if the enrollee does not provide reasonable notice; or fewer than 14 days if the individual's QHP issuer is able to terminate coverage more quickly. Paragraph (d)(3) was added to clarify that for an enrollee who is no longer eligible for coverage through the Exchange, the last day of coverage is the last day of the month following the month in which notice described by § 155.330(e) is sent by the QHP. We noted in new paragraph (d)(4) that for an enrollee receiving advance payments of the premium tax credit, the last day of coverage will be the last day of the first month of the

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grace period. In paragraph (d)(5) we noted that the last day of coverage for non-payment of premiums for enrollees not receiving advance payment of the premium tax credit is in accordance with State law.

6. Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)
The Affordable Care Act directs each State that chooses to operate an Exchange to establish insurance options for small businesses through a Small Business Health Options Program (SHOP). States that choose to operate an Exchange may also merge SHOP with the individual market Exchange.

a. Standards for the Establishment of a SHOP (§ 155.700)
In § 155.700, we proposed the general standard that an Exchange must provide for the establishment of a SHOP that meets the standards of this subpart.

Comment: Some commenters requested that, in the case of a State that establishes either a SHOP or an Exchange serving the individual market, but not both, the Secretary certify this as an Exchange in accordance with the Affordable Care Act.

Response: Section 1311(b) of the Affordable Care Act envisions an Exchange that both facilitates the purchase of QHPs and provides for the establishment of a SHOP. We interpret this to mean that a State that fails to fulfill both standards has not established an Exchange in accordance with the Affordable Care Act.

Comment: Some commenters proposed that the SHOP may want to fulfill additional functions outside the scope of the proposed rule in order to offer employers a streamlined experience when managing their employee benefits. These commenters proposed that the SHOP sell other types of insurance, administer COBRA on behalf of participating employers, administer flexible spending accounts, assist small employers in setting up Section 125 plans, and oversee wellness programs.

Response: Section 155.1000(b) directs the Exchanges to only offer health plans that have been certified as QHPs. We will take these comments into account as we consider future guidance on the offering of other products on the Exchange.

Comment: One commenter requested that we clarify the meaning of “coordination” and sharing of ***18396** information between the Exchange and the SHOP as described in the preamble to the proposed rule.

Response: As discussed in the proposed rule, there are many economies of scale that may arise from integrated Exchange and SHOP establishment. We believe that there are natural opportunities for the Exchange and the SHOP to benefit from shared data sources and coordinated activities.

Comment: One commenter discussed the possible use of health reimbursement arrangements from multiple employers as a means of purchasing coverage through the SHOP, aggregating premium contributions from multiple employers to support the employee's purchase of a QHP.

Response: The possible use of different forms of health reimbursement arrangement to purchase coverage through the Exchange or the SHOP is beyond the scope of this final rule, and will be addressed in future guidance.

Summary of Regulatory Changes
We are finalizing the provisions proposed in § 155.700 of the proposed rule, with one modification: in new paragraph (b), we added a definition of “group participation rule.”

b. Functions of a SHOP (§ 155.705)

In § 155.705, we proposed the minimum functions of a SHOP. The SHOP must carry out all the functions of an Exchange described in this subpart and in subparts C, E, and K of this part, except for standards related to individual eligibility determinations, enrollment standards related to qualified individuals, standards related to the premium tax credit calculator, standards related to exemptions from the individual coverage requirement, and standards related to the payment of premiums by individuals, Indian tribes, tribal organizations, and urban tribal organizations.

We also proposed that a SHOP must adhere to additional enrollment and eligibility standards described in § 155.710, § 155.715, § 155.720, § 155.725, and § 155.730. In addition, the SHOP must at a minimum facilitate the special enrollment periods described in § 156.285(b)(2). Specifically, we proposed that all of the special enrollment periods that apply to individual market coverage in the Exchange also apply in the SHOP, with the exception of special enrollment periods associated with a change in citizenship status or lawful presence or eligibility for advance payments of the premium tax credit or cost-sharing reductions. We noted that the proposed rule did not eliminate any special enrollment periods established by other laws (including, but not limited to, HIPAA (Pub. L. 104-191)). We also clarified that the two exceptions described above also apply to qualified employees in a SHOP. We invited comment on special enrollment periods for the SHOP and how they might differ from those that would apply to the Exchange for the individual market.

We proposed that a qualified employer may choose a level of coverage under section 1302(b) of the Affordable Care Act, within which a qualified employee may choose an available plan at that level of coverage. We also provided flexibility for a SHOP to choose additional ways for qualified employers to offer one or more plans to their employees and listed several potential options. We sought comment on our proposed approach, which established a standard for employee choice within a level of cost sharing while providing SHOPs the option to offer broader employee choices among plans of different levels of cost sharing.

We also invited comment on whether QHPs offered in the SHOP should waive application of minimum participation rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation.

To simplify the administration of health benefits among small employers, we proposed that the SHOP allow qualified employers to receive a single monthly bill for all QHPs in which their employees are enrolled and to pay a single monthly amount to the SHOP. We further proposed that the SHOP collect from employers offering multiple coverage options a single cumulative premium payment.

We proposed three unique criteria for certification for a SHOP: rate setting and premium payment standards; enrollment period standards; and enrollment process standards. Specifically, we proposed that the SHOP direct all QHP issuers to make any changes to rates at a uniform interval that is either monthly, quarterly, or annually. As described in § 155.725, we proposed to permit rolling enrollment in a SHOP, which allows qualified employers to purchase coverage in QHPs at any point during the year. We invited comment on whether we should allow a more permissive or restrictive timeframe than monthly, quarterly, or annually. We also invited comment on what rates should be used to determine premiums during the plan year.

We also proposed that if a State merges the individual and small group risk pools, the Exchange may only offer QHPs to employers and employees that meet the deductibles set forth in section 1302(c)(2)(A) of the Affordable Care Act. If a State does not merge the individual and small group risk pools, we proposed that a SHOP may only make small group QHPs available to qualified employees.

Finally, we proposed to codify the statutory option for States to allow insurers in the large group market to sell large group products to large groups through the SHOP beginning in 2017.

Comment: We received several comments regarding the proposed exclusion of a premium calculator from the minimum functions for the SHOP in proposed § 155.705(a)(3). Some commenters requested that a premium calculator be included,

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arguing that it assists employers in estimating their total costs. Other commenters noted that instead of providing individuals with an estimation of their cost of coverage after any applicable tax credits or cost sharing reductions, a premium calculator in the SHOP may show employees their premiums after any applicable employer contributions.

Response: We believe that a premium calculator will assist employees in determining their cost of coverage after any applicable employer contribution at little to no additional burden on SHOPs or employers. Therefore, we have added new § 155.705(b)(11) in this final rule to clarify that a SHOP must provide a premium calculator to qualified employers. To support States in developing a premium calculator for the SHOP, HHS will provide model computer code.

Comment: In response to the proposed § 155.705(b)(1), which stated that a SHOP must facilitate the special enrollment periods described in § 156.285(b)(2), many commenters expressed concern about the preamble discussion regarding a lack of a special enrollment period in SHOP based on change in immigration or citizenship status. These commenters recommended that, rather than clarifying that a SHOP would not need to offer a special enrollment period based on a change in immigration or citizenship status, HHS should clarify that special enrollment periods in SHOP should be based on whether an individual is newly hired by a "qualified" employer or whether an individual becomes a newly eligible "qualified employee." Further, commenters recommended that HHS clarify that new hires or newly eligible qualified employees should not need a ***18397** special enrollment period because the qualified employers should allow them to enroll at any time during the plan year.

Response: We have modified the language in § 155.725(g) and § 156.285(b) in this final rule to clarify the provision of an enrollment period for an employee who becomes a "qualified employee" rather than just new hires. We believe this clarification more accurately reflects the intent that enrollment periods will be provided to those who become qualified employees outside of the initial or annual open enrollment period, such as employees who have, for example, completed an employer's waiting period for benefits, changed from part time to full time status, or are newly hired.

Comment: We received numerous comments in response to proposed § 155.705(b)(2) and (3) on the employee and employer choice provisions. Many commenters supported additional employee choice options, such as offering plans across cost-sharing levels. Other commenters supported more limited employee choice options, often expressing concern that allowing employee choice across cost-sharing levels and even within a cost-sharing level would result in substantial risk selection. Some commenters supported broad employer choice to offer either a wider or narrower range of employee choices, including offering a single QHP. Several commenters suggested that the Affordable Care Act directs the SHOP to give employers the option to offer a single QHP. One commenter suggested initially implementing a pure employer choice model with no employee choice. A few commenters suggested adding a defined contribution model to the list of additional choice options from the preamble to the proposed rule.

Response: We believe the proposed rule appropriately balances the employee choice standards of the Affordable Care Act with flexibility for SHOPs to allow employers greater choice in their plan offering options. Under this model, employees will likely have more plan choice than they currently have in the small group market, where traditionally an employer offers only one plan to its employees.[FN9] However, nothing in the Affordable Care Act limits a SHOP's ability to offer an employer additional options, including choice across cost-sharing levels. We believe that States and SHOPs are best positioned to strike the proper balance among competing priorities: flexibility, meaningful consumer choice, and protection of the market against risk selection. Thus, we have retained the proposed wording of § 155.705(b)(2) and (b)(3) in the final rule.

We also note specifically that the SHOP may allow employers to offer only one plan to its employees. We believe this is supported by section 1312 of the Affordable Care Act, which defines a "qualified employer" as a small employer that elects to make all full-time employees eligible for one or more QHPs offered in the small group market through the Exchange. However, we do not believe that this definition establishes that the SHOP must give employers the option to offer only a single plan.

With regard to the comments on defined contribution, we note that the method through which an employer offers QHPs to its employees is independent of how the employer chooses to contribute toward the premium cost of coverage.

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Comment: One commenter expressed concern that allowing employers to enroll their qualified employees into a single QHP may trigger the application of ERISA, and that the Affordable Care Act was intended to supersede ERISA and provide stronger Federal and State protections to consumers.

Response: Issues on the application of ERISA are within the purview of Department of Labor. In this rule, we clarify that a SHOP may permit employers to offer employees a single QHP.

Comment: One commenter on proposed § 155.705 requested that HHS clarify whether the employer or the SHOP will be responsible for maintaining records on employee QHP selections, and further expressed concern that the employer would be unable to monitor its employees' QHP selections.

Response: As described in § 155.705(b)(4)(i) of this final rule, the SHOP is responsible for providing each qualified employer with a bill listing the employees enrolled under that employer, the QHP each employee is enrolled in, and the cost of the QHP.

Comment: We received several comments regarding the proposed § 155.705(b)(4), which stated that a SHOP must provide a "single bill" to qualified employers and aggregate premium payments from employers. Many commenters supported this proposal, noting that it was essential to the effective operation of providing employees with a choice of QHP and should ease the burden on small employers of administering group health benefits. Some commenters recommended that the single bill list for each employee the portion of the premium the employee is responsible for and the portion of the premium for which the employer is responsible, while others suggested that the SHOP assist employers in calculating an average premium for its employees. In contrast, other commenters suggested that premium aggregation should not be a minimum function of the SHOP or should be optional for employers not providing their employees with a choice of QHP. Some commenters noted that health plans currently provide their own the billing services and that a standard on the SHOP to aggregate premiums may add to the administrative cost of selling QHPs through the SHOP.

Response: We believe that premium aggregation dramatically decreases the burden on an employer of participating in the SHOP by permitting the employer to write a single check for the total premium amount due. We do not believe that SHOP premium aggregation will increase the administrative burden on issuers who already perform billing services, because such issuers will no longer have to submit, track, and support a large number of paper bills to individual employers. Further, we believe that the process of resolving discrepancies will be simplified, since the issuer only needs to reconcile with one entity—the SHOP.

Additionally, we believe that bills provided by the SHOP should contain in addition to the total amount due by the employer, the portion of each employee's premium for which the employer is responsible and the portion for which the employee is responsible, and have revised paragraph § 155.705(b)(4)(i) of this final rule to reflect this clarification. We note that this information may be collected on the SHOP single employer application. The SHOP may also include an average premium on the billing statement to assist employers in smoothing premium costs between employees.

Comment: Some commenters responding to proposed § 155.705 requested clarification regarding procedures for dispute resolution for potential scenarios where the SHOP failed to remit payment to QHP issuers in a timely manner or failed to collect the correct amount from employers. One commenter recommended that proposed § 155.720(d) allow a grace period for employees and employers for making premium payments based on evidence of a "good faith" effort.

***18398** Response: Because States vary dramatically in statutory and regulatory standards related to non-payment or late payment of premiums, we do not believe a Federal uniform standard and process could effectively prevent such errors. Instead, we encourage SHOPs to create standard operating procedures regarding the payment and remittance of premiums. We also recommend that SHOPs standardize grace periods across QHPs. Because proper oversight of the flow of funds is essential, we direct the SHOP to maintain records and evidence of standard accounting procedures in order to allow for effective auditing of the premium aggregation service.

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Comment: Commenters generally supported the option for a State to merge the individual and small group markets subject to the provisions of proposed § 155.705(b)(7).While commenters had a variety of views on the advisability of merging the markets, most commenters agreed that, if a State merges the markets, QHPs offered to small employers in the merged market must meet the maximum deductible provision in section 1302(c) of the Affordable Care Act. One commenter said that QHPs in a merged market should not be subject to a maximum deductible, and another commenter stated that there should be no restrictions on the deductible in the small group market.

Response: We do not believe that the statute allows issuers who participate in a merged market to be exempted from offering small businesses the maximum deductible in the Affordable Care Act; therefore, we are finalizing § 155.705(b)(7) as proposed.

Comment: Commenters expressed concern that limiting employees to small group market QHPs rather than in any QHP that meets the maximum deductible provision in section 1302(c) of the Affordable Care Act may make it more difficult to achieve portability of coverage across employment situations, including periods of unemployment and self-employment, and may complicate the aggregation of employer contributions from different employers. The commenters asked that the standard be changed or removed in the final rule.

Response: While we understand the concern about portability between small group and individual market products, section 1311(b)(1)(B) of the Affordable Care Act clearly states that the SHOP is “designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State.” We have therefore retained the language in § 155.705(b)(8) in this final rule.

Comment: Several commenters expressed concerns about the possibility of adverse selection and other market disruptions that might result from a State's choice to allow large group market issuers to offer QHPs in the large group market through the SHOP. Two commenters specifically expressed concern about an automatic SHOP expansion to the large group market. Several commenters recommended that States not expand the SHOP; one commenter suggested that HHS delay the expansion; and one commenter asked that HHS create safeguards to prevent adverse selection. Finally, one commenter asked that we interpret section 1312(f)(2)(b) of the Affordable Care Act to allow States the latitude to expand the SHOP earlier than 2017.

Response: Section 2701(a)(5) of the PHS Act provides that if the State exercises the option of offering large group market QHPs in the SHOP, the rating rules in section 2701 that apply to the small group market will also apply to all coverage offered in that State's large group market, except for self-insured group health plans. A State must specifically elect the expansion. We also do not believe that we have the authority to delay—or to allow earlier implementation of—the State's ability to make this election. Accordingly, we are not modifying the final rule to provide for any such modifications.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.705 of the proposed rule, with the following modifications: in paragraph (b)(4)(i), we clarified the data elements that must be included in the monthly bill sent by the SHOP. In new paragraph (b)(4)(iii), we added a standard for the SHOP to maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years, to conform to the standards for the individual Exchange. We also clarified in paragraph (b)(5) that the SHOP must ensure that each QHP meets the certification standards in § 156.285. In new paragraphs (b)(10) and (11), we noted that the SHOP may authorize minimum participation standards on certain conditions, and established that the SHOP must develop a premium calculator to assist qualified employers and employees. Finally, we made several technical clarifications and modifications.

c. Eligibility Standards for SHOP (§ 155.710)

In § 155.710, we proposed the eligibility standards for qualified employers and qualified employees seeking to purchase coverage through a SHOP, and proposed to codify the general standard that the SHOP make QHPs available to qualified

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employers. Specifically, we proposed that the SHOP ensure that an entity is a small employer, or an employer with no fewer than one employee and no more than 100 employees, unless a State elects to limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016.

We also proposed to define "employer," "small employer," and "large employer" based on the PHS Act, and to adopt the PHS Act methodology for counting employees, where employees are counted equally regardless of their status as a part time employee or full time employee. Noting that States use a variety of methods to determine employer size for purposes of determining eligibility for the small group market, we solicited comment on this approach.

We further proposed that the SHOP must ensure a qualified employer provides an offer of coverage through a SHOP to all of its full-time employees, and that the employer can elect to cover all employees through the SHOP serving the employer's principal business address or by providing coverage to each eligible employee through the SHOP serving the employee's primary worksite. In cases where the employer elects to cover all employees through the SHOPs serving their worksites, we proposed that a SHOP must accept the application of such an employer, subject to any minimum participation rules authorized by the SHOP. In addition, we proposed to allow an employer participating in the SHOP to continue its participation if the number of workers employed fluctuates after the employer's initial eligibility determination. We also clarified that only an employee who receives an offer of coverage through the SHOP from a qualified employer may be a qualified employee.

Comment: Many commenters addressed the question of whether businesses consisting entirely of sole proprietors, 2 percent S-corporation shareholders, and their family members, with no common law employees, should be eligible to purchase coverage through a SHOP. Several commenters were in favor of either including sole proprietors in the definition of eligible employer or allowing States to decide whether to expand their definition of a small group to encompass sole proprietors, stating that this would be analogous to the HIPAA interpretation that States could extend HIPAA protections to more ***18399** employers. Other commenters suggested deferring to State definitions of small group to avoid confusion and minimize possible differences between the SHOP and the outside market.

Many commenters supported allowing sole proprietors to choose either Exchange individual market or SHOP coverage. Some commenters suggested deferring to State law to allow those States to continue offering small group coverage to sole proprietors. Many other commenters supported the proposed rule's exclusion of sole proprietors from the small group market, noting that the current rationale for allowing sole proprietors to purchase in the small group market—to provide access to a guaranteed issue product with modified community rating—will not be relevant in 2014 because of individual market reforms. Several of these commenters suggested that the final rule make clear that sole proprietors are eligible for coverage in the Exchange. Two commenters suggested using the COBRA standard to determine the number of employees, which would also exclude sole proprietors. Other commenters who supported the rule as proposed suggested that allowing sole proprietors and S-corporation owners a choice between markets would create possible adverse risk selection.

Response: The Affordable Care Act and the proposed rule base their definitions of "employer," "employee," "small employer," and "large employer" on the definitions in the Public Health Service Act (PHS Act). Section 2791 of the PHS Act incorporates by reference the definition of employee in section 3(6) of ERISA. Further, section 2791 provides that an employer is defined by reference to section 3(5) of ERISA. To be an employer eligible to purchase coverage through the SHOP, the employer must employ at least one common law employee. Under 29 CFR 2510.3-3, an employee would not include a sole proprietor or the sole proprietor's spouse.

We find no authority to interpret what constitutes a group health plan differently than set forth in the proposed rule. And, we note that even though both markets will have guaranteed issue and similar rating rules, enrollment of individuals is limited to the annual open enrollment period while enrollment of groups can occur throughout the year. We have therefore retained the definitions in proposed § 155.20, and our interpretation of what constitutes a group health plan.

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Comment: A number of commenters addressed the issue of how employees should be counted in determining employer size. Commenters noted that States use different methods to calculate employer group size when determining small group market eligibility. Several commenters noted that there are also different Federal methods for determining employer size for different purposes, and that these differing methods may be confusing to small employers. While some commenters supported the proposed approach, to count all full-time and part-time employees, other commenters suggested specific alternatives, including but not limited to a full-time equivalent method like that used in section 4980H of the Code, as added by section 1513 of the Affordable Care Act, to determine whether an employer is a large employer; the full-time equivalent method used to determine whether Federal COBRA continuation of coverage standards apply; or counting full-time employees only. Finally, a number of commenters suggested that each Exchange defer to the applicable State's method of determining group size or transitioning from current State methods of counting employees to a Federal method.

Response: CMS has previously issued guidance on determining employer size that includes part-time employees in the count.[FN10] For example, the method described in the preamble to the proposed rule would count part-time employees as full employees. A second method proposed in a 2004 proposed rule issued by the Department of the Treasury, the Department of Labor, and HHS, in which the number of full-time equivalent employees is determined.[FN11] Because of the range of comments received to the proposed rule and because the method of counting employees has implications that extend beyond the operation of the SHOP, we are not finalizing at this time a rule for determining employer size. We are considering future rulemaking to address the method of determining employer size for purposes of deciding whether an employer is a small employer or a large employer.

Comment: Several commenters suggested that the proposed rule articulate the method of determining whether a small employer is subject to or exempt from the shared responsibility standards, since that determination is different from the determination of eligibility for participation in the SHOP.

Response: Formal guidance about the method of determining whether a small employer is subject to the shared responsibility provisions is outside the scope of this final rule.

Comment: Several commenters supported the flexibility of the employer and employee eligibility standards in proposed § 155.710, including allowing employers with worksites in the service areas of multiple SHOPs to offer coverage to their employees through the SHOP serving the employees' worksites. Some commenters requested clarification regarding the coordination of information necessary for the effective implementation of such an eligibility standard. Other commenters requested clarification of how employer groups can calculate premiums in a way that mitigates the effects of age rating in instances where workers obtain coverage through more than one Exchange. Finally, one commenter recommended that employee eligibility be limited to the State in which the employer's headquarters is located.

Response: We recognize the benefits of allowing employers in multiple States flexibility regarding the SHOPs in which they may opt to enroll. We believe this eligibility standard does not establish a significant level of coordination between SHOPs, though nothing in this section would preclude a SHOP from establishing processes or standard operating procedures to coordinate across service areas. Employers electing to participate in multiple SHOPs must meet the eligibility standards of each SHOP in which they wish to participate and prior to 2017 may not employ more than 100 employees in total in accordance with section 1312(f)(2) of the Affordable Care Act. We acknowledge, however, that standards related to the calculation of premiums in the small group market may vary from State to State in a manner that does not allow differences in cost due to age or location to be spread easily among all employees across State lines.

Comment: One commenter objected to the proposed § 155.710(b)(2), which stated that the SHOP must ensure that a qualified employer provides an offer of coverage through the SHOP to all full-time employees because it places an administrative burden on the SHOP and would be difficult to enforce. Other commenters suggested that a multi-employer plan should be able to offer ***18400** coverage to its participants through the SHOP only to the employees of a participating small employer covered under a collective bargaining agreement.

Response: Our eligibility process allows the SHOP to accept an attestation by an employer that it will offer coverage to all of its full-time employees, minimizing the commenter's concern about burden. Multiemployer plans that qualify as QHPs may offer coverage in SHOP but, like other QHPs, must follow rules applicable to QHPs. Additionally, we intend to address commenters' concerns surrounding multi-employer plans in future guidance.

Comment: One commenter suggested that additional guidance might be needed with regard to multi-employer plans purchasing coverage through the SHOP, particularly with regard to determining the work site, establishing eligibility and enrollment procedures, billing and premium collection, and other administrative procedures.

Response: Multiemployer plans can play a role as an aggregator of premium contributions, and an arranger of coverage, and intend to address commenters' concerns in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.710 of the proposed rule without substantive modification.

d. Eligibility Determination Process for SHOP (§ 155.715)

In § 155.715, we proposed that a SHOP determine eligibility consistent with the standards described in § 155.710. Specifically, we proposed that a SHOP must verify either through the attestation of the employer or through additional methods developed by the SHOP, that a qualified employer has fulfilled all of the standards specified in § 155.710, including that the employer is a small employer, it is offering coverage through the SHOP to all full-time employees, as well as verifying that at least one employee works in the SHOP's service area.

Consistent with the statutory directive for HHS to provide a single, streamlined application form, we also proposed that the SHOP use only two application forms: one for qualified employers and one for qualified employees. We further proposed that for the purpose of determining eligibility in the SHOP, the SHOP may use the information attested to by the employer or employee on the application but must, at a minimum, verify that an individual attempting to enter the SHOP as an employee is listed on the qualified employer's roster of employees to whom coverage is offered. We also proposed that the SHOP have processes to resolve occasions when the SHOP has a reason to doubt the information provided through the employer and employee applications. In addition, similar to the individual market Exchange standards, we proposed that the SHOP notify an employer or employee seeking coverage of the SHOP's eligibility determination and the employer or employee's right to appeal.

Finally, we proposed that if a qualified employer ceases to purchase any coverage through the SHOP, the SHOP must ensure that: (1) each QHP terminates the coverage of the employer's qualified employees enrolled in QHPs through the SHOP; and (2) each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the employer's withdrawal and its termination of coverage prior to such withdrawal and termination. We solicited comments on whether this notification must inform the employee about his or her eligibility for a special enrollment period in the Exchange and about the process of being determined eligible for insurance affordability programs.

Comment: We received several comments regarding the eligibility determination process for employees proposed in § 155.715. Some commenters opposed the processes for individual employee verification, stating that the process may increase the administrative burden on businesses. Others suggested that the SHOP should not verify employee eligibility and questioned the Secretary's authority for such verifications. Commenters recommended that any SHOP eligibility process conform to the standards of sections 1411(g) and 1411(h) of the Affordable Care Act. Some additionally proposed an alternative process whereby employers applying for coverage in a SHOP present a list of qualified employees with reference to associated Employment Identification Numbers (EIN) in order to prevent employer and employees applicants from gaming the eligibility process. Commenters additionally recommended that the final rule prohibit the SHOP from collecting information for

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verification of citizenship status or eligibility for the advance payment of the premium tax credit, as described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act.

Response: We note that in accordance with § 155.705(a), SHOPs must comply with the standards of part 155 subpart C including the privacy and security standards of § 155.260 and § 155.270. These sections implement section 1411(g) of the Affordable Care Act.

The employee eligibility process as proposed would direct the SHOP to verify only that an employee applying for coverage through the SHOP is a qualified employee—an employee offered coverage by a qualified employer. We believe that such verification is necessary to ensure the effective operation of the SHOP and the prevention of abuse. An employee applying to the SHOP for coverage may easily be both verified and determined to be a qualified employee by the SHOP solely on the list of qualified employees provided to the SHOP by the employer.

Because citizenship verification is the responsibility of the employer at the time of hiring, we have added language in this final rule to clarify that the SHOP will not perform re-verification of citizenship status.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.715 of the proposed rule, with the following modifications: in new paragraph (c)(3), we clarified that a SHOP may only collect the minimum information necessary to verify the information provided in an application. In new paragraph (c)(4) we reiterated that the SHOP may not perform individual eligibility determinations as described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act. In paragraph (d)(1)(iv)(A), we established that the SHOP must mention an employer's right to appeal in any notice of denial of eligibility. In paragraph (g)(2), we specified that the SHOP must ensure that any employees affected by a qualified employer's withdrawal from the SHOP are notified and receive information about other coverage options. Finally, we made several changes throughout this section to improve the precision of the language used.

e. Enrollment of Employees Into QHPs Under SHOP (§ 155.720)

In § 155.720, we proposed that the SHOP establish a uniform enrollment timeline and process, standardized to a plan year, for all employers and QHPs in the SHOP. In addition, we proposed that the SHOP must ensure that qualified employees who select a QHP are notified of the effective date of coverage, whether such notice is executed by the QHP or by the SHOP.

We also proposed that information maintained by the SHOP must include records of qualified employer participation and qualified employee enrollment, and that reconciliation of enrollment information with QHPs ***18401** occur at least monthly. We invited comments on whether we should establish target dates or guidelines so that multi-State qualified employers are subject to consistent rules.

Finally, we proposed that if a qualified employee voluntarily terminates coverage from a QHP, the SHOP must notify the individual's employer.

Comment: Several commenters suggested that proposed § 155.720(a) clarify the duties of the SHOP and QHP issuers when facilitating employee enrollment into QHPs.

Response: Section 155.705 directs a SHOP to carry out the minimum functions in other subparts of the part. Consistent with the proposed rule, § 155.720(c)(2) of the final rule directs a SHOP to fulfill the standards of § 155.400, which establishes standards related to enrollment of individuals into QHPs.

Comment: One commenter requested clarification that QHP issuers do not have to participate in both the SHOP and individual Exchanges.

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Response: Nothing in this part establishes that an issuer must participate in both the SHOP and the individual Exchange. However, we note that Exchanges may wish to establish such participation in both markets as a condition of certification.

Comment: One commenter to this section recommended automatic enrollment of employees into new QHPs when there are mergers between QHP issuers or when one QHP offered by a specific QHP issuer is no longer offered, but there are other options available to the individual through the same QHP issuer.

Response: We believe that States may wish to take variable approaches to managing the enrollment; and therefore, we are not establishing a standard to offer automatic enrollment in this final rule.

Comment: Several commenters to proposed § 155.720(b) recommended that the final rule afford States further flexibility with respect to enrollment timelines. A few commenters suggested that the SHOP base its timelines on eligibility rules for enrollment on the current market practices. A few commenters recommended that the final rule exclude any target dates and guidelines in § 155.720, while another commenter recommended that the rule establish basic guidelines and leave the selection of exact dates to the SHOP. Yet another commenter expressed concern that the proposed rule did not provide sufficient flexibility for industries that typically begin coverage on October 1 and recommended that SHOPs be permitted to provide special group enrollment for those groups or amend the rule to afford States greater flexibility to address those circumstances. Conversely, another commenter proposed that § 155.720 include target dates and guidelines so that multi-State employers are subject to consistent rules. One commenter supported similar enrollment processes and timelines across QHPs to allow qualified employees the greatest opportunity to select preferred plans and ease administrative burden for multi-State employers.

Response: We believe that § 155.720 provides adequate flexibility for a State to develop its process in a way that is most suitable to local situations. Thus, we have not included specific dates in the section and have allowed States flexibility to address specific needs or concerns, including current market environment and special industries.

Comment: Two commenters responding to this section and § 155.725 recommended that HHS develop a transaction standard with respect to collected enrollment information.

Response: We plan to provide guidance on the timing, format, and content of the enrollment information transmissions to QHP issuers.

Comment: Several commenters suggested proposed § 155.720(e) specify how SHOPs can ensure that QHPs provide notices to employees of effective coverage dates. One commenter supported the policy that SHOPs be held accountable for employees receiving notices of effective dates of coverage. One commenter recommended that QHPs transmit confirmation of enrollment to the SHOP, and another urged HHS not to add a standard that the SHOP must send a duplicate notification to the enrollee.

Response: SHOPs must be able to enforce the notification standard; we believe that § 155.720 provides a State with the flexibility to establish its SHOP enrollment timeline, procedures, and enforcement mechanisms that work best for the particular State. The QHP should be responsible for sending notification; we have clarified in § 155.720(e) of this final rule that a QHP, and not the SHOP, must send the notification.

Comment: In response to proposed § 155.720(f) and (g), one commenter opposed the policy for the SHOP to reconcile information and keep records, noting that it is unclear under the Affordable Care Act why SHOP should maintain records.

Response: The reconciliation of information and the retention of records of participants and participant information by the SHOP is a necessary standard for the smooth operation of the SHOP and effective oversight of the SHOP.

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Comment: Several commenters to proposed § 155.720(g) supported the idea of reconciliation of enrollment information but disagreed on the frequency and on who should determine the frequency. One recommended that this paragraph establish monthly reconciliation and that SHOPs allow QHPs to query a SHOP at any time for information on qualified employers and employees. A few commenters recommended flexibility for States to establish reporting and auditing standards.

Response: We recognize the need for periodic reconciliation of enrollment information between the SHOP and the QHPs. However, States should have the flexibility to determine how often such reconciliation is necessary, provided that reconciliation is completed no less frequently than once per month. Therefore, we are not adding a more specific standard in the final rule.

Comment: In response to the standards in proposed § 155.720(h) related to termination of a qualified employee, some commenters recommended allowing SHOPs to ensure that disenrollment requests from current employees to come through the employer because such a process would ensure the employer receives notification and is able to communicate to the employee the potential consequences of disenrollment. One commenter recommended that an employee who ends employment should consult with the employer regarding available coverage options after employment ends. Another commenter recommended the notification standard be placed on the QHP issuer and not on the SHOP.

Response: We believe that § 155.720(h) of this final rule ensures that an employer will receive appropriate notification while preserving an employee's ability to terminate coverage without the added step of consulting with the employer or creating an additional administrative burden on the employer. We believe that the notification standard should remain with the SHOP and that the associated administrative burden will be minimal.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.720 of the proposed rule, with the following modification: in paragraph (f), we clarified that SHOPs must retain records for ten years, which is changed from the proposed seven years. We added new paragraph (i), ***18402** which directs the SHOP to report to the IRS employer participation and employee enrollment information for tax administration purposes. Finally, we made a few technical modifications to streamline the regulation text.

f. Enrollment Periods Under SHOP (§ 155.725)

In § 155.725, we proposed that the SHOP adhere to the start of the initial open enrollment period for the Exchange, which is October 1, 2013 for coverage effective January 1, 2014, and ensure that QHP issuers adhere to coverage effective dates in accordance with § 156.260. We noted that the initial open enrollment date represents the first date employers may begin participating in the SHOP. In addition, to align enrollment processes between the SHOP and the small group market, we proposed a rolling enrollment process in the SHOP whereby qualified employers may begin participating in the SHOP at any time during the year.

We invited comment on two provisions related to SHOP enrollment: that qualified employers may enroll or change plans once per year or during an applicable special enrollment period; and that an employer's plan may not align with the calendar year.

We also proposed an annual employer election period in advance of the annual open enrollment period, during which time a qualified employer could modify the employer contribution towards the premium cost of coverage and the plans it intended to offer to employees during the next plan year. We noted that this annual election period may be specific to each qualified employer and therefore must occur at a fixed point in the plan year, not at a fixed point during the calendar year. In addition, we proposed that the SHOP must notify participating employers that their annual election period is approaching, and solicited comment on this standard and whether we should establish that the notice be sent at a specified interval (for example, 30 days before the relevant election period).

We solicited comment on our proposal that the SHOP establish an annual employee open enrollment period for qualified employees, to occur at a fixed point during the plan year, during which the employee would have the option to renew or change

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coverage. We proposed that a qualified employee who is hired outside of the initial or annual open enrollment period would have a specified window set by the SHOP to seek coverage in a QHP beginning on the first day of employment. We also proposed that the SHOP establish effective dates of coverage for qualified employees consistent with § 155.720. Finally, we proposed that if an enrollee remains eligible for coverage in a QHP through the SHOP, the individual will remain in the QHP selected during the previous plan year with limited exceptions, in which case the individual would be disenrolled at the end of the coverage year. We invited comments on our approach to differentiating individual and small group market enrollment and the proposed structure for initial, rolling, and annual open enrollment through the SHOP.

Comment: In response to proposed § 155.725(a), some commenters opposed aligning the enrollment periods in § 155.725 with the individual Exchange and recommended that SHOP enrollment should be aligned with other group markets.

Response: In § 155.725(a), we align the SHOP initial open enrollment period with an individual Exchange for the first opportunity when coverage may be purchased through the SHOP. Under § 155.725(b), we establish rolling enrollment in the SHOP, which we believe is consistent with current practice in the small group market where plan years do not necessarily correspond to calendar years. We have retained these provisions in the final rule.

Comment: In response to the standards in proposed § 155.725(a)(2), one commenter requested clarification that effective dates depend on the completion of eligibility and enrollment standards, and recommend that such standards must be met by December 7, 2013 to secure a coverage effective date of January 1, 2014.

Response: A SHOP must permit an individual to enroll in a QHP only after a qualified employee has been determined eligible and has completed any enrollment standards. We believe that the standards in § 155.410 of this final rule provide sufficient time for QHP issuers to effectuate enrollment.

Comment: A few commenters on this section recommended adding a standard that SHOPs develop a plan to encourage maximum enrollment during the initial open enrollment period, noting concerns about adverse selection if certain employers wait to enroll until health care needs make it more advantageous. One commenter recommended allowing employers to pro-rate their initial year of participation and then begin their next plan year on January 1st of the following year to minimize public confusion and aid implementation.

Response: We believe that States have the flexibility under the rule to best assess their local market environment and to develop plans to encourage enrollment and discourage adverse selection.

Comment: Many commenters on proposed § 155.725(e) recommended that the annual employee open enrollment period last at least 30 days. Some commenters recommended that open enrollment should be standardized for all QHPs. Several supported a notification period for employees before the annual enrollment period. One commenter recommended the employer, and not the SHOP, decide the open enrollment period, and a few commenters recommended the Federal government defer to States to establish open enrollment periods.

Response: We have added language to § 155.725(e) of this final rule establishing a standardized open enrollment period of at least 30 days. We note that States will have the flexibility to establish open enrollment periods based on the specific market landscape of the State, and believe that § 155.725 provides that flexibility. We further believe that employees should receive a notification in advance of the open enrollment period and have added a standard in new § 155.725(f) that the SHOP provide notification to qualified employees of the open enrollment period in advance of the period.

Comment: Several commenters on proposed § 155.725(d) supported the policy that the SHOP must notify the employer in advance of the annual employer election period. A few supported a notification period of 30 days or at least 30 days, one requested flexibility in determining when employers must be notified, and one recommended that the notification period align

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with the outside market to prevent additional administrative burden on QHPs. Conversely, one commenter opposed a notification standard for the SHOP, stating that this function is currently handled by health insurance issuers.

Response: We believe that the SHOP should provide notification of the open enrollment period but do not believe that we should prescribe specific timing for the notification. We believe that § 155.725 of the proposed rule provides the SHOP with the requested flexibility for notification timing. Finally, we note that the SHOP is the appropriate entity to notify employers because a single employer could have employees enrolled in QHPs across several issuers. Therefore, we are not changing this standard in the final rule.

Comment: A few commenters on proposed § 155.725(c) recommended that the annual employer election ***18403** period last at least 30 days. One commenter recommended that an employer must submit an application to participate in SHOP at least 120 days prior to the start of the plan year.

Response: We recognize the importance of an annual employer election period of at least 30 days and have added language to § 155.725(c) to that effect. However, we note that States have the flexibility to establish longer annual employer election periods if they so choose.

Comment: In response to proposed § 155.725(h), one commenter requested clarification on the auto-enrollment process where a QHP ceases to exist and an individual does not select another QHP.

Response: Auto-enrollment in the SHOP is only applicable per redesignated § 155.725(i) of this final rule in situations in which a qualified employee enrolled in a QHP through the SHOP remains eligible for coverage. In such cases, the employee will remain in the QHP selected during the previous year unless the qualified employee terminates coverage, enrolls in another QHP, or the QHP is no longer available. We note that if a QHP ceases to exist, resulting in a loss of minimum essential coverage for the enrollee, the enrollee will be eligible for a special enrollment period per § 155.725(a)(3). We also note that under § 156.290(b), a QHP issuer that does not seek recertification with the Exchange for a QHP must provide written notice to each enrollee. However, in these cases where an enrollee's former QHP is no longer available, there is no auto-enrollment standard in the SHOP should the individual not select another QHP during a special enrollment period or open enrollment period.

Comment: Many commenters offered feedback on the proposed § 155.725(g), which stated that the SHOP must establish effective dates of coverage for enrollees in the SHOP. A few commenters requested that the final rule clarify the SHOP's obligation to establish coverage effective dates. One commenter recommended that coverage take effect on the first day of the month following the date of enrollment for enrollment transactions completed by the 20th of the month. In cases where enrollment is completed after the 20th, the commenter recommended that coverage take effect on the first day of the month that follows the next month. In contrast, some commenters disagreed with the policy that SHOPs must establish effective dates of coverage, noting that employers and carriers currently perform this function.

Response: Per redesignated § 155.725(h) of this final rule, the SHOP must establish coverage effective dates consistent with § 155.720. We believe that a single policy of effective dates in the SHOP ensures consistency and note that we proposed using the same effective dates as the individual Exchange for the initial enrollment period in order to increase the administrative simplicity for Exchanges and issuers. We believe the § 155.410 standards provide sufficient time for processing enrollment information before the effective date of coverage. Therefore, we are finalizing redesignated § 155.725(h), as proposed. We further note that a SHOP must not only establish effective dates but must also ensure notification of the effective dates in accordance with § 155.720.

Comment: Some commenters to § 155.725 recommended that employees receive advance notice if the QHP in which they are enrolled will no longer be offered through the SHOP for the upcoming plan year. Another commenter recommended that employees in this circumstance receive advance notice of other affordable options, including insurance affordability programs.

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Response: We note that § 156.285(d)(1)(ii) of this final rule directs any QHP issuer that chooses not to renew its participation in the SHOP to notify affected enrollees and qualified employers. We believe that this notification standard, combined with the annual open enrollment period, provides sufficient opportunity for enrollees to review their coverage options and make a new plan selection. Therefore, we are not adding a notification standard in this section.

Comment: Several commenters on proposed § 155.725(f) supported the policy that SHOPs provide coverage to any new employees hired outside of the initial or annual open enrollment period and that SHOPs be able to make that coverage available on the employee's first day of employment. One commenter recommended a predetermined, regulated length of time for the enrollment period. One commenter expressed concern with the limited ability to amend an employee's coverage and recommended that employees have an opportunity to state a case for needing to change coverage similar to special enrollment rules. One commenter suggested that there should be a special enrollment period if an employer reduces its contribution. Other commenters questioned how this standard relates to probationary periods, specifically the Affordable Care Act provision that permits group plans to impose waiting periods of no more than 90 days for coverage of new employees.

Response: In general, we recognize the importance of providing coverage to new employees hired outside of the initial or annual open enrollment. Thus, we have clarified in redesignated § 155.725(g) of this final rule to assure that the SHOP provides an employee who becomes a qualified employee a period to seek coverage that would be effective on the first day of becoming a qualified employee rather than on the first day of employment. This revision refines the standard to encompass not only new employees, but also situations where an employee moves from part to full time status or completes a waiting period. In the case of a waiting period, an employee could become a qualified employee under § 155.710(e) when the qualified employer makes an offer of coverage after the waiting period is over. It still retains the ability for a new and qualified employee to seek coverage on the first day of employment. States will be able to set a time for this period under § 155.720. We believe that § 155.725 does not preclude a State from creating special enrollment periods in addition to the ones established by the rule.

Comment: One commenter on proposed § 155.725(h) recommended that because eligibility of a qualified employee to enroll in a QHP through the SHOP is available on the basis of employment by a qualified employer, the employer should be responsible for renewing its employees' coverage at the end of a plan year.

Response: We believe that § 155.725(c) adequately addresses that concern by specifically establishing that a SHOP must provide qualified employers with an annual election period in which a qualified employer may change its participation in the SHOP for the next year, including the method it makes QHPs available to qualified employees, the level of employer contribution, the level of coverage offered, and the QHP or plans offered. Therefore, we are finalizing this provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.725 of the proposed rule, with the following modifications: in new paragraph (a)(3) we clarified that a SHOP must provide the special enrollment periods described in § 155.420, with the exception of those described in paragraphs (d)(3) and (6) of that section. We provided in paragraph (c) that the SHOP must allow qualified employers a period of no less than 30 days to alter plan selections prior to the ***18404** open enrollment period. We established in paragraph (e) that the annual employee open enrollment period must be standardized, and must be at least 30 days. In new paragraph (f), we direct the SHOP to provide notification to a qualified employee of the annual open enrollment period. In redesignated paragraph (g) we clarified that the SHOP must offer an enrollment period to newly qualified employees. Finally, we redesignated proposed paragraphs (f), (g), and (h) as paragraphs (g), (h), and (i), respectively, and made several minor changes throughout this section to make the regulation text more precise and to add clarity.

g. Application Standards for SHOP (§ 155.730)

In 155.730, we outlined the proposed application-related standards for participation in the SHOP. Specifically, we proposed that the SHOP use a single employer application and the information the application should collect (that is, employer name and

address, number of employees, employer identification number, list of qualified employees and SSNs). We sought comment on what, if any, other employer information SHOPs should collect via the employer application.

Similarly, we proposed that the SHOP must use a single employee application for each employee to collect eligibility information and QHP selection. We noted that a SHOP may modify or reduce the individual Exchange application for SHOP applicants, if desired and subject to approval by the Secretary. We also proposed that a SHOP may also use a model single employer application and model single employee application created by HHS or an alternative application approved by HHS. Finally, we proposed that the SHOP must allow employers and employees to submit their eligibility and enrollment information consistent with § 155.405(c).

Comment: We received several comments regarding the preamble discussion in the proposed rule that the SHOP should not make eligibility determinations for Medicaid or CHIP. Many commenters recommended that the final rule outline a role for the SHOP in providing information about these programs.

Response: There are a number of ways that employees can learn about insurance affordability programs. We do not think that the application for SHOP is the most effective venue for providing this information.

Comment: We received several comments related to the limitations on the information that may be collected on SHOP applications in accordance with proposed § 155.730(a). Some commenters requested that the final rule not impose any limitations on the information that the SHOP may request of employees, noting that such restrictions could limit how well the SHOP can serve qualified employers and qualified employees. Other commenters supported the proposed rule's focus on a simple application standard and limiting the information collected to information necessary to facilitate applications, eligibility determinations, and enrollment.

Response: We believe that limiting the collection of information on the application to data relevant for eligibility determinations, enrollment, and reporting by the SHOP or by QHP issuers balances the need to minimize the burden placed on applicants with the information needs of the SHOP and QHP issuers. Therefore, we are finalizing the provisions of § 155.730(a) as proposed.

Comment: One commenter suggested that the application collect the NAIC code of each employer applying to the SHOP under proposed § 155.730(a).

Response: We do not believe that it is essential for the SHOP application to collect each employer's NAIC code, since it is beyond what is minimally necessary for the purpose of the SHOP.

Comment: Some commenters were strongly opposed to the standard that the SHOP collect the social security number (SSN) of employees on the employer application in accordance with proposed § 155.730(a)(4). These commenters stated that effective alternate methods of authenticating employees exist, recommended that this standard be removed from the final rule.

Response: While employees may be effectively authenticated without the employer providing employee SSN on the employer application, employee taxpayer identification numbers (most commonly an employee's SSN) are needed for QHP issuers to comply with the standards of section 1502 of the Affordable Care Act. Although we retain the employees' names and taxpayer identification numbers as elements of the employer application, we have clarified in § 155.715(c)(4), that the SHOP may not re-verify the citizenship status of the employee or make a determination of eligibility for an advance payments of the premium tax credit. We note that employees already provide their Social Security number to employers for a variety of purposes and this information is disclosed by the employer to both State and Federal agencies of for such purposes as unemployment insurance and tax purposes.

Comment: Some commenters requested that the SHOP be permitted to adopt an alternative employer or employee application without obtaining formal approval from HHS, as proposed in § 155.730(e), in order to prevent the delay in the adoption of

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such applications. Other commenters agreed with the proposed policy that HHS approve any alternative application to ensure it meets the standards of this section.

Response: The HHS review of any proposed alternative application is intended to ensure that it conforms to the standards proposed in this section. Therefore, we are maintaining the standard under § 155.730(e), as proposed.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 155.730 of the proposed rule, with two modifications. In paragraph (e) we clarified that a SHOP may develop and submit for HHS approval an alternative application for employers and employees. Additionally, in new paragraph (g) we provide for additional safeguards to address commenters concern regarding the collection and use of dependent information for purposes other than processing enrollment in a QHP and made several minor changes throughout this section to make the regulation text more precise and to add clarity.

7. Subpart K—Exchange Functions: Certification of Qualified Health Plans

This subpart codifies section 1311(d)(4)(A) of the Affordable Care Act, which establishes that Exchanges, at a minimum, implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by HHS. This subpart also clarifies the Exchanges' responsibility related to the inclusion in the Exchange of certain multi-State plans. We note that as States establish Exchanges, each State has choices related to certification of QHPs for the Exchange through the piece of legislation, executive order, or charter that creates the Exchange. Alternatively, the Exchange itself may be able to exercise discretion under existing State and Federal law.

a. Certification Standards for QHPs (§ 155.1000)

In § 155.1000, we proposed the overall responsibilities of an Exchange to certify QHPs. We proposed that QHPs must have in effect a certification issued or recognized by the Exchange as QHPs ***18405** and that an Exchange may only make available as a QHP a health plan that has in effect a certification issued or recognized by the Exchange as a QHP. We proposed to define a multi-State plan as a plan under contract with OPM to offer a multi-State plan that offers a benefits package that is uniform in each State and consists of the benefit design standards described in section 1302 of the Affordable Care Act; meets all standards for QHPs; and meets Federal rating standards in accordance with section 2701 of the PHS Act, or a State's more restrictive rating standards, if applicable.

We proposed that an Exchange may certify a QHP if the QHP meets minimum certification standards described in subpart C of part 156 and if the Exchange determines the QHP is in the interest of qualified individuals and qualified employers in the State. We noted than an Exchange could adopt an “any qualified plan” certification, engage in selective certification, or negotiate with plans on a case-by-case basis; the proposal also permitted an Exchange to establish additional certification criteria.

Comment: A few commenters requested that HHS redefine a multi-State plan in proposed § 155.1000(a) as a plan that is described under section 1334 of the Affordable Care Act to ensure continuous alignment between this final rule and forthcoming regulations on multi-State plans promulgated by the U.S. Office of Personnel Management (OPM).

Response: We believe the commenters' approach would better align this final rule with forthcoming regulations on multi-State plans. Therefore, we are revising the regulation text in final § 155.1000 to reference section 1334 of the Affordable Care Act. The final rule in this subpart has been revised throughout to acknowledge the role of OPM in certifying multi-State plans.

Comment: Several commenters requested additional information on how the Office of Personnel Management will administer multi-State plans. Commenters proposed specific recommendations, including that OPM deem existing health plans that operate in multiple States as multi-State plans, or that multi-State plans include protections for certain types of benefits (for example, benefits related to end-stage renal disease).

Response: The standards and processes related to multi-State plans will be addressed in forthcoming regulations implementing section 1334 of the Affordable Care Act promulgated by OPM. These issues are outside the scope of this final rule, which only addresses multi-State plans in connection with Exchange obligations to recognize multi-State plans as certified by OPM.

Comment: Several commenters requested that HHS clarify the language in proposed § 155.1000(c)(2) permitting an Exchange to certify a QHP if the Exchange determines that such QHP is in the interest of qualified individuals and qualified employers.

Response: We interpret § 155.1000(c)(2), as proposed and as finalized, as providing an Exchange with broad discretion to certify health plans that otherwise meet the QHP certification standards specified in part 156 in a way that best meets the needs of local consumers and businesses. We refer commenters to pages 41891 and 41892 of the Exchange establishment proposed rule for a more comprehensive discussion of the strategies an Exchange could use to apply the “interest” test, including consideration of the reasonableness of the expected costs supporting the QHP's premium and cost-sharing structure, past performance of the QHP issuer, quality improvement activities, enhancements of provider networks, the QHP service area, or past rate increases.

Comment: A few commenters requested that HHS clarify the meaning of the exclusions in proposed § 155.1000(c)(2)(i) through (iii), which place certain limits on an Exchange's ability to exercise the “interest” test described in proposed § 155.1000(c)(2).

Response: As proposed and as finalized, § 155.1000(c)(2)(i)-(iii) codifies sections 1311(e)(1)(B)(i)-(iii) of the Affordable Care Act, which limits an Exchange's ability to apply the “interest” test in certifying qualified QHPs. Specifically, we clarify that an Exchange cannot exclude an otherwise eligible QHP on the sole basis that it is a fee-for-service plan, through the use of premium price controls, or because the QHP covers treatments or services necessary to prevent patient deaths that the Exchange determines are inappropriate or too costly.

Comment: One commenter requested that the final rule clarify that any certification standards or processes developed in accordance with this section apply uniformly to any subsidiary Exchanges. Another commenter requested that a QHP issuer be permitted to operate statewide, even where subsidiary Exchanges cover smaller service areas.

Response: There may be multiple compelling and appropriate reasons for a State to create additional standards, or to take a different approach to certification, in different market regions. For example, a State may wish to employ different contracting strategies in a highly competitive, urban service area versus a rural service area. Further, we believe that the definition of an Exchange in § 155.20 and the authority to have a regional or subsidiary Exchange provided in § 155.140 establish that a subsidiary or regional Exchange not only must meet all Exchange responsibilities, but also have the same authority and discretion as an Exchange that serves an entire State. Therefore, we are not establishing uniform standards for subsidiary Exchanges within a State; we note, however, that HHS must review and approve subsidiary Exchanges. We expect that States will consider the implications of developing subsidiary Exchanges, including the potential effects on issuer participation in the State.

Comment: One commenter generally expressed concern about aligning market rules and consumer protections inside and outside of the Exchange.

Response: We note that nothing in the final rule limits a State's ability to adjust market and other rules outside of the Exchange to better align with the rules and protections that exist within the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1000 of the proposed rule, with the following modification: we revised the definition of a multi-State plan in paragraph (a) to mean a QHP that is offered in accordance with section 1334 of the Affordable Care Act, to ensure ongoing consistency with forthcoming regulations implementing this section. In paragraph (b), we amended the provision to clarify the language.

b. Certification Process for QHPs (§ 155.1010)

In § 155.1010, we proposed that the Exchange establish procedures for the certification of QHPs that are consistent with the certification criteria outlined in § 155.1000(c). We also proposed that a multi-State plan offered through OPM be deemed certified by an Exchange and noted that multi-State plans will need to meet all the standards for a QHP, as determined by OPM. To ensure consumers have a robust selection of QHPs during the open enrollment period, we further proposed that the Exchange complete the certification of QHPs prior to the open enrollment periods established in § 155.410. Finally, we proposed that the Exchange monitor QHP issuers for demonstration ***18406** of ongoing compliance with certification standards.

Comment: In response to proposed § 155.1010(a) on QHP certification, a number of commenters expressed support for Exchange flexibility in designing the certification process. Conversely, several commenters recommended a uniform, national set of certification standards and processes and proposed specific features, such as that the certification process consider past premium increases, an issuer's medical loss ratio, quality information, or provider payment standards. Several commenters requested that the final rule provide additional detail on the certification standards that Exchanges will use to evaluate QHPs.

Response: We recognize the importance of ensuring a basic set of uniform consumer protections across all Exchange markets through the setting of minimum certification standards for QHP issuers. We believe that States are best positioned to adapt and expand on these standards to meet the needs of consumers served by the Exchange, given local market conditions. Therefore, while Exchanges have discretion to identify certification standards above and beyond those provided for in the final rule, including the features suggested by commenters, we are not specifying additional elements in this final rule.

Comment: Many commenters expressed support for a specific contracting model the Exchange could adopt in accordance with proposed § 155.1010(a); of these, approximately half endorsed an “any willing plan” approach, in which the Exchange would contract with all QHPs that meet the relevant certification criteria. The other half of the commenters favored more proactive forms of “active purchasing,” including selective contracting with QHPs.

Response: As we noted in the preamble to the Exchange establishment proposed rule, we believe that an Exchange's certification approach may vary based upon market conditions and the needs of consumers in the service area. Accordingly, in this final rule, we offer flexibility to Exchanges on several elements of the certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs. An Exchange could adopt its contracting approach from a variety of contracting strategies, including an any-qualified plan approach, a selective contracting model based on predetermined criteria, or direct negotiation with all or a subset of QHPs. Therefore, we are not prescribing a specific contracting model in this final rule.

Comment: Many commenters expressed support for the provisions in § 155.1010(b) of the proposed rule related to the deemed certification of multi-State plans and emphasized the importance of creating a level playing field for all QHPs within an Exchange. Several commenters recommended that the final rule clarify that multi-State plans and CO-OPs will be treated identically to other plans; for example, multi-State plans and CO-OPs would comply with any additional certification criteria established by an Exchange, and could be excluded in States that selectively contract.

Response: The final rule establishing the CO-OP program, “Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program,” published at 76 FR 77392 (December 13, 2011) directs CO-OPs to comply with all standards generally applicable to QHP issuers. We anticipate that specific standards for multi-State plans will be described in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act.

We note that the Affordable Care Act specifically provides a deeming process for multi-State plans and CO-OPs. Based on this fact, we do not believe these plans can be excluded from participation, including in Exchanges that adopt selective certification approaches.

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Comment: Several commenters supported flexibility for States to establish a certification timeline for QHPs, as provided in proposed § 155.1010(c). In contrast, some commenters recommended that the final rule specify a certification timeline or suggested specific times by which health plans must be certified as QHPs, such as 10 months prior to the beginning of the relevant open enrollment period.

Response: In developing the certification timeframe, an Exchange may need to consider market conditions in the State, including the potential for participation by new QHP issuers. As a result, we are not establishing a specific deadline by which an Exchange must complete certification, other than that certification must be completed prior to the open enrollment period for those QHPs that will be made available during open enrollment. We have revised the regulation text by replacing the proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open enrollment period must be certified before the beginning of such period. We encourage Exchanges to certify QHPs before the open enrollment period to the extent possible, and to consider the needs of consumers, issuers, and other stakeholders when establishing certification timelines.

Comment: Multiple commenters requested clarification as to how Exchanges will continually monitor compliance with certification standards as described in proposed § 155.1010(d). Several commenters offered specific recommendations related to ongoing monitoring, including that HHS establish a national complaint tracking database; that QHPs demonstrate compliance rather than placing the burden of proof on Exchanges; that HHS establish penalties for non-compliance; and that Exchanges consider network adequacy and provider payment practices.

Response: The Exchange is generally responsible for monitoring ongoing QHP compliance with certification standards. There are existing and variable mechanisms for monitoring health plan performance; therefore, we believe Exchanges are best positioned to develop a process and infrastructure for monitoring QHP performance in the Exchange. This could include coordination with State departments of insurance, reviews of health plan performance, and other approaches. We note that the final rule gives Exchanges the express authority to decertify a QHP at any time for non-compliance with certification standards, including the discretion to establish sanctions for non-compliance.

Comment: Several commenters requested that the final rule clarify whether a multi-State plan may cover non-excepted abortion services if its service area includes one or more States where coverage of such services is prohibited by State law.

Response: Specific standards for multi-State plans will be described in future rulemaking published by OPM in accordance with section 1334 of the Affordable Care Act.

Comment: A few commenters requested that Exchanges be permitted to contract with other State agencies, such as the State department of insurance, to certify, recertify, and decertify QHPs for participation in the Exchange.

Response: Exchanges may enter into agreements with eligible entities in accordance with § 155.110, including other State agencies, to perform Exchange functions such as QHP certification. The Exchange is responsible for establishing processes for QHP certification, recertification, ***18407** and decertification. The Exchange may choose to carry out these functions by contracting with the State department of insurance or another appropriate entity, but must retain ultimate accountability for the certification and review of QHPs in accordance with § 155.110.

Comment: A few commenters addressed the certification processes for the individual Exchange and SHOP under proposed § 155.1010(a). While some commenters recommended that the certification process be identical for both Exchanges, others supported two distinct processes in States where the individual Exchange and SHOP are separately administered.

Response: The administrative structure of the individual Exchange and SHOP may vary by State. Further, the final rule offers significant flexibility to Exchanges in designing the certification process and does not prescribe a particular approach. Therefore, the final rule neither prescribes a single, uniform process nor two complementary processes for certification.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1010 of the proposed rule, with the following modifications: we redesignated proposed paragraphs (c) and (d) as final paragraphs (a)(1) and (a)(2) to clarify that the certification timeline and the direction for Exchanges to monitor QHPs for ongoing compliance are considered part of the certification process. In paragraph (a)(1), we added language to increase flexibility for an Exchange to certify a QHP during the benefit year by replacing the proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open enrollment period must be certified before the beginning of such period. We revised the language in paragraph (b) to clarify that both multi-State plans and CO-OPs must be recognized by the Exchange as certified (we have previously finalized that Exchanges must recognize CO-OP QHPs in 45 CFR 156.520(e)(1), published at 76 FR 77414).

c. QHP Issuer Rate and Benefit Information (§ 155.1020)

In § 155.1020, we proposed that Exchanges must receive a QHP issuer's justification for a rate increase prior to the implementation of such an increase, and ensure that the QHP issuer posts the justification on its Web site. Specifically, we proposed to codify the statutory direction in section 1311(e)(2) of the Affordable Care Act that an Exchange consider the following factors related to health plan rates when determining whether to certify QHPs: (1) The justification of a rate increase prior to the implementation of the increase; (2) the recommendations provided to the Exchange by the State under section 2794(b)(1)(B) of the PHS Act; and (3) any excess rate growth outside the Exchange as compared to the rate of growth inside the Exchange, including information reported by the States. We also solicited comment on how to best align section 2794 of the PHS Act and section 1311(e)(2) of the Affordable Care Act with respect to review of rates. Finally, we proposed that the Exchange must, at least annually, receive from QHP issuers information on rates, covered benefits, and cost sharing for each QHP, in a form and manner specified by HHS.

Comment: Many commenters expressed support for the standard in proposed § 155.1020(a) that an Exchange ensure that any rate increase justification is prominently posted on the QHP issuer's Web site. Several commenters requested clarification of the meaning of "prominently" posted or made specific recommendations that, for example, the Exchange Web site link to the justification on the issuer's Web site, that the Exchange Web site separately post the justification, or that the Exchange Web site include a pop-up "warning" to enrollees who select a QHP for which there was a recent rate increase.

Response: In the final rule, we have amended § 155.1020(a) to direct the Exchange to provide access to the rate increase justification posted on the issuer's Web site. We believe that this additional standard would provide greater transparency, and make it easier for consumers to access information about rate increases when considering QHPs. We note that nothing in this final rule would preclude an Exchange from separately posting an issuer's justification or otherwise informing consumers about rate increase justifications, as suggested by commenters.

Comment: A few commenters recommended that the final rule specify that the Exchange must collect rate justifications in accordance with proposed § 155.1020(a) in a timely manner.

Response: The Exchange must collect rate justifications in advance of the annual certification or recertification process, so that the Exchange can meaningfully consider the information when determining whether to make a QHP available through the Exchange. This is implicit in the operation of § 155.1010 and § 155.1020. However, recognizing that Exchanges may establish different timelines for certification and recertification within the parameters described in § 155.1010, we do not establish a separate uniform date for the collection of such justifications in the final rule.

Comment: One commenter requested that HHS clarify that any discussion of the State Insurance Commissioner or State department of insurance in the preamble to the proposed rule encompasses any relevant State regulator.

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Response: While the statute gives the Exchange this authority, we believe that that the intent of § 155.1020 is that the Exchange consider recommendations from the State agency or official responsible for complying with section 2794(b) of the PHS Act.

Comment: Many commenters suggested ways Exchanges could consider rate increase justifications under proposed § 155.1020(b). Some commenters favored a rigorous rate review process that would go beyond the functions currently performed by State regulators, such as by collecting additional information from QHP issuers implementing rate increases (for example, evidence of efforts to control costs through value-based benefit designs).

In contrast, several other commenters recommended that the final rule reaffirm the traditional role of States in reviewing rates. Commenters further urged HHS to minimize the potential for duplication and inconsistency by encouraging the Exchange to leverage a State's program under section 2794 of the PHS Act to review rates. One commenter requested that the final rule clarify that an Exchange's ability to act in response to a rate increase would be limited to deciding whether to make a QHP available through the Exchange.

Response: We encourage the Exchange to leverage existing State rate review processes to the extent appropriate. As we highlighted in the preamble to the proposed rule, such coordination could include posting or adopting the same format used for rate justifications submitted to the State. However, we note that in some cases an Exchange may engage in more in-depth consideration of QHP issuers' justifications when determining whether to make a QHP available on the Exchange. As a result, we do not limit the ability of Exchanges to conduct additional reviews of rate increase justifications, although we recommend that Exchanges consider the administrative burden on issuers associated with any such reviews. We ***18408** note that an Exchange's consideration of rate increases is limited to whether a QHP should be made available on the Exchange.

Comment: In response to the provision in proposed § 155.1020(b) that an Exchange consider rate increases, many commenters requested that HHS clarify how the Exchange must incorporate such review into the QHP certification process. A few commenters recommended that excessive rate increases be considered cause for refusal of certification or decertification. Conversely, one commenter recommended that Exchanges initially not consider rate increases in the certification of QHPs, and that in later years the level or review would be proportional to the size of the rate increase. Finally, a few commenters requested that the final rule clarify how HHS will oversee Exchange review of rate increases.

Response: An Exchange may choose from a variety of approaches with respect to QHP issuer rate increases. For example, an Exchange may exercise the discretion provided in § 155.1000(c)(2) by opting to not make available QHPs implementing rate increases that the Exchange determines are not sufficiently justified. Other Exchanges may choose to rely more heavily on the process and determinations made by the applicable State regulator. Therefore, we are not prescribing a specific process or standard that the Exchange must follow in its consideration of rate increase justifications in this final rule.

Comment: One commenter requested that the final rule clarify the applicability of the provisions in this section to multi-State plans.

Response: Standards and processes related to multi-State plans will be addressed in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act. Because OPM will administer contracts with multi-State plans, we anticipate that OPM may collect certain data, including rate and benefit data, from multi-State plans. To avoid duplicate reporting and minimize administrative burden, we have amended proposed § 155.1020(b) and (c) to clarify that OPM will provide a process for rate increase consideration of multi-State plans and a process for multi-State plans to submit rate and benefit information, respectively.

Comment: Two commenters requested the meaning of the standard in proposed § 155.1020(b)(1)(iii) that an Exchange consider any excess of rate growth outside versus inside the Exchange. One commenter requested clarification of whether HHS will establish a uniform, national limit on rate increases. Another commenter requested that HHS clarify the meaning of premium price controls. One commenter recommended that the final rule discourage or prohibit the Exchanges from holding down

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rates and creating “spillover” increases outside the Exchange or in other States, for multi-State plans. Finally, one commenter recommended that the rate review function inside and outside of the Exchange be combined.

Response: As indicated in the preamble to the proposed rule, we encourage Exchanges to work closely with State departments of insurance when considering issuer rate increases. With respect to § 155.1020(b)(1)(iii), we note that an Exchange should consider the rate of growth in rates for similar products that are offered outside versus inside the Exchange, which may help the Exchange in its consideration of rate increase justifications.

The term premium price controls is not defined in section 1311(e) of the Affordable Care Act, which this provision implements. We note that review of rate information in accordance with this section is the responsibility of the Exchange; therefore, we are not defining the term “premium price controls” or setting a national limit in this final rule.

Comment: A few commenters requested that the final rule clarify the content and timing of reporting of the rate and benefit information described in proposed § 155.1020(c). One commenter recommended that the information be reported twice per year. Several commenters urged HHS to direct the Exchange also collect information on benefit exclusions.

Response: We intend to clarify the format and content of data submission in accordance with this section in future guidance. Because the purpose of the collected information is to support the QHP certification process, the timing is implicit in the operation of this provision in conjunction with § 155.1010(a). We note that we interpret § 155.1020(c)(1) to direct Exchanges to collect rate information for pediatric dental benefits offered in accordance with section 1302(b)(1)(J) of the Affordable Care Act, and for any benefits in excess of the other benefits offered under section 1302(b) of the Affordable Care Act. Exchanges will need to be able to identify such information to support the administration of advance payments of the premium tax credit.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1020 of the proposed rule, with a few exceptions. In paragraph (a), we added that the Exchange must provide access to rate justification information on its Internet Web site. We also clarified throughout this section that the U.S. Office of Personnel Management will determine the process by which OPM will consider rate increases and by which multi-State plans submit rate and benefit information to the Exchange.

d. Transparency in Coverage (§ 155.1040)

In § 155.1040, we proposed how section 1311(e)(3) would be implemented: that Exchanges direct health plans seeking certification as QHPs to submit transparency information outlined in § 156.220 to the Exchange, HHS, and other entities. We also proposed to direct the Exchange to monitor the use of plain language by QHP issuers when making available QHP transparency data, consistent with guidance developed jointly by the Secretary of HHS and the Secretary of Labor. In addition, we proposed that the Exchange direct QHP issuers to make cost-sharing information available to enrollees.

Comment: With respect to proposed § 155.1040(a), several commenters recommended that Exchanges serve as data aggregators for transparency information. One commenter requested that Exchanges be permitted to contract with other entities to collect and analyze transparency data.

Response: While we believe some Exchanges may wish to aggregate transparency data across QHPs to facilitate the comparison of plans, other Exchanges may prefer not to take on this function, and others may contract with another entity to collect and analyze transparency data consistent with § 155.110. Regardless, by law, we note that the Exchange must condition certification of a QHP on its submission of such transparency data in accordance with § 156.220.

Comment: A few commenters recommended that HHS consult with consumers and other stakeholders in developing plain language guidance in accordance with proposed § 155.1040(b). Other commenters suggested specific elements to include (for

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example, translation services). One commenter recommended that QHP issuers be permitted to attest to the use of plain language to reduce the administrative burden on the Exchange.

Response: We note that "plain language" is defined in § 155.20. HHS and the Department of Labor will jointly develop and issue guidance on best practices of plain language writing, and ***18409** will inform the public about the process for developing such guidance.

Comment: Several commenters recommended that the Exchange Web site inform consumers of their ability to request cost-sharing information from QHP issuers in accordance with proposed § 155.1040(c) of this section.

Response: We will consider including sample language to this effect in the Exchange Web site template.

Comment: Multiple commenters requested that HHS clarify the oversight and enforcement process for data reporting in accordance with proposed § 155.1040(a), including by specifying any sanctions that the Exchange may impose on QHP issuers for failure to report the data. One commenter specifically recommended that QHP issuers be directed to prepare compliance reports addressing transparency data and consumer inquiries regarding cost sharing.

Response: We expect that each Exchange will develop a compliance and enforcement approach that will apply to this and other certification standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1040 of the proposed rule, with the following modification: in paragraph (a) we clarified that the U.S. Office of Personnel Management will determine the process through which multi-State plans submit transparency data.

e. Accreditation Timeline (§ 155.1045)

In § 155.1045, we proposed that the Exchange establish the time period within which any QHP issuer that is not already accredited must become accredited following certification of a QHP. This provision is consistent with § 156.275, in which we proposed that all QHP issuers must be accredited with respect to their QHPs within the timeframe established by the Exchange.

Comment: We received many comments in response to our proposed standard to allow Exchanges to determine a uniform period following certification by which QHP issuers must be accredited. A number of commenters agreed with our proposal that the States should be given flexibility to determine this timeline. Several other commenters disagreed with our proposal to allow Exchanges to set the timeline for accreditation for QHPs and requested that HHS establish a Federal timeline for accreditation that all Exchanges must follow. Several commenters suggested appropriate accreditation timelines for HHS to establish. Another commenter suggested that allowing QHP certification without accreditation runs counter to the intent of the law and State autonomy in determining the accreditation timeline fails to offer adequate consumer protection.

Response: We maintain our regulation text as stated in the proposed rule. We believe that this proposal is consistent with our efforts to ensure that Exchanges have the discretion to implement QHP issuer standards that best meet the needs of their Exchange enrollees. To draw new issuers to the Exchange, we note that an Exchange may want to provide issuers with additional time beyond initial certification to become accredited. Section 1311(c)(1)(D)(ii) of the Affordable Care Act clearly provides for the Exchange to establish the timeframe.

Comment: We received a single comment to our proposed provision in § 155.1045 requesting that plans be allowed to select their own accrediting entity. We also received a comment suggesting criteria that the Secretary should use to recognize accrediting entities.

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Response: We expect to engage in future rulemaking to adopt a process and criteria for the recognition of accrediting entities.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1045 of the proposed rule with the clarification that the Office of Personnel Management will establish the accreditation period for multi-State plans as part of the certification of those plans.

f. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

To ensure that Exchange network adequacy standards are appropriate for QHP issuers and reflect local patterns of care, we proposed in § 155.1050 that each Exchange ensure that enrollees of QHPs have a sufficient choice of providers. We discussed, in preamble, different measures of network adequacy and solicited comment on whether the final rule should set Federal minimum network adequacy standards or direct the Exchanges to set specific types of standards, including additional qualitative or quantitative standards. We also requested comment on an additional standard that the Exchange ensure that QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas.

Comment: A few commenters requested that HHS clarify how the network adequacy standards will be monitored and enforced. Commenters recommended that the Exchange report on oversight of network adequacy, or use specific tactics to monitor network adequacy (for example, secret shopper events, monitoring of appointment wait times).

Response: Many States direct health insurance issuers to evaluate the adequacy of their provider networks on an ongoing basis and monitor network adequacy in their traditional role of regulating health insurance. We encourage Exchanges to coordinate with State departments of insurance in monitoring QHP networks for sufficient access, and this final rule provides Exchanges with discretion to establish their own monitoring procedures to assure ongoing compliance. We anticipate that Exchanges will identify a variety of tools and strategies to monitor QHP compliance with all certification standards, including standards related to network adequacy. Accordingly, we are not prescribing specific oversight and enforcement strategies in this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1050 of the proposed rule, except that we are revising the regulation text to clarify that an Exchange must ensure that each QHP complies with network adequacy standards established in accordance with § 156.230.We are reorganizing the regulation text for increased clarity and flow by moving the network adequacy standard to § 156.230. In addition, the regulation text is revised to clarify that the U.S. Office of Personnel Management will ensure compliance with network adequacy standards for multi-State plans as part of the certification of those plans. Finally, for reasons described in § 156.230, we clarified that a QHP issuer may not be prohibited from contracting with any essential community provider. For a complete discussion of the comments on network adequacy standards, please refer to § 156.230.

g. Service Area of a QHP (§ 155.1055)

In § 155.1055, we proposed that Exchanges have a process to establish or evaluate the service areas of QHPs to determine whether the following criteria are met: (1) the service area covers a minimum geographical area that meets certain conditions, and (2) has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations.

Comment: Many commenters supported the service area standard in ***18410** proposed § 155.1055(a). However, several commenters recommended alternative standards, such as that all QHPs must serve the entire Exchange service area, the entire State, areas smaller than a county, or contiguous areas. Some commenters suggested that HHS refrain from requiring QHPs to offer coverage Statewide to ensure that local health plans may participate, while others encouraged Exchanges to align standards with market-wide standards.

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Response: Under the proposed and final rule policy, Exchanges have the ability to establish or evaluate QHP service areas in such a way that would allow for participation by local health plans, provided that such standard is established without regard to the factors listed in § 155.1055(b). We recommend that Exchanges consider aligning QHP service areas with rating areas established by the State in accordance with section 2701(a)(2) of the PHS Act. To the extent QHPs operate within such uniform service areas, this policy would facilitate consumers' ability to compare premiums of QHPs, promoting competition within the Exchange market. Furthermore, aligning QHP service areas with rating areas may simplify consumer understanding and Exchange administration of eligibility determinations for premium tax credits, which may be complex if QHP service areas are highly individualized.

Comment: Several commenters expressed concern that allowing Exchanges to set unique service area standards would conflict with existing State standards that are meant to prevent against discriminatory service areas.

Response: We acknowledge that some States already have in place service area standards that protect against red-lining and other "cherry-picking" practices where the issuer only offers plans to geographic areas that are expected to have lower risk. We believe that § 155.1055 of this final rule provides a sufficiently broad standard such that an Exchange operating in a State with equally or more protective service area standards that prevent discrimination could use those standards for QHP issuers as well. To the extent that the broad standard here is more protective than existing State law, however, the Exchange must apply this regulatory standard to QHPs.

Comment: One commenter requested examples of the "necessary" or "nondiscriminatory" standards in proposed § 155.1055(b). Another commenter suggested that the Medicare Advantage precedent would be useful in determining whether service of part of a county would fall under necessary or non-discriminatory standards. Two commenters suggested that HHS specifically incorporate the parameters relating to a small geographic service area contained in the Medicare manual.

Response: We believe that the Medicare Advantage "county integrity rule" described in 42 CFR 422.2 (defining service area) is a useful resource for evaluating service areas, and we noted in the preamble to the proposed rule that the service area standard in § 155.1055 mirrors the standard established by Medicare Advantage (76 FR 41866, at 41894 (July 15, 2011)). While we believe that the standards set forth by Medicare Advantage guidance provide examples of how to apply this standard, we note that States have discretion to interpret "necessary, non-discriminatory, and in the best interest of qualified individuals and qualified employers." For example, if a State has an existing service area standard that ensures service areas are not discriminatory and are in the best of the consumer, then the Exchange could decide to establish its service areas to be the same as the existing State standard. However, this provision provides authority for an Exchange to set stricter QHP standards if it observes service areas that specifically exclude certain areas.

Comment: A number of commenters requested clarification on the difference between a service area and a rating area.

Response: A rating area, as described in § 156.255(a) and section 2701(a)(2) of the PHS Act, is a geographic area established by a State that provides boundaries by which issuers can adjust premiums in accordance with section 2701(a)(1)(A)(ii) of the PHS Act. In contrast, a service area is the geographic area in which an individual must reside or be employed (in accordance with standards outlined in § 155.305 and § 155.710) in order to enroll in a given QHP. As noted previously, we recommend that Exchanges consider aligning QHP service areas with rating areas to foster competition, promote consumer understanding, and reduce administrative complexity.

Comment: One commenter recommended that HHS encourage States to establish service areas in accordance with proposed § 155.1055 as soon as possible using county or other existing area boundaries, noting that new regional boundaries will increase administrative and logistical complexity of assembling a provider network.

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Response: QHP issuers will need to understand QHP standards as early as practicable, and we encourage Exchanges to be transparent and clear about standards as far in advance of QHP certification as possible. As noted above, Exchanges do not need to establish new service area boundaries if existing service areas are not discriminatory.

Comment: Several commenters voiced concern about the lack of an overarching standard that Exchanges ensure a sufficient number of health plans in all geographic areas of an Exchange.

Response: In general, we clarify that the expectation of § 155.105(b)(3) is that, to the extent possible, an Exchange must ensure that QHPs are available throughout the entire State. We encourage Exchanges to establish or negotiate service areas with QHP issuers to ensure that residents living in the Exchange service area have access to QHPs.

Comment: A few commenters suggested that the final rule specifically establish that service areas of QHPs cannot be drawn to avoid dividing Tribal communities and reservations, or former reservations, into different service areas.

Response: We note that § 155.1055(b) establishes that QHP service areas be established in a non-discriminatory manner. We encourage the Exchange to consider the impact of QHP service areas on Tribal communities when evaluating or developing service areas and to initiate Tribal consultation in connection with these issues.

Comment: A few commenters recommended the final rule add "economic factors" to the list of factors by which a QHP issuer cannot establish service areas in proposed § 155.1055(b). Another set of commenters were concerned that the proposed rule only prevented discriminatory service areas within counties, but not between counties.

Response: We believe that this provision adequately addresses the underlying causes of "red-lining," which is to exclude populations that are high utilizing, high cost, or medically-underserved. In addition, while § 155.1055(a) addresses discriminatory service area practices within a county, § 155.1055(b) establishes that the general service area delineations must be established without regard to a variety of factors that could be used to "cherry-pick" healthy from unhealthy risk by geography.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1055 of the proposed rule with a modification to strengthen the language that directs Exchanges to ensure that the service area standards are met.

***18411 h. Stand-alone Dental Plans (§ 155.1065)**

In § 155.1065, we proposed that an Exchange allow limited scope stand-alone dental plans to be offered as stand-alone plans or in conjunction with a QHP, provided that the plans furnish at least the pediatric essential dental benefit described under section 1302(b)(1)(j) of the Affordable Care Act. We also proposed that the stand-alone dental plan comply with section 9832(c)(2)(A) of the Code and section 2791(c)(2)(A) of the PHS Act. We also proposed to allow an Exchange to certify a health plan as a QHP if it does not offer the pediatric essential dental benefit, provided that a stand-alone dental plan is offered through the Exchange.

We requested comment on whether some of the QHP certification standards and consumer protections, such as a network adequacy, should also apply to stand-alone dental plans as a Federal minimum and what limits Exchanges may face on placing certification standards on dental plans given that they are excepted benefits. We also invited comment on whether we should set specific operational minimum standards related to allocation of advance payments of the premium tax credit, calculating actuarial value, and ensuring the availability of pediatric dental coverage in the Exchange. Lastly, in response to comments to the RFC, we requested comment on whether we should establish that all dental benefits must be offered and priced separately from medical coverage, even when offered by the same QHP issuer.

Comment: With respect to proposed § 155.1065(b), one commenter interpreted section 1311(d)(2)(B)(ii) of the Affordable Care Act to mean that an Exchange must allow a stand-alone dental plan to offer coverage in an Exchange. The commenter requested

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clarification on whether the partnering of a QHP with stand-alone dental plans as their subcontractors for pediatric dental care would be consistent with this provision.

Response: We interpret the phrase regarding the offering of stand-alone dental plans "either separately or in conjunction with a QHP" to mean that the Exchange must allow stand-alone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options.

Comment: A number of commenters expressed concern regarding the applicability of cost-sharing limits and annual and lifetime limits to stand-alone dental plans. Commenters requested clarity on whether such limits applied, and cautioned that if stand-alone dental plans do not have to comply with the same out-of-pocket, annual, and lifetime limit standards that would apply QHPs, then there would be an unlevel playing field.

Response: We accept the recommendation of commenters that cost-sharing limits and the restrictions on annual and lifetime limits should apply to stand-alone dental plans for coverage of the pediatric dental essential health benefit. The Affordable Care Act directs any issuer that must meet the coverage standards in section 1302(a) to cover each of the ten categories; thus, any issuer covering pediatric dental services as part of the essential health benefits must do so without annual or lifetime limits as defined under the Affordable Care Act and its implementing guidance, even if such issuers are otherwise exempt from the provisions of Subparts I and II of Part A of Title XXVII of the PHS Act (including PHS Act section 2711) under PHS Act section 2722. We note that for any benefit offered by a stand-alone dental plan beyond those established under section 1302(b)(1)(J) of the Affordable Care Act, standards specific to the essential health benefits would not apply. We plan to provide more detail in the future regarding how a separately offered pediatric dental essential health benefit would be considered under standards that apply to a full set of essential health benefits.

Comment: With respect to proposed § 155.1065(b), several commenters specifically recommended that stand-alone dental plans be directed to offer a child-only pediatric dental plan. The commenters were concerned that an Exchange with only family dental coverage options and QHPs that do not have to cover the pediatric dental benefit would decrease the enrollment of children in dental coverage, as the advance payment of the premium tax credit would only be applicable to the pediatric dental essential health benefit. Others were concerned that the stand-alone dental plans would not have capacity to cover all potential enrollees which, combined with the exemption for QHPs to not offer the pediatric dental coverage when stand-alone dental plans are available, would create insufficient access to child-only options.

Response: In this final rule, § 155.1065(a)(3) would apply the standard of § 156.200(c)(2) to offer a child-only plan to stand-alone dental plans certified to be offered through the Exchange. In the new paragraph § 155.1065(d), we direct an Exchange to consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage. By "sufficient access," we mean to convey that Exchanges should ensure that, when combined, stand-alone dental plans have the capacity (in terms of solvency and provider network) to provide child-only coverage to all potential children enrolling in coverage through the Exchange.

Comment: A set of commenters addressed the request for comment in the proposed rule on whether the final rule should establish that QHPs must separately offer and price coverage for the pediatric dental essential health benefit so that consumers have the potential to enroll in dental coverage that is different from the dental benefits offered by the QHP they selected. Some suggested a standard for QHPs to separately price and offer pediatric dental coverage so consumers could make direct comparisons based on premium, cost-sharing, and benefits. Other commenters stated that it would be easier for consumers if the benefits were bundled. A number of commenters also recommended that HHS direct QHPs to offer medical-only options without pediatric dental coverage.

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Response: If an Exchange determines that having QHPs separately offer and price pediatric dental coverage is in the interest of the consumer, as described in § 155.1000(c), then the Exchange may establish such standard as a condition of QHP certification. Otherwise, QHPs are not uniformly directed to separately price and offer pediatric dental coverage under this final rule.

Comment: A few commenters urged HHS to allow health plans outside of the Exchange to have the same exemption as QHPs inside the Exchange, in that health plans would not have to cover pediatric dental if a stand-alone plan existed in the market.

Response: This request is outside the scope of this final rule, which addresses explicitly the standards for QHPs. Section 1302(b)(4)(F) of the Affordable Care Act specifically addresses the exemption in terms of QHPs offered through an Exchange.

Comment: With respect to proposed § 155.1065(b), a small number of commenters requested that Exchanges ensure that stand-alone dental plans are offered as both fee-for-service plans and managed care plans.

Response: Section 1311(e)(1)(B)(i) prohibits the Exchange from excluding a plan from the Exchange because it is a fee-for-service plan.

Comment: Several commenters suggested that a way to indicate to QHPs ***18412** that they will not have to cover pediatric dental coverage would be to issue a request for proposals to stand-alone dental plans in advance of the QHP certification process.

Response: We have not set any operational standards in § 155.1065. Each Exchange has discretion in determining how to implement this provision.

Comment: With respect to proposed § 155.1065(c), many commenters voiced support for allowing an Exchange to direct issuers of stand-alone dental plans to comply with any QHP certification standards and consumer protections, with some specifying network adequacy and cost-sharing standards. Many commenters stated that certification standards are necessary to ensure a level playing field between pediatric dental coverage offered through QHPs or stand-alone products. A few commenters requested that HHS direct Exchanges to establish uniform certification and recertification standards for medical and stand-alone dental plans. A small number of commenters recommended that HHS not establish standards for stand-alone dental plans, or specified certain standards that should not apply, such as quality and accreditation. One commenter suggested that QHP issuers not have to comply with any standard that does not apply to stand-alone dental plans for the offering of pediatric dental coverage.

Response: We are persuaded by comments suggesting that stand-alone dental plans comply with QHP certification standards, as such standards will help ensure a consistent level of consumer protections as QHPs. Accordingly, we have added a new provision to § 155.1065(a)(3) establishing that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits. For example, to the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet § 155.1045. We also note that the Exchange may establish certification standards that are specific to the unique nature of stand-alone dental plans. For example, an Exchange can set a different network adequacy standard for stand-alone dental plans than for medical plans. For the purposes of this provision, any application of QHP standards to stand-alone dental plans by the Exchange would only apply to stand-alone dental plans offered through the Exchange.

Comment: A small number of commenters sought clarification on whether stand-alone vision plans could be offered through the Exchanges. Other commenters also sought clarification about the offering of other types of insurance that are not health plans, such as disability insurance.

Response: HHS is still evaluating this issue and plans to provide more details regarding the offering other coverage through an Exchange in future guidance.

18413** ***Summary of Regulatory Changes

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We are finalizing the provisions proposed in § 155.1065 of the proposed rule, with three modifications: in paragraph (a)(2), we clarify that section 2711 of the PHS Act would apply to the pediatric dental essential health benefit covered by a stand-alone dental plan. In new paragraph (a)(3), we established that stand-alone dental plans must comply with all QHP certification standards subject to certain exceptions. In new paragraph (c) we directed Exchanges to consider whether stand-alone dental plans will provide sufficient access to the pediatric dental essential health benefit during certification of stand-alone dental plans. Finally, we redesignated proposed paragraph (c) as paragraph (d).

i. Recertification of QHPs (§ 155.1075)

In § 155.1075, we proposed that the Exchange implement procedures for the recertification of health plans as QHPs that include a review of the general certification criteria outlined in § 155.1000(c). We also proposed to permit the Exchange to determine the frequency for recertifying QHPs. We invited comment on whether we should outline specific standards associated with the term length for recertification. In addition, we proposed that, after reviewing all relevant information and determining whether to recertify a QHP, the Exchange must notify a QHP issuer of its recertification status and take appropriate action. Finally, we solicited comments on the appropriateness of the proposed recertification deadline of September 15 of the applicable calendar year.

Comment: With respect to the recertification process described in proposed § 155.1075(a), many commenters provided feedback on our proposal to permit Exchanges to establish the frequency of recertification. While some commenters supported the flexibility provided in the proposed rule, others recommended that HHS establish the frequency for recertification and offered specific recommendations about the recertification interval, such as every one year, three years, or as-needed based on certain “triggering” events.

Response: We believe that Exchanges are best positioned to establish the frequency of or other parameters for recertification that reflect local market conditions or existing State regulatory processes. We believe varying intervals for recertification and approaches could be appropriate in some circumstances, and therefore are not establishing a uniform frequency for recertification in this final rule.

Comment: Multiple commenters recommended that specific elements be considered during the recertification process described in proposed § 155.1075(a), such as a QHP issuer's complaint history, sanctions imposed by State regulators, or interaction with tribes and/or American Indian/Alaska Native populations. Commenters also suggested that the recertification process include a review of the QHP's network and engagement with essential community providers.

Response: An Exchange must establish a recertification process that includes a review of the minimum certification criteria outlined in § 155.1000(c) of the final rule, and must monitor QHPs for ongoing compliance with certification criteria, as specified in § 155.1010(d). At its discretion, an Exchange may establish additional recertification criteria or review processes, if the Exchange believes such criteria will improve the consumer experience.

Comment: While some commenters supported the proposed recertification deadline of September 15th of the applicable calendar year as indicated in proposed § 155.1075(b), others recommended greater flexibility for States or an alternate deadline, such as August 15 of each year.

Response: Recertification should be completed, and the appropriate parties notified, in advance of the open enrollment period so that consumers, issuers, and Exchanges have sufficient time to prepare for and make decisions about the upcoming plan year. In the proposed rule, we set forth the dates for the initial and annual open enrollment periods. In this final rule, we believe it is also appropriate to establish the annual deadline for recertification. We believe that the proposed deadline of September 15th provides sufficient time for Exchanges and issuers to participate in a robust recertification process, and also ensures that consumers will be fully informed of their plan choices at the start of each open enrollment period. Therefore, we are finalizing the proposed recertification deadline of September 15th in this rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1075 of the proposed rule, except that in paragraph (a) we clarified that, consistent with the revisions to § 155.1010, multi-State plans and CO-OPs are not subject to the Exchange recertification process.

j. Decertification of QHPs (§ 155.1080)

In § 155.1080, we proposed that the Exchange implement procedures for the decertification of health plans as QHPs, which we defined as the termination by the Exchange of the certification status and offering of a QHP. We also proposed that the Exchange must establish an appeals process for health plans that have been decertified. We requested comments generally on the proposed decertification process and asked specifically whether there were other appropriate authorities that could assist Exchanges in the decertification process. Finally, we proposed that if a QHP is decertified, the Exchange must provide notice of the decertification to parties who may be affected, including the QHP issuer, enrollees of the decertified QHP, HHS, and the State department of insurance.

Comment: With respect to the decertification process proposed in § 155.1080(b), some commenters supported the flexibility given to Exchanges to design the decertification process in the proposed rule, while other commenters suggested specific approaches to decertification. A few commenters requested that the final rule identify “triggering events” for decertification, such as a determination that a QHP's network is inadequate; others requested that HHS provide additional clarification on when decertification would be appropriate.

Response: We continue to provide Exchanges discretion in designing the decertification process and making decertification decisions. The final rule establishes that an Exchange may decertify a QHP at any time for failure to comply with the minimum certification standards described in § 155.1000(c), and any additional certification standards established by the Exchange. We believe that this flexibility is necessary to allow an Exchange to tailor its process for compliance and decertification to be appropriate for the market conditions in the State. The Exchange is responsible for establishing the decertification process, including the approach used to identify plans that are out of compliance with certification standards or the associated sanctions.

Comment: One commenter requested additional information on whether multi-State plans may be decertified through the process described in proposed § 155.1080(b).

Response: The Affordable Care Act establishes a deeming process for multi-State plans; as a result, we clarify that multi-State plans are exempt from the Exchange's recertification and decertification processes.

Comment: Several commenters requested that HHS clarify the consequences of an Exchange's failure to decertify plans that are out of compliance with certification standards as described in proposed § 155.1080(c), and recommended that Exchanges be directed to decertify non-compliant QHPs.

Response: QHPs with persistent or significant compliance issues should be decertified and removed from the Exchange; however, we recognize that Exchanges may, for example, wish to pursue intermediate sanctions for minor violations of certification standards that do not adversely impact consumers, so long as such actions are consistent with applicable law. While it is our expectation that an Exchange would decertify a QHP that is not compliant with certification standards or where the health and safety of an enrollee may be at-risk, this final rule permits Exchanges to explore a variety of oversight and enforcement strategies, up to and including decertification. We intend to address oversight of Exchanges through future implementation and rulemaking under section 1313 of the Affordable Care Act.

Comment: One commenter recommended that an Exchange be permitted to certify new plan(s) to replace decertified QHP(s) during the benefit or plan year in accordance with proposed § 155.1080(c).

Response: We believe it is important for QHPs to be certified prior to the open enrollment period to ensure all consumers have the same plan options, and are aware of those options before they make their plan selections. However, we believe that an Exchange should have the option to replace a decertified QHP with another QHP in certain cases, for example if the decertification of a QHP resulted in no or few QHP choices in some regions of an Exchange's service area. We have revised the regulation text in § 155.1010(a)(1) to provide additional flexibility for an Exchange to certify QHPs during the benefit year by replacing the proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open enrollment period must be certified before the beginning of such period.

Comment: A few commenters requested that the final rule clarify that QHPs decertified in accordance with proposed § 155.1080(c) may retain non-Exchange membership.

Response: Decertification would not affect enrollees who purchased QHP coverage directly or not through the Exchange, because such members' enrollment occurred outside the Exchange. However, such a plan could no longer be marketed as a QHP following decertification and the population enrolled in that plan through the Exchange would be provided a special enrollment period to transfer to a different QHP in accordance with § 155.420(d) and § 155.430(b)(2)(iv). While the Exchange regulates enrollment through the Exchange, any sanctions or other actions related to a QHP's non-Exchange membership would be at the discretion of the State insurance commissioner.

Comment: A few commenters requested additional information on the appeals process described in proposed § 155.1080(d) or suggested specific parameters, such as 30 days to file and 30 days to hear an appeal.

Response: Consistent with the authority to design the decertification process, the Exchange is responsible for outlining the parameters of the appeals process, including timing, what entity will hear appeals, and other factors.

Comment: Several commenters endorsed a special enrollment period for individuals whose QHP has been decertified under proposed § 155.1080(c), and advocated that enrollees be permitted to change levels of coverage during such special enrollment period. One commenter recommended that consumers receive a special enrollment period if the QHP in which they are enrolled appeals a decertification. One commenter recommended that enrollees be given 63 days to enroll in other coverage, while another suggested that coverage by the decertified QHP continue until enrollees make new plan selections.

Response: Enrollees would have an opportunity to select a new QHP once a QHP has been decertified. Allowing enrollees to switch plans in advance of a formal determination could create unnecessary disruption in the Exchange.

Consistent with § 155.410, enrollees whose QHP is decertified would have access to a special enrollment period lasting 60 days from the date of the decertification. We believe that 60 days is a sufficient amount of time to select a new QHP. Finally, as described in the ***18414** comment and response to § 155.410, we are revising the regulation text to permit enrollees to change levels of coverage during a special enrollment period.

Comment: One commenter requested clarification on why HHS needs to receive information on decertified QHPs, as in proposed § 155.1080(e)(3).

Response: HHS needs access to information on decertification of QHPs for a number of policy and operational reasons. For example, HHS will need to administer a termination of advance payments of the premium tax credit and payment of cost-sharing reductions to issuers of decertified QHPs.

Comment: Several commenters proposed standards for notices related to decertification and non-renewal identified in proposed § 155.1080(e), such as that the notices be available in multiple languages, identify appropriate consumer resources, or include information targeted to specific populations such as American Indians and Alaska Natives. Alternatively, a few commenters

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recommended that HHS publish model notices. Finally, one commenter recommended that the final rule direct Exchanges and QHP issuers to confirm receipt of notices related to decertification and non-renewal.

Response: Under this final rule, all notices to consumers issued by the Exchange must conform to the minimum standards outlined in § 155.230, while notices issued by a QHP issuer must conform to standards established by § 156.250. These include protections for individuals with limited English proficiency or disabilities, and establish that all notices be written in plain language. Further, to the extent that State law or Exchange policies provide for greater accessibility or additional content, an Exchange may provide notices that exceed the minimum standards in this final rule.

We believe that establishing a standard that Exchanges and QHP issuers confirm that each notice of decertification or non-renewal has been received by the appropriate enrollee would place a significant burden on Exchanges and issuers and could demand resources that are better used for other customer service functions. Further, we believe it is consistent with the current practices of many other programs to rely upon the contact information provided by each enrollee without confirming that each mailing has been successfully received.

Comment: One commenter requested that HHS clarify that in the case of a SHOP, each enrollee, and not each employer, must receive a notice of decertification or non-renewal described in proposed § 155.1080(e), as appropriate.

Response: For purposes of SHOP, each enrollee must receive a notice of decertification or non-renewal. We note that § 156.285(d)(1)(ii) directs QHP issuers offering QHPs through a SHOP to provide notices to both enrollees and qualified employers.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.1080 of the proposed rule, except that in paragraph (b) we clarified that, consistent with the revisions to § 155.1010, multi-State plans and CO-OPs are not subject to the Exchange decertification process.

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

Part 156 contains the proposed standards for QHPs and QHP issuers that are intended to promote robust and meaningful consumer choice.

1. Subpart A—General Provisions

a. Basis and Scope (§ 156.10)

Proposed § 156.10 of subpart A specified the general statutory authority for the ensuing regulation and noted that the scope of part 156 is to establish standards for health plans and health insurance issuers related to the benefit design standards and in regard to offering QHPs through an Exchange. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Definitions (§ 156.20)

Most of the terms that we proposed to define in this section refer to terms proposed in § 155.20. Beyond these terms, we proposed that the term "benefit design standards" mean the "essential health benefits package" defined in section 1302(a) of the Affordable Care Act. We did not receive comments on this section that were not addressed elsewhere, and are finalizing the definitions as proposed.

c. Financial Support (§ 156.50)

In § 156.50, we proposed that participating issuers pay user fees to support ongoing operations of an Exchange, if a State chooses to impose such fees. We proposed to define the term "participating issuer" to mean an issuer offering plans that participate in the specific function that is funded by the user fee. We further proposed that participating issuers pay any fees assessed by a State-based Exchange, consistent with Exchange authority outlined in § 155.160.

Comment: Several commenters on proposed § 156.50 recommended that HHS modify the definition of "participating issuer" by simplifying and broadening the proposed definition. Specifically, two commenters requested that HHS clarify whether the proposed definition would mean that Exchanges would charge user fees in proportion to an issuer's participation in specific Exchange functions.

Response: The definition proposed in § 156.50 is structured to accommodate the variety of functions that an Exchange could perform. We note that the proposed definition does not direct an Exchange to pro-rate or otherwise tailor user fees to the specific functions in which an issuer participates. Rather, an Exchange could, but is not directed to, charge uniform user fees to all participating issuers. We note that the Affordable Care Act suggests user fees charged to participating issuers as a means for States to ensure that an Exchange is self-sustaining. We track that statutory language in this final rule when using the term participating issuer.

Comment: A few commenters recommended that § 156.50(b) of the final rule clarify that participating issuers must pay all assessments established by an Exchange, whether structured as user fees or otherwise.

Response: We believe that participating issuers are responsible for paying any assessments established by an Exchange irrespective of how such assessments are structured. Therefore, we are revising the regulation text in § 156.50 of this final rule to reflect this clarification.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.50 of the proposed rule, with the following modifications: in paragraph (b), we clarified that a participating issuer must remit user fees to a State-based or a Federally-facilitated Exchange. We further clarified in paragraph (b) that a QHP issuer must remit any fees charged by the Exchange in accordance with § 155.160, whether structured as user fees or otherwise.

2. Subpart C—Qualified Health Plan Minimum Certification Standards

Section 1311(c)(1) of the Affordable Care Act authorizes the Secretary, by regulation, to establish criteria for the certification of health plans as QHPs; we implement that authority in this subpart. The proposed rule clarified that, unless otherwise noted, the standards for QHPs proposed in this subpart do not supersede existing State ***18415** laws or regulations applicable to the health insurance market generally, apply specifically to the certification of QHPs for participation in the Exchange, and do not exempt health insurance issuers from any generally applicable State laws or regulations.

a. QHP Issuer Participation Standards (§ 156.200)

In § 156.200, we outline the proposed standards on QHP issuers as a condition of participation in the Exchange. These include: (1) Complying with the standards in this subpart; (2) complying with the proposals established in accordance with subpart K of part 155, and in the small group market, § 156.705; (3) ensuring that each QHP complies with the benefit design standards defined in § 156.20; (4) being licensed and in good standing to offer health insurance in the State; (5) implementing and reporting on quality improvement strategies consistent with section 1311(g) of the Affordable Care Act; (6) paying applicable user fees; and (7) complying with standards related to risk adjustment under part 153. We noted that States may choose to establish additional conditions for participation beyond the minimum standards established by the Secretary. We also proposed that to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP and that the issuer meets all applicable standards.

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We also outlined the set of proposed standards with which a QHP issuer must comply related to the offering of a QHP, and specified that the QHP issuer must comply with the standards set forth in this subpart on an ongoing basis. The offering standards included: (1) Offering at least one QHP in the silver and gold coverage level; (2) offering a child-only plan at the same level of coverage; and (3) offering the QHP at the same premium rate when the QHP is offered directly by the issuer or through an agent or broker (implemented through § 156.255(b)). Finally, we proposed that a QHP issuer not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Comment: Several commenters requested that HHS clarify the standard that a QHP issuer be in “good standing” to offer health insurance in proposed § 156.200(b)(4). While many commenters supported the proposed provision as written, a few suggested that HHS strengthen the standard. Conversely, one commenter recommended that “in good standing” be defined to exclude minor violations. One commenter recommended that QHP issuers be held accountable for demonstrating good standing, such as by providing an attestation from the relevant State regulator.

Response: As described in the preamble to the proposed rule, we interpret “good standing” to mean that an issuer faces no outstanding sanctions imposed by a State's department of insurance. Therefore, the specific violations or infractions that would jeopardize standing may vary by State. With respect to determining licensure and standing, Exchanges may wish to use a number of means, such as attestation or verifying the information directly with State departments of insurance. Accordingly, we do not prescribe a specific process in this final rule, but instead allow Exchanges discretion in determining the best way to substantiate licensure and standing.

Comment: Several commenters requested that HHS harmonize quality reporting standards in proposed § 156.200(b)(5) with other public programs, suggested quality measures HHS could consider to evaluate QHPs, and made specific recommendations regarding both the quality improvement strategy and quality rating system. Commenters also requested that national quality standards be utilized and quality used as a factor in QHP certification decisions. Other commenters requested that quality information be publicly reported to consumers to inform QHP selection.

Response: We will provide additional detail on the content and manner of quality reporting under this section in future guidance.

Comment: In response to proposed § 156.200(c)(1), one commenter recommended that plans be permitted to achieve the bronze level of coverage over time, while participating in an Exchange as a QHP.

Response: Section 1301(a)(1)(B) of the Affordable Care Act directs a QHP to provide the essential health benefits package, which includes compliance with the level of coverage standards outlined in section 1302; therefore, a health plan that does not meet the bronze level of coverage cannot be certified as a QHP and made available through the Exchange. HHS will issue future rulemaking on section 1302, but the Affordable Care Act does not provide for a transitional process to achieving the coverage levels.

Comment: Many commenters offered feedback on the standard for QHP issuers to offer a corresponding child-only plan for any QHP offered through the Exchange, described in proposed § 156.200(c)(2). Several commenters recommended that HHS permit individuals up to age 26 to enroll in child-only coverage; two commenters recommended that instead of offering a separate child-only plan, QHP issuers be directed or permitted to accept enrollees of any age into a QHP offered to single qualified applicants.

Response: Section 1302(f) of the Affordable Care Act directs a QHP issuer that offers a non-catastrophic plan on the Exchange to offer an identical child-only plan. We clarify that a QHP issuer could satisfy this standard by offering a single QHP to qualified applicants seeking child-only coverage, as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules. Section 1302(f) further specifies that for purposes of this standard, a child-only plan is available to individuals under age 21 at the beginning of the benefit year. We lack the authority to alter the age limitation for enrollment into a child-only plan.

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Comment: In response to this section, a few commenters requested that HHS confirm whether a QHP may contract with providers that serve specific populations, such as tribal health care providers, without violating the anti-discrimination provisions in proposed § 156.200(e).

Response: The anti-discrimination provisions included in § 156.200(e) are intended to protect enrollees and potential enrollees from discriminatory practices on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. A QHP issuer may contract with health care providers that are authorized or directed by law to serve specific populations, such as Indian health providers, without violating these provisions. We note that a QHP issuer must meet all standards related to network adequacy and essential community providers specified in § 156.230 and § 156.235, respectively.

Comment: With respect to proposed § 156.200 in general, several commenters recommended that certain issuers, such as Medicaid managed care organizations, church plans and union plans, be permitted to offer certified QHPs on a limited-issue basis.

Response: As established in section 1301(a) of the Affordable Care Act, all QHPs must be offered by licensed health insurance issuers that are subject to the guaranteed issue provisions, effective January 1, 2014. Under section 2702 of the PHS Act, these issuers must issue coverage to any individual who applies ***18416** for coverage in a particular health plan. Though the statute allows issuers to stop accepting new enrollees to preserve financial solvency or due to provider network capacity under section 2702(c) and (d), respectively, the issuer must close off enrollment, or begin accepting new enrollees again, uniformly rather than selectively. We note that HHS will address the authority under 2702 under separate rulemaking.

We recognize the potential for significant movement of individuals between the Exchanges and Medicaid, as well as the potential for members of a family to be covered separately under the Exchange, Medicaid, and CHIP. We recognize that QHPs offered by Medicaid managed care organizations (MMCOs) may be able to play an important role in keeping family members covered under a common issuer and in the same provider network, promoting continuity of coverage, and mitigating the potential negative effects of "churning" between Medicaid and the Exchanges. HHS may provide additional guidance on this topic in the future. Additionally, we intend to address commenters' concerns surround multi-employer plans in future guidance.

Comment: A few commenters recommended that each Exchange include at least one QHP that is also a Medicaid MCO to minimize enrollee churn. A handful of commenters recommended that the Exchange be directed to deem Medicaid MCOs and other safety net health plans as QHPs. Similarly, one commenter recommended that safety net health plans be permitted to achieve licensure gradually while participating in the Exchange.

Response: Medicaid MCOs must meet the same standards as other plans to become QHPs. However, we note that Exchanges have discretion to develop specific certification criteria in a manner that might facilitate participation by Medicaid MCOs, including the establishment of the accreditation timeline as specified in § 155.1045 and the setting of QHP service areas in § 155.1055. We also note that there may be opportunities to leverage the Exchange Web site in a manner that would allow the Exchange to identify issuers that participate in both the Exchange and Medicaid managed care.

Comment: A few commenters requested that HHS clarify States' ability to develop additional certification and participation standards for QHPs.

Response: We clarify that nothing in this section precludes an Exchange from establishing additional certification criteria or issuer participation standards beyond those specified in the final rule if in the interest of qualified individuals and qualified employers served by the Exchange, per final § 155.1000(c) and the preamble discussion for that section in this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.200 with the following modification: we have removed proposed paragraph (c)(3) related to offering a QHP at the same premium rate inside and outside of the Exchange to avoid duplication of § 156.255(b).

b. QHP Rate and Benefit Information (§ 156.210)

In § 156.210, we proposed that a QHP's rates must be applicable for an entire benefit year or, for the SHOP, plan year. We also proposed that QHP issuers submit rate and benefit information to the Exchange and that a QHP issuer submit a justification for a rate increase prior to the implementation of such increase for purposes described more fully in § 155.1020. Additionally, we proposed that QHP issuers post rate increase justifications on their Web sites so they can be viewed by consumers, enrollees, and prospective enrollees.

Comment: Several commenters supported the provision in proposed § 156.210(a) that QHP issuers set rates for an entire benefit or plan year. Conversely, some commenters recommended an exception for plans participating in the SHOP, or to accommodate Federal or State regulatory changes.

Response: All QHPs, including those participating in the SHOP, must offer a set rate for an entire benefit or plan year. We note that while QHP issuers in SHOP may establish new rates quarterly or annually, issuers must charge the same contract rate for a plan year. We note that most Federal and State regulatory changes are proposed well in advance of becoming effective, so the number of regulatory changes that would take effect in the middle of a benefit or plan year will be limited. Therefore, no exceptions are provided in the final rule.

Comment: One commenter recommended that QHP issuers notify enrollees in advance of any rate increase.

Response: The final rule strengthens the transparency standards regarding rate increases. In § 155.1020, QHP issuers must submit to the Exchange a justification for a rate increase prior to the implementation of the rate increase. Potential and current enrollees will be able to compare QHPs and rates through the Exchange Web site. Accordingly, we are not adding an additional notice obligation to this section.

Comment: Several commenters offered feedback on the scope of the standard to post rate increase justifications in proposed § 156.210(c). While some commenters recommended posting of all rate increases, others recommended that posting be limited to rate increases determined unreasonable by a State's program for the review of rates under section 2794 of the PHS Act.

Response: The Affordable Care Act, at section 1311(e), demands the posting of all rate increase justifications submitted by a QHP issuer. Therefore, § 156.210(c) establishes that all rate increase justifications must be posted, irrespective of whether the increase is subject to review by a State's program under section 2794 of the PHS Act to determine if it is an unreasonable increase or the determination of such review. We continue to encourage Exchanges to leverage existing State processes, including a State's program under section 2794 of the PHS Act, to minimize the potential burden on QHP issuers associated with this section.

Comment: In response to the provision in proposed § 156.210(c) that QHP issuers submit and post rate increase justifications, a few commenters recommended that HHS clarify that such justifications must be written in plain language and must not be deceptive.

Response: We encourage Exchanges to use the rate increase justifications submitted as part of the State's program under section 2794 of the PHS Act, because the format for these justifications were developed with input from the National Association of Insurance Commissioners and incorporates consumer-friendly language.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.210 of the proposed rule without modification.

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c. Transparency in Coverage (§ 156.220)

In § 156.220, we proposed a transparency standard as a condition for certification of QHPs in accordance with section 1311(e)(3) of the Affordable Care Act. The proposed rule listed specific data elements that issuers must provide, from the Affordable Care Act: (1) Claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment; (4) data on disenrollment; (5) data on the number of claims that are denied; (6) data on rating ***18417** practices; (7) information on cost sharing and payments with respect to any out-of-network coverage; and (8) information on enrollment rights under title I of the Affordable Care Act. We sought comment on whether QHP issuers should be directed to submit this information to the Exchange and other entities, or to make such information available to the Exchange and other entities. We also proposed that QHP issuers provide the specified information in plain language. Finally, we proposed that QHP issuers make available to the enrollee information on cost-sharing responsibilities for a specific service by a participating provider under that enrollee's particular plan.

Comment: Many groups commented on the data elements included in § 156.220(a) of the proposed rule. Several commenters supported the proposed rule as written, with one commenter recommending that HHS maintain the list as proposed without additional elements. However, other commenters, suggested specific enhancements or clarifications to the proposed approach or requested that HHS establish uniform standards and methodologies. A few commenters recommended that HHS include reporting of additional data elements, such as information about condition-based exclusions. Some commenters requested that HHS provide sample forms, define key terms, or outline a specific reporting format (for example, a summary statement accompanied by data tables).

Other commenters recommended elements or approaches to transparency reporting, such as segmenting data by enrollee demographics, collecting information at the issuer level, or reporting at the product level. A few commenters provided recommendations on where transparency information should be submitted and where the information should be made available. One commenter encouraged HHS to apply the same standards to all plan types, including catastrophic plans. Several commenters recommended that HHS collect transparency data annually. Finally, one commenter stated that these standards should be extended to Medicaid and CHIP populations.

Response: We believe that QHP issuers should submit transparency information in a manner and timeframe that maximizes the utility of such information to the Exchange, HHS, and individuals. HHS intends that the reporting obligations established in this section and § 155.1040 will be aligned with the transparency reporting standards under section 2715A of the PHS Act. HHS, together with the Departments of Labor and the Treasury, will coordinate guidance on the transparency in coverage standards. As a result, we are not describing specific data formats, definitions, or frequency of reporting with respect to § 155.1040 in this final rule. We note that data reporting for Medicaid and CHIP plans is outside the scope of this final rule.

Comment: Several commenters agreed with the plain language provision in proposed § 156.220(c) as written. In addition, several commenters requested that HHS clarify how it will enforce plain language standards, with some expressing concern about the Exchange or HHS being able to check the accuracy of the plain language information submitted by QHP issuers. The commenters recommended that HHS direct QHP issuers to provide data with plain language information.

Response: We note that each Exchange will be responsible for ensuring QHP issuer compliance with this standard. HHS and the Department of Labor will jointly develop and issue guidance on best practices of plain language writing, which will assist Exchanges in determining whether issuers are using plain language, as defined in § 155.20.

Comment: We received a number of comments supporting the cost-sharing transparency in proposed § 156.220(d). Several commenters recommended that the provision be amended to allow the consumer to be able to request information by phone, fax, email, or online. One commenter requested that HHS clarify whether the obligation to provide enrollee cost-sharing information is prospective or retrospective in nature. Several commenters recommended that HHS establish that the cost-sharing information be provided free of charge by QHP issuers to the enrollees.

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Response: As noted previously, HHS will coordinate with the Departments of Labor and Treasury on guidance for the transparency in coverage standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.220 of the proposed rule without modification.

d. Marketing and Benefit Design of QHPs (§ 156.225)

To preserve a level playing field within and outside of the Exchange and to leverage existing State activities, we proposed in § 156.225 that QHP issuers must to comply with any applicable State laws and regulations regarding marketing by health insurance issuers as a certification standard, as established by section 1311(c)(1)(A) of the Affordable Care Act. We also proposed to prohibit QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs and sought comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether such activities are taking place. Additionally, we invited comment on a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives, and on whether HHS should establish a standard that QHP issuers not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP.

Comment: Many commenters offered feedback on whether the final rule should include a broad prohibition against deceptive marketing practices. A number of commenters supported such a prohibition and suggested specific Federal standards that HHS could adopt, such as Medicare Advantage, Medicare Prescription Drug Program, or Medicaid standards. Conversely, many commenters supported State flexibility with respect to marketing rules and oversight. A few commenters expressed concern that a Federal standard could be overly restrictive.

Response: States have significant experience with, and existing infrastructure to support, monitoring and oversight of health plan marketing activities. The National Association of Insurance Commissioners (NAIC) has provided guidance to the States in the form of the Model Unfair Trade Practices Act. The Model Act has been adopted by 45 States and the District of Columbia. The NAIC has also issued an Advertisements of Accident and Sickness Insurance Model Regulation, which has been adopted by 42 States. Both the Model Act and Model Regulation are extensive and position States to address misleading or deceptive practices. As a result, we are finalizing the marketing standards with the flexibility afforded in the proposed rule.

Comment: Many commenters offered standards or clarifications for inclusion in proposed § 156.225(b), such as a list of discriminatory versus acceptable marketing practices; a prohibition on inducements and other tactics prone to abuse; secret shopper events; focus group testing of marketing materials; and standardized compensation for agents and brokers in the Exchange.

Response: We note that the above tactics could be appropriately included in an Exchange's monitoring and ***18418** oversight activities, as well as its marketing rules. While we are not establishing that an Exchange implement specific standards for the reasons described in the preceding response, we encourage Exchanges to consider a variety of standards, tools, and strategies to promote transparent and consumer-oriented conduct in the Exchange.

Comment: Many commenters urged HHS to codify the statutory prohibition against benefit designs that have the effect of discouraging enrollment of higher-need consumers in § 156.225(b) of the final rule.

Response: We note that section 1311(c)(1)(A) specifically prohibits QHP issuers from utilizing benefit designs that have the effect of discouraging enrollment by higher-need individuals. We have modified § 156.225(b) in this final rule to codify the statutory prohibition.

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Comment: A few commenters recommended that the Exchange be permitted to decertify QHPs based on improper marketing practices.

Response: Section 155.1080 of the final rule gives the Exchange the authority to decertify a QHP at any time for failure to comply with certification standards, including standards related to marketing practices.

Comment: Several commenters recommended that HHS repeat the anti-discrimination standards established in § 156.200(e) in this section.

Response: We believe that the broad prohibition on discrimination in § 156.200(e) clearly bars discrimination in marketing practices as well as other operations of the QHP issuer, and that repeating this language in § 156.225 is unnecessary.

Comment: Several commenters encouraged HHS to establish a level playing field with respect to marketing inside and outside of the Exchange. Specifically, a few commenters recommended that the final rule clarify that QHP issuers must comply with all State laws and regulations that govern marketing other health insurance products, such as statutes prohibiting unfair or deceptive acts or practices.

Response: We note that adopting the proposed rule's approach would ensure QHPs conform to any standards, laws, or regulations that govern the marketing of non-QHP health insurance products in a State.

Comment: Several commenters recommended that HHS direct Exchanges to report on oversight activities related to marketing. A few commenters additionally recommended that an Exchange Blueprint detail the Exchange's proposed approach to marketing oversight.

Response: Exchanges are responsible for ensuring compliance with the marketing standards of this section. States have significant experience in regulating marketing of health insurance issuers, and Exchanges may leverage the current monitoring practices of States with respect to marketing of health insurance. As a result, we are not imposing an additional reporting obligation for Exchanges in this area.

Comment: In response to the concern expressed in the proposed rule preamble that certain groups (for example, Medicare beneficiaries) may be vulnerable to deceptive marketing tactics, one commenter suggested that the Exchange electronically verify whether QHP enrollees are also enrolled in other coverage.

Response: We encourage Exchanges to develop a variety of strategies to identify improper marketing practices. We note that subpart D of this final rule provides for electronic verification of some types of other coverage in § 155.320(b).

Comment: A handful of commenters recommended that HHS establish a mechanism to receive consumer complaints related to marketing practices.

Response: Consumers who encounter marketing practices that they believe are deceptive or improper should be able to report such practices to the Exchange or State regulator, as appropriate. Because the Exchange is responsible for monitoring marketing of QHPs and taking any appropriate action, we believe that establishing a separate Federal complaint reporting mechanism is unnecessary.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.225 of the proposed rule, with the following modifications: in paragraph (b) we codified statutory language prohibiting QHP issuers from employing benefits designs that could discourage enrollment of individuals with significant health needs. Accordingly, we added “and Benefit Design” to the title of this section.

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e. Network Adequacy Standards (§ 156.230)

In § 156.230, we proposed the minimum criteria for network adequacy in order for health plans to be certified as QHPs. We proposed that QHP issuers meet network adequacy standards established by the Exchange in accordance with § 155.1050 and consistent with the provisions of section 2702(c) of the PHS Act as amended by the Affordable Care Act. In the proposed rule, the network adequacy standard, stated in proposed § 155.1050, established "sufficient choice of providers" as the touchstone of whether a provider network is adequate. The preamble discussion identified several different measures of network adequacy and sought comment on whether to include additional qualitative and quantitative standards to measure network adequacy.

We proposed that a QHP issuer make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request, and that the directory identify providers who are no longer accepting new patients. We sought comment on standards we might set to ensure that QHP issuers maintain up-to-date provider directories. We refer commenters to the summary of proposed § 155.1050 in this final rule and to the preamble to the proposed rule for additional discussion of the proposed policy.

Comment: Many commenters offered feedback on the network adequacy standard, initially included in proposed § 155.1050. Some commenters supported the flexibility provided to States in the proposed rule, noting that such flexibility could facilitate the alignment of markets inside and outside of the Exchange. Conversely, many commenters recommended that HHS establish a national, uniform standard for network adequacy. These commenters offered numerous standards HHS could adopt, including the NAIC Managed Care plan Network Adequacy Model Act, or the current standards for Medicare Advantage plans, Medicaid managed care plans, or TRICARE plans. Finally, a few commenters generally requested that HHS clarify the meaning of "sufficient number" of providers.

Response: A number of competing policy goals and considerations come into play with examinations of network adequacy: that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange. In balancing these considerations, we have modified § 156.230(a)(2) in this final rule to better align with the language used in the NAIC Model Act. Specifically, the final ***18419** rule establishes a minimum standard that a QHP's provider network must maintain a network of a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay. We believe this modification provides additional protection for consumers by communicating our expectations with respect to the number and variety of providers that should be present in a QHP's provider network. Further, the modified standard establishes a baseline ("all services * * * without unreasonable delay") against which network adequacy can be measured. We note that nothing in the final rule limits an Exchange's ability to establish more rigorous standards for network adequacy. We also believe that this minimum standard allows sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside the Exchange and are relevant to local conditions. Finally, placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.

Comment: Several commenters urged HHS to codify the potential additional standards listed in the preamble to the proposed rule (access without unreasonable delay, reasonable proximity of providers to enrollees' homes or workplaces, ongoing monitoring process, and out-of-network care at no additional cost when in-network care is unavailable), with the largest number of commenters expressing support for the provision of out-of-network care at no additional cost when in-network care is unavailable. Other commenters recommended specific alternatives to these elements, such as a "60 minutes or 60 miles" or "15-20 minutes" standard.

Response: Based on comments, we have modified § 156.230(a)(2) in this final rule to codify the standard that services must be available without unreasonable delay. With respect to the other specific suggestions offered by commenters, we are concerned that the proposed standards may not be compatible with existing State regulation and oversight in this area. We believe that the

modification to final § 156.230(a)(2) strikes the appropriate balance between assuring access for consumers and recognizing the historical flexibility and responsibility given to States in this area.

Comment: Several commenters recommended that the final rule strengthen access protections in medically underserved, rural, or professional shortage areas, and for vulnerable populations, such as limited English proficient individuals or individuals with disabilities. With respect to medically underserved areas, some commenters suggested approaches that HHS could take, such as supporting higher payment rates in these areas. Others advocated for State flexibility to develop local solutions. One commenter requested that the final rule clarify that a QHP's network cannot be deemed inadequate in a professional shortage area.

Response: We did not accept comments recommending specific, national standards given that network adequacy is typically —and diversely—regulated by States. As described above, we amended § 156.230(a)(2) in this final rule to clarify that the provider networks maintained by QHP issuers must offer access to all services without unreasonable delay. We believe that this modified standard enhances protections for all Exchange consumers, including vulnerable populations, while preserving flexibility for States to develop local solutions to ensure access. Furthermore, we believe that the standards for inclusion of essential community providers in QHP provider networks in proposed § 156.235 will also help to strengthen access in medically-underserved areas and for vulnerable populations.

Comment: Many commenters recommended that the network adequacy provisions include specific provider types, such as pediatricians, tribal health care providers, mental health professionals, teaching hospitals, or women's health care providers.

Response: While QHP networks should provide access to a range of health care providers, we are concerned that mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services (that is, essential health benefits). Accordingly, we have modified § 156.230(a)(2) of this final rule to require QHP issuers to maintain networks that include sufficient numbers and types of providers, including providers that specialize in mental health and substance abuse, to ensure access to all services. We specifically highlight mental health and substance abuse services because we recognize that the essential health benefits will create new demands for access to mental health and substance abuse services, and that such services have traditionally been difficult to access in low-income and medically underserved communities. By highlighting mental health and substance abuse providers in the network adequacy standard, we seek to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. In addition, we are clarifying in § 155.1050 of this final rule that, because inclusion of essential community providers is related to network adequacy, a QHP issuer may not be prohibited from contracting with any essential community provider described in final § 156.235(c). We urge States to consider local demographics, among other elements, when developing network adequacy standards and note that nothing in the final rule would preclude an Exchange from identifying specific provider types that are particularly essential in a State.

Comment: A few commenters recommended that the final rule direct QHP networks to maintain growth capacity, or the ability to accept additional enrollees or utilization.

Response: We believe that the higher standard in § 156.230(a)(2) of this final rule helps address the commenters' concerns. Further, we believe that the reference to section 2702(c)(2) of the PHS Act, included in section 1311(c)(1) of the Affordable Care Act, implies Congressional intent to protect current enrollees from unreasonable delays in access to care if QHPs expand enrollment too quickly. Therefore, we are not prescribing a uniform growth capacity standard for all Exchanges in the final rule, though we note that an individual Exchange would be able to set such a standard.

Comment: A few commenters supported the language in the preamble to the proposed rule encouraging Exchanges and QHP issuers to consider broadly defining the providers that can furnish primary care services. However, other commenters raised concerns about this broader definition and noted that other programs, such as Medicare and Medicaid, identify a limited set of providers who may be considered primary care providers.

Response: We continue to encourage Exchanges to consider a broader definition of the types of providers who may furnish primary care services, because this should improve access to such services for consumers, particularly those in medically underserved or rural areas. We also recognize that the definition of a “primary care provider” should be consistent across health insurance programs to the extent possible, and we ***18420** encourage Exchanges to be mindful of existing definitions and approaches in other health insurance programs when outlining corresponding standards for QHP issuers participating in the Exchange. All provider contracts executed by QHP issuers participating in the Exchange must be fully compliant with State scope of practice laws.

Comment: A few commenters requested that HHS provide technical assistance on the various network adequacy benchmarks that are available (for example, NAIC, Medicare Advantage, TRICARE, Medicaid managed care) as States develop Exchange standards.

Response: We continue to work with States on a variety of issues related to Exchange establishment and operations, and will consider providing more specific technical assistance on existing network adequacy standards in the future.

Comment: Several commenters recommended that additional items be included in QHP provider directories described under proposed § 156.230(b), such as each provider's specialty, affiliation, licensure, or languages spoken. A few commenters requested that HHS establish that the provider directory must be easily searchable for Indian Health Service/Tribal/Urban (I/T/U) providers. Finally, a few commenters recommended that provider directories include non-physician providers.

Response: Consistent with current industry practice, we expect QHP issuers' provider directories to include information on each provider's licensure or credentials, specialty, and contact information, which could include any institutional affiliation. The Exchange may establish additional data elements that QHP issuers must include, such as identifying Indian Health Service/Tribal/Urban (I/T/U) providers.

We note that while a provider directory could include appropriate non-physician providers, we afford Exchanges discretion regarding their inclusion in the provider directory. A provider directory that includes providers whose scope of practice is limited should generally identify the services that the provider is contracted to perform, for example, by displaying such providers only when consumers search for certain services (for example, primary care).

Comment: Multiple commenters recommended that the Exchange consolidate QHP provider directories as described in the preamble to the proposed rule. Conversely, some commenters recommended maximum flexibility for QHP issuers to submit provider information.

Response: We encourage, but do not direct, Exchanges to consolidate QHP provider directories to make it easier for consumers to locate the QHPs in which their providers participate. Exchanges may also want to establish links to the provider directory on a QHP issuer's Web site.

Comment: Several commenters requested that HHS clarify how frequently QHP issuers must update provider directories under proposed § 156.230(b). Recommendations offered by commenters ranged from in real time to annually. A few commenters raised concerns about the proposed standard that directories identify providers who are not accepting new patients, noting that this could result in continuous updates.

Response: We afford each Exchange with discretion to provide guidance to QHP issuers with respect to the updating of provider directories, including how frequently issuers must identify providers who are no longer accepting new patients. We urge Exchanges to consider the appropriate balance between supporting consumer choice and the burden on QHP issuers associated with this standard (which should be lower for electronic directories than for hard copy directories). Further, in establishing such standards, we expect Exchanges to consider the information needs of current versus potential enrollees.

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Comment: A few commenters recommended that HHS establish that provider directories developed in accordance with proposed § 156.230(b) must offer meaningful access to individuals with limited English proficiency and/or disabilities, for example by making directories available by phone.

Response: We note that, because they are made available to enrollees, provider directories must meet the standards for applications, forms, and notices established in § 155.230 of this final rule, which include accommodations for individuals with limited English proficiency and/or disabilities.

Comment: A few commenters suggested that QHP issuers be directed to notify enrollees if their particular provider drops out of the network.

Response: Although a provider's contracting status has significant implications for patients—especially those who regularly see a particular provider for treatment of a chronic or complex condition—we do not set a uniform standard for notification of individual patients if their providers drop out of the QHP's network. Such a uniform standard on QHPs might not be consistent with practices in the non-Exchange market, and would raise QHP administrative costs.

Comment: HHS received comments that section 408 of the Indian Health Care Improvement Act (IHCIA), should be interpreted to obligate QHPs to include health programs operated by the IHS, Tribes, Tribal organizations, and Urban Indian organizations as providers in their networks. Several commenters also recommended that HHS clarify the applicability of section 206 of the ICHIA to QHPs.

Response: The primary purpose of section 408 of IHCIA is to deem Indian health providers as eligible to receive payment from Federal Health Care Programs for health care services provided to Indians if certain standards are met. Eligibility to receive payment under section 408 of IHCIA does not depend on in-network status with a QHP. Section 206 of IHCIA provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. We believe that section 206 will foster network participation because it benefits QHPs to contract with Indian health providers to establish the payment terms to which the parties agree. Accordingly, we are not modifying the regulation text to reflect this comment.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.230 of the proposed rule with the following modification: in new paragraph (a)(2), we modified the standard previously proposed in § 155.1050 to clarify that a QHP issuer must maintain a provider network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. We also specifically include providers that specialize in mental health and substance abuse, because mental health and substance abuse services are essential health benefits and because mental health parity applies to QHPs.

f. Essential Community Providers (§ 156.235)

In § 156.235, we proposed that a health plan's network must include a sufficient number of essential community providers who provide care to predominantly low-income and medically-underserved populations to ***18421** be certified as a QHP. We solicited comment on how to define a sufficient number of essential community providers. We also defined the types of providers included in the definition of essential community providers consistent with the Affordable Care Act, which specifically identifies all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. We also solicited comment on the extent to which the definition should include other similar types of providers that serve predominantly low-income, medically-underserved populations and furnish the same services as the providers referenced in section 340B(a)(4) of the PHS Act.

In the preamble to this section, we acknowledged that two provisions of the Affordable Care Act regarding payment of essential community providers and payment of Federally Qualified Health Centers (FQHCs) may conflict and invited comment on this issue. We also invited comment on specific payment and contracting issues related to Indian health providers. Finally, we requested comment on other special accommodations that should be made when contracting with Indian health providers, such as the use of a standardized Indian health provider contract addendum.

Comment: HHS received many comments seeking clarity on the proposed standard in § 156.235(a) that QHPs include in their provide networks a "sufficient" number of essential community providers. Many commenters recommended that QHP issuers include in their provider networks all essential community providers in the area; contract with any willing essential community provider; or contract with certain types of providers, such as family planning providers. Some commenters suggested HHS define sufficiency based on specific ratios of enrollees to providers, maximum travel times, or the Need for Assistance worksheet used by the Health Resources and Services Administration.[FN12] One commenter suggested that HHS base the sufficiency standard in part on the Health Professions Shortage Areas, Medically Underserved Areas and Medically Underserved Populations designated by the Health Resources and Services Administration.

In contrast, other commenters supported the proposed rule and urged HHS to maintain a broad definition of "sufficient" that allows Exchanges to establish standards appropriate for their States. A number of commenters urged HHS to strike a balance between having QHP issuers provide enrollees with adequate access to care from essential community providers and allowing QHP issuers to employ innovative network designs that improve quality and contain costs.

Response: Based on comments received, we believe that additional clarification of the "sufficiency" standard is necessary. Accordingly, we have modified final § 156.235(a) to direct that each QHP's network have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. We believe that this approach more clearly articulates our expectations with respect to sufficiency than the standard included in the proposed rule with respect to essential community providers while continuing to balance the accessibility of essential community providers with network flexibility for issuers. We emphasize that Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, including a standard that QHP issuers offer a contract to any willing essential community provider. HHS intends to monitor the effectiveness of this provision in ensuring access to essential community providers, and it may be subject to further modification.

Comment: HHS received several comments suggesting that QHP issuers be exempt from the standard in proposed § 156.235(a) to include essential community providers in their provider networks if the Exchange's service area does not include low-income or medically-underserved populations.

Response: Section 1311(c)(1)(C) of the Affordable care Act directs all QHP issuers to include essential community providers in their provider networks; therefore, we have not amended the regulation to provide the exemption suggested by the commenter. Further, we note that the statute and final rule acknowledge that essential community providers may not be available throughout a QHP's service area. We believe that the inclusion of "where available" in both places creates flexibility for QHP issuers to contract with essential community providers in a manner that reflects the relative availability of these providers and the needs of local communities.

Comment: A number of commenters urged us to address the services that a QHP issuer should cover when provided by an essential community provider in its provider network, as described in proposed § 156.235(a)(1). Some commenters suggested that QHP issuers be directed to cover all services furnished by the essential community provider. Some commenters expressed concern that QHP issuers might contract with essential community providers for a few services, thus fulfilling the essential community provider "sufficiency" standard but prohibiting access to the full breadth of services through such providers.

Response: While we believe the statutory directive to include essential community providers in QHP provider networks must translate to meaningful access to care for low-income and medically underserved populations, section 1311(c)(1)(C) of the Affordable Care Act provides that nothing in the standard to include essential community providers obligates a QHP to cover any specific medical procedure. We generally anticipate and expect QHP issuers will contract with essential community providers for all services furnished by the provider that are otherwise covered by the QHP.

Comment: Several commenters supported an exemption from the standards in this section for staff-model health plans or integrated delivery system-based health plans, though one commenter urged HHS to make such an exemption contingent upon the organization demonstrating that its provider network still provides meaningful access to all forms of care to potential enrollees in the service area. One commenter suggested that HHS establish a provision similar to Medicaid's "freedom of choice" provision in 42 U.S.C. 1396(a)(23) in order to allow enrollees in staff-model QHPs to receive covered services from other providers if needed at no additional cost to the enrollee; the commenter specifically cited concerns that a religiously-sponsored integrated delivery health plan may not offer a full range of reproductive health services. Conversely, several commenters opposed any exemption for staff-model or integrated delivery system plans.

Response: Based on comments, we are persuaded that the obligation to contact with essential community providers should address the unique contracting structure of staff-model health plans and integrated delivery system-based health plans that provide a majority of services "in-house." We are concerned that ***18422** establishing a standard for such plans to contract with essential community providers would result in these plans having to alter their business models, which may obviate the benefits of integration. In the proposed rule, we noted that we were weighing whether to provide consideration for plans that solely provide services "in-house". In light of comments, however, we recognize that staff model and highly integrated delivery system plans do not provide services solely "in house"; rather, as a practical matter, they must provide some level of out-of-network services (for example, emergency services) and often must contract with Centers of Excellence or certain specialists to provide patients with access to highly specialized services. As a result, we have added under final § 156.235(b) a provision directing Exchanges to offer an alternate standard for plans with a majority of services furnished by "in-house" providers. Under the alternate standard, health insurance issuers that provide a majority of covered professional 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 and medically underserved individuals. We note that this alternate standard does not permit an Exchange to grant any QHP issuer a wholesale exception to standards related to essential community providers.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters urged HHS to clarify the term "generally applicable payment rates" and ensure that essential community providers are reimbursed at a reasonable level by establishing minimum reimbursement standards for all essential community providers. Suggestions for such a benchmark included the Medicaid prospective payment system (PPS) rate under 42 U.S.C. 1396a(bb), Medicare rates, or a reimbursement rate at least equal to the issuer's negotiated rate with a similarly situated non-essential community provider. Commenters also recommended that QHPs offer "generally applicable payment rates" by service line to ensure that plans do not mask low rates for particular services by providing higher rates for less-utilized service, or otherwise discriminate against essential community providers in contract negotiations.

Response: QHP issuers should not discriminate against essential community providers through contract negotiations, or otherwise attempt to circumvent the obligation to include such providers in-network by offering unfavorable rates. In this final rule, we are not specifically establishing that a generally applicable payment rate be based on a particular benchmark or be calculated using a particular method (for example, by service line), but clarify that "generally applicable payment rate" means, at a minimum, the rate offered to similarly situated providers who are not essential community providers as defined in this section.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters offered feedback on the appropriate payment rates for Federally-qualified health centers, or FQHCs. Several commenters supported payment of Medicaid PPS rates to all FQHCs some commenters advocated that Exchange provide wrap-around payments to FQHCs, as is currently the practice in State Medicaid programs. Other commenters supported payment of the issuer's generally applicable

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payment rates, while other commenters recommended allowing payment of mutually agreed upon rates. A few commenters offered unique suggestions not explicitly contemplated in the proposed rule, such as negotiating based on Medicare rates or permitting States to establish payment rates for essential community providers.

Response: The Affordable Care Act, at section 1302(g), establishes payment of FQHCs at the applicable Medicaid PPS rate. However, the Affordable Care Act also supports, at section 1311(c)(2), payment of essential community providers, including FQHCs, at the QHP issuer's generally applicable payment rate. We are amending the regulation text in final § 156.235(e) to codify both sections 1302(g) and 1311(c)(2) of the Affordable Care Act. We interpret these two provisions to mean that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate, or 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 payment rate.

Comment: Several commenters suggested that, rather than direct QHP issuers to contract with essential community providers under proposed § 156.235(a), Exchanges should provide incentives for QHP issuers to contract with essential community providers.

Response: Including essential community providers in QHP provider networks is a minimum certification standard specifically established by Section 1311(c)(1)(B) of the Affordable Care Act. This does not preclude Exchanges from offering incentives to QHP issuers (such as priority placement on the Exchange Internet Web site) to contract with more essential community providers than the Federal minimum standard.

Comment: In response to the list of essential community providers in proposed § 156.235(b), many commenters recommended inclusion of specific provider types, including but not limited to rural health clinics, community mental health centers, family planning clinics, Ryan White Care Act providers, pediatricians and children's hospitals, tribal health care providers, providers that serve limited English proficient populations, school-based clinics, or the entirety of a health system that includes a 340(B) or disproportionate share hospital. Some commenters also expressed concern about the potential for exclusion of or discrimination against specific types of essential community providers, such as those that are academic medical centers, by issuers, States or Exchanges. Conversely, a few commenters recommended that each State define essential community providers.

Response: We acknowledge that a wide variety of health care providers and institutions serve low-income and medically underserved individuals, and we note that the definition of essential community providers contained in the proposed rule encompasses a broad range of providers that serve low income and underserved communities, including FQHCs, disproportionate share hospitals, Ryan White Care Act Title II and III grantees, and urban Indian organizations. We clarify that the list of essential community providers provided in paragraphs (c)(1) and (c)(2) are not an exhaustive list and are not meant to exclude QHP issuers from contracting with other providers that serve predominantly low-income, medically underserved individuals.

In § 156.235(c) of the final rule, we are finalizing the proposed rule definition, with a slight modification. Based upon comments regarding the potential for exclusion of or discrimination against essential community providers and consistent with the intent explicit in section 1311(c)(1)(C) of the Affordable Care Act that access to essential community providers be maximized in QHPs, we clarify that any provider that meets the criteria for an essential community provider in § 156.235(c), or met the criteria on the publication date of this regulation unless the provider lost its status under § 156.235(c)(1) or (c)(2) thereafter as a result of violating Federal law, must be considered an essential community provider. We intend to monitor this policy and revisit as necessary.

***18423** We note that the definition in the final rule, taken from the section 1311(c)(1)(C) of the Affordable Care Act, provides a test to determine whether a provider is an essential community provider and a non-exhaustive list of examples. An Exchange may apply the test contained in the definition (providers that serve predominantly low-income, medically underserved individuals) to a particular service area to identify additional essential community providers. Finally, we note that each QHP provider network

must be sufficient in number and types of providers to assure that all services, including mental health and substance abuse services, will be accessible without unreasonable delay.

Comment: A few commenters recommended that HHS develop a standard Indian Addendum for contracting with tribal health care providers.

Response: We recognize that furnishing QHP issuers with a standard Indian Addendum to a provider contract may make it easier for QHP issuers to contract with Indian providers. We note that QHP issuers may not be aware of the various Federal authorities that govern contracting with Indian health providers, and such an Addendum may lower the perceived barrier of contracting with Indian providers. We plan to develop a template for contracting between QHP issuers and tribal health care providers. While we do not uniformly mandate that QHP issuers use the template, we believe that QHP issuers will find it in their interest to adopt such a template when contracting with Indian providers. We also note that Exchanges may elect to direct QHP issuers to use the Indian Addendum when contracting with Indian providers.

Comment: One commenter recommended that all entities designated as essential community providers qualify for special drug pricing under section 340B(a)(4) of the Public Health Service Act. Conversely, another commenter requested that the final rule clarify that QHP issuers are not obligated to contract with all 340(B) pharmacies. One commenter suggested that HHS work with States and Exchange governing boards to ensure that providers have a clear understanding of how key 340(B) principles apply in the Exchange context in order to avoid confusion and violation of 340(B) anti-diversion rules.

Response: This rule concerns the establishment and operation of Exchanges and the certification standards for QHPs; nothing in this final rule changes or affects the operation of section 340(B) of the Public Health Service Act. As a result, requests to interpret section 340B of the Public Health Service Act are outside the scope of this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.235 of the proposed rule, with the following modifications: in paragraph (a)(1) we modified QHP issuer's contracting responsibilities with respect to essential community providers to reflect a reasonable access standard and a broad range of providers standard. In new paragraph (a)(2) we added an alternate standard for QHP issuers that provide a majority of professional services with “in-house” providers. In paragraph (c), we clarified the definition of an essential community provider. We also added new paragraphs (d) and (e) to interpret and implement Affordable Care Act section 1311(c)(2) (regarding payment rates to essential community providers) and section 1302(g) (regarding payment of FQHCs); in doing so we indicate that QHP issuers and FQHCs may negotiate rates and mutually agree on a payment rate other than the Medicaid PPS rate.

g. Treatment of Direct Primary Care Medical Home (§ 156.245)

In § 156.245, we proposed to permit QHP issuers to provide coverage through a direct primary care medical home (PCMH) that meets the standards established by HHS, provided that the QHP meets all standards otherwise applicable. We requested comment on what standards HHS should establish under this section.

Comment: Multiple commenters recommended that direct PCMHs described in proposed § 156.245 be accredited, or comply with existing industry standards such as the Joint Principles of the Patient-Centered Medical Home [FN13] developed by the Patient Centered Primary Care Collaborative. Other commenters expressed general support for PCMHs or provided data on the effectiveness of the PCMH model.

Response: We believe that Exchanges offer an opportunity to advance innovative models of delivery that can improve the care experience for patients and providers. Consistent with this overall goal, we have structured the direct PCMH provision to encourage, rather than limit, innovative care models. While we recognize the importance of accreditation and quality assurance,

we are not establishing that direct PCMHs be accredited in order to participate in QHP networks. We encourage QHP issuers to consider the accreditation, licensure, or performance of all network providers.

Comment: Several commenters suggested that the definition of direct PCMHs in proposed § 156.245 be expanded to include accountable care organizations or specialists who serve as a patient's "health home."

Response: While non-primary care clinicians can play a significant role in care coordination, particularly for patients with multiple or complex conditions, the statute specifically provides for inclusion of primary care medical homes. We do not interpret that phrase as including providers of non-primary care services, such as specialists. However, we note that nothing in this section prohibits or limits a QHP issuer's ability to pursue other innovative care models or contracting structures, such as increasing payments to specialists who coordinate an individual's care, or contracting with accountable care organizations.

Comment: A few commenters requested that HHS clarify what coordination is contemplated between a QHP and a contracted direct PCMH under proposed § 156.245.

Response: QHP issuers that choose to contact with direct PCMHs for primary care services will need to consider how to promote a seamless consumer experience. For example, the QHP issuer should ensure that enrollees understand how to use the direct PCMH model, identify which services will be provided by the direct PCMH and which will not, and have clear information on how to access specialists and other non-primary care providers.

Comment: Several commenters generally recommended that HHS encourage QHP issuers to contract with direct PCMHs, direct issuers to contact with a specific number of direct PCMHs, establish that a certain percentage of network providers must be affiliated with direct PCMHs, or direct QHP issuers to report on the number of in-network direct PCMHs.

Response: While we believe that an Exchange could create incentives for QHP issuers to contract with direct PCMHs, such incentives are more appropriately considered within the context of local provider market conditions, including the relative availability of direct PCMHs. As a result, we are not directing Exchanges to create incentives for contracting with direct PCMHs. We encourage Exchanges to promote, and QHP issuers to explore, ***18424** innovative models of delivery along the care spectrum.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.245 of the proposed rule without modification.

h. Health Plan Applications and Notices (§ 156.250)

In § 156.250, we proposed basic standards for the format of applications and notices provided by the QHP issuer to the enrollee, specifically that QHP issuers must adhere to the standards established for notices in § 155.230.

We received a number of comments on this section. Because § 156.250 cross-references to § 155.230, we have responded to all comments on applications and notices in § 155.230. Accordingly, we are finalizing § 156.250 as proposed.

i. Rating Variation (§ 156.255)

Consistent with the rating rules established in the Affordable Care Act, we proposed § 156.255 to codify the statutory provision that allows QHP issuers to vary premiums by the rating areas established under section 2701(a)(2) of the PHS Act. We further proposed that each QHP issuer offer a QHP at the same premium rate without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent. We also proposed that a QHP issuer cover all the following groups using some combination of the following categories: (1) Individuals; (2) two-adult families; (3) one-adult families with a child or children; and (4) all other families. We sought comment on how we might structure family rating

categories while adhering to section 2701(a)(4) of the PHS Act, which establishes that any family rating using age or tobacco rating may only apply those rates to the portion of the premium that is attributable to each family member.

Additionally, we requested comment on how to apply four family categories when performing risk adjustment. We also invited comment on alternatives to the four categories for defining family composition, and how to balance potential consumer confusion associated with more categories while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market. Finally, we noted that we were also considering whether to direct QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates, and sought comment on the potential considerations of this approach.

Comment: A few commenters asked why the proposed rule did not address section 1312(c) of the Affordable Care Act related to a single risk pool.

Response: The proposed rule and this final rule only address standards that are unique to Exchanges, QHP issuers and QHPs. The single risk pool provision applies to health insurance issuers in the individual and small group market and to enrollees who do not enroll in health plans through the Exchange. Therefore, it is outside the scope of this final rule. We anticipate future rulemaking on other Affordable Care Act provisions that apply to insurance markets generally.

Comment: One commenter suggested that the final rule establish a process whereby a State demonstrates that existing State laws related to rating outside of the Exchange will not undermine the Exchange.

Response: We are continuing to evaluate the relationship and interaction of State rating laws, the market reform provisions in section 2701 of the PHSA, and the provisions to implement the Exchange standards. We may issue further guidance in the future.

Comment: In response to the proposed § 156.255(a) on rating areas, one commenter suggested that we codify the standard that rating areas must be applied consistently inside and outside of the Exchange, which we discussed in preamble of the proposed rule (76 FR 41901). A few commenters requested that HHS establish a standard set of criteria for rating area boundaries that reflect actual differences in health costs within a State.

Response: Section 2701(a)(2) of the PHS Act directs States to establish rating areas, which will be reviewed by the Secretary of HHS. Section 1301(a)(4) of the Affordable Care Act directly references the rating areas outlined in section 2701(a)(2) of the PHS Act, which ensures that the rating areas are applied consistently both inside and outside the Exchange. The requested provision is outside the scope of this final rule; we anticipate future rulemaking on other Affordable Care Act provisions that apply to insurance markets generally.

Comment: Several commenters requested that HHS more clearly define what “same plans” would need to be offered at the same premium rate for proposed § 156.255(b). The commenters raised concerns that issuers would offer two plans with very minor differences and then charge a different premium for what is essentially the same plan, which could result in adverse selection against the Exchange.

Response: We believe that, generally, this provision means that health plans that are substantially the same as a QHP should charge the same premium and encourage States to use this standard when evaluating compliance with this provision. HHS may further clarify this standard in future rulemaking or guidance.

Comment: Several commenters voiced support for proposed § 156.255(b), while others had questions regarding whether user fees charged for enrollment would undermine the same premium provision. Some commenters suggested that HHS direct Exchanges to apply user fees to QHPs offered outside of the Exchange in order to ensure pricing parity.

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Response: We clarify that States have substantial flexibility in establishing a funding mechanism for an Exchange to meet the self-sustaining provision of section 1311(d)(5) of the Affordable Care Act, implemented in this final rule at § 155.160. As noted in the statute and the regulation text, user fees on QHPs are one mechanism to achieve this status. Such fees may be set based on a broad or narrow set of issuers, on enrollment volume, including enrollment that is not through the Exchange, or be set without regard to enrollment.

Comment: Several commenters suggested that we direct QHP issuers to offer QHPs outside of the Exchange.

Response: Nothing in Federal law prohibits a QHP issuer from offering the QHP for sale directly to an individual or through an agent/broker in addition to through the Exchange. We note that a State law may address this issue. Further, enrollees in such a plan would not qualify for advanced payments of premium tax credits, among other Exchange benefits.

Comment: In response to proposed § 156.255(c), several commenters raised issues regarding rating rules that were discussed in the proposed rule, including the incorporation of the tobacco rating factor described in section 2701(a)(1)(A)(iv) of the PHS Act (76 FR 41901). Other commenters made suggestions about the application of a rating structure to a tax household.

Response: In the final rule, we have removed proposed § 156.255(c), which addresses rating categories. We anticipate that implementation of section 2701(a)(1)(A) of the PHS Act will establish standards that apply to health insurance issuers in the individual and small group market, including QHP issuers.

18425** ***Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.255 of the proposed rule, with the exception of removing paragraph (c).

j. Enrollment Periods for Qualified Individuals (§ 156.260)

In § 156.260, we proposed that QHP issuers must accept and enroll qualified individuals during the initial open enrollment period, during the annual open enrollment period thereafter, and during special enrollment periods, as applicable. We further proposed that QHP issuers adhere to the effective dates of coverage established in § 155.410 for all enrollment periods in the Exchange, and provide enrollees with notice of effective dates of coverage.

Comment: HHS received many comments about enrollment periods in accordance with § 155.410 and § 155.420, which are summarized and addressed in those sections of the final rule. One commenter remarked specifically on proposed § 156.260 and requested that HHS clarify whether a QHP could refuse enrollment to an applicant previously proven to have committed fraud.

Response: A QHP issuer may not refuse enrollment to a new applicant who has previously proven to have committed fraud. We note that section 2703(b) of the PHS Act, with which QHP issuers must comply, includes an exception to the guaranteed renewability standard in certain instances of fraud, but includes no parallel exception for new coverage. We further note that § 156.270(a) permits QHP issuers to rescind coverage under certain circumstances.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.260 of the proposed rule, with a minor technical modification and no substantive changes.

k. Enrollment Process for Qualified Individuals (§ 156.265)

In § 156.265, we proposed that QHP issuers adhere to the Exchange's process for enrollment in QHPs, which includes standards for the collection and transmission of enrollment information. Additionally, we proposed that QHP issuers use the application adopted in accordance with § 155.405 when accepting applications from individuals seeking to enroll in a QHP through the

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Exchange enrollment process. After collecting the uniform enrollment information from an applicant, we proposed that the QHP issuer send the information to the Exchange, in accordance with the standards established in § 155.260 and, as applicable, § 155.270.

Consistent with the standards established in accordance with § 155.260 and in § 155.270, we proposed that QHP issuers receive enrollment information electronically from the Exchange. We sought comment on the frequency with which plans should receive electronic enrollment information. We also proposed that QHP issuers abide by the premium payment process established by the Exchange and described in § 155.240.

We further proposed that QHP issuers provide enrollees in the Exchange with an enrollment package, and the summary of benefits and coverage document. We solicited comment on what should be included in an enrollment package. Finally, we proposed that QHP issuers reconcile enrollment files with the Exchange no less than once a month, and that QHP issuers acknowledge the receipt of enrollment information in accordance with Exchange standards established in § 155.400.

Comment: Some commenters recommended that proposed § 156.265(b) prohibit agents, brokers and Web-based entities from performing eligibility determinations.

Response: An agent, broker, or Web-based entity cannot perform eligibility determinations as part of enrollment through the Exchange. We note that section (b)(2)(A) of 36B of the Internal Revenue Code as amended by the Affordable Care Act establishes that an individual must enroll "through the Exchange" in order to access advance payments of the premium tax credit and cost-sharing reductions. However, in § 155.220(c)(1), we specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual receives an eligibility determination through the Exchange Web site.

Comment: In response to the provisions described in proposed § 156.265(b), several commenters suggested that an individual have an eligibility determination before enrolling in a QHP. Other commenters expressed concern regarding the privacy of individuals' information when a QHP issuer facilitates the enrollment of an individual through the Exchange as described in proposed § 156.265(b), particularly when the individual seeks an eligibility determination. One commenter suggested that the QHP issuer refer individuals to the Exchange to carry out activities related to eligibility and enrollment.

Response: An individual must receive an eligibility determination from the Exchange before enrolling in a QHP through the Exchange. Accordingly, we have added new paragraph § 156.265(b)(1) to clarify that the QHP issuer may only enroll a qualified individual after the Exchange has notified the QHP issuer that the individual has been determined eligible consistent with the standards identified in part 155 subpart D, and on the basis of enrollment information sent from the Exchange to the QHP issuer. In addition, in § 156.265(b)(2), we specify that QHP issuers must direct the individual to file an application with the Exchange or ensure the applicant receives an eligibility determination for coverage through the Exchange through the Exchange Internet Web site. These provisions ensure that the applicant's information is collected only by the Exchange and thus firewalled from issuers and agents and brokers and accordingly protected. We do not provide regulatory standards for enrollment in a QHP that is not enrollment through the Exchange and defer to issuers as to their business practices for that. We reiterate that the assistance and protections described in part 155 apply to Exchange enrollment.

Protecting the personal health and other information provided by potential enrollees during the eligibility and enrollment process is critical. Further, we note that when the QHP issuer conducts relevant enrollment functions on its own behalf, that appears to be an activity covered by the HIPAA privacy and security rules in part 164.

Comment: HHS received a few comments in response to proposed § 156.265(d), which obligates issuers to follow the premium payment process established in § 155.240. One issuer recommended that payment directly to the QHP serve as the last resort for enrollees, another commenter requested that enrollees retain this option in the final rule. One commenter suggested that

the enrollee pay only one entity (that is, the Exchange or the QHP issuer) for the entire benefit year. Finally, one commenter suggested that the Exchange be directed to aggregate premiums to avoid unpredictable administrative costs for issuers.

Response: As this option is statutorily established under section 1312(b) of the Affordable Care Act, consumers must have the option to remit premium payments directly to QHP issuers. Therefore, we are maintaining the language in § 155.240(a), which directs an Exchange to allow enrollees to pay ***18426** premiums directly to QHP issuers. For a full discussion of issues related to premium payment, please refer to the responses to comment in § 155.240.

Comment: Many commenters offered suggestions related to the enrollment package described under proposed § 156.265(e). Many commenters recommended that HHS establish meaningful access standards; standards suggested by commenters included language written at the 6th grade level, in-language “taglines” in fifteen languages directing enrollees to oral translation services, or existing HHS Limited English Proficiency guidance. Other commenters recommended that the package include information about how to file a complaint. Some commenters suggested that HHS direct issuers to follow existing State and Federal law governing the contents of enrollment packages.

Response: The enrollment information package is subject to the accessibility and readability standards established in § 156.250, which cross-references the access standards set forth in section § 155.230(b); therefore, we have not amended the regulation text in this section because it would be duplicative. States have the flexibility to establish that the enrollment package include information on grievance and appeal rights, but we note that this information is already described in the summary of benefits and coverage as specified in guidance published by the Departments of HHS, Labor, and the Treasury under PHS Act section 2715, which an enrollee would receive at essentially the same time. We also note that issuers must continue to follow existing law regarding the content of the enrollment package.

Comment: One commenter suggested that QHP issuers be able to attach the individual's choice of QHP to the individual's application to determine eligibility when that application originates with the QHP issuer.

Response: HHS will consider comments recommending that an individual's QHP selection be included in an application that is initiated with the QHP issuer as we develop guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.265 of the proposed rule, with the following modifications: We have rewritten paragraph (b) to describe more clearly the process to enroll an applicant through the Exchange when the applicant approaches the QHP issuer directly. We modified paragraph (e) to state that the enrollment information package must comply with accessibility and readability standards in § 155.230(b). We eliminated paragraph (f) referencing the summary of benefits and coverage document. Because of the elimination of the paragraph on summary of benefits and coverage, the remaining provisions have redesignated numbers.

l. Termination of Coverage for Qualified Individuals (§ 156.270)

In § 156.270, we proposed standards for QHP issuers regarding the termination of coverage of individuals enrolled in QHPs through the Exchange, and proposed that a QHP issuer may terminate coverage for non-payment of premium, fraud and abuse, and relocation outside of the service area, among other situations permitted by the Exchange. Additionally, we proposed that QHP issuers provide a notice of termination of coverage to the enrollee and the Exchange, consistent with the standards for effective dates in § 155.430. We solicited comment on the information that should be included in the termination notice.

We also proposed standards for QHP issuers regarding the application of the grace period for non-payment of premiums by individuals receiving advance payments of the premium tax credit. Specifically, we proposed that a QHP issuer must provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium. During the grace period, we clarified that the QHP issuer must pay all appropriate

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claims, apply any payment received to the first billing cycle in which payment was delinquent, and continue to collect the advance payments of the premium tax credit on behalf of the enrollee from the department of the Treasury.

We also proposed to direct QHP issuers to provide a notice to enrollees who are delinquent on premium payments and sought comment on the potential elements of such a notice. Additionally, we proposed that QHP issuers maintain records of terminations of coverage in accordance with Exchange standards as established in § 155.430. Finally, we proposed that QHP issuers abide by the effective dates for termination of coverage as described in § 155.430.

Comment: Many commenters were concerned that the notices described in proposed § 156.270(b) and (e) should meet meaningful access standards and are accessible for LEP individuals and for individuals with disabilities.

Response: QHP notices must meet standards for LEP individuals and for individuals with disabilities. Section 156.250 of the final rule states that all notices from a QHP issuer must meet the standards outlined in § 155.230(b).

Comment: Some commenters were concerned that a QHP issuer could terminate coverage under this section without sufficient notice. Other comments urged HHS to track reasons for termination of coverage for oversight purposes. Finally, a few commenters asked us to clarify how QHP issuers and the Exchange would share information about termination of coverage.

Response: In response to comments, we have added paragraph (b)(1) to the final rule to state that QHP issuers must notify enrollees at least 30 days prior to terminating coverage, and further that the notice must include a reason for termination. We also added 156.270(b)(2) to the final rule to state that the QHP issuer must notify the Exchange of the termination effective date and reason for termination.

Comment: A significant number of commenters voiced concerns that the proposed policy in § 156.270(d) that directed QHP issuers to pay all appropriate claims during the 3-month grace period would exacerbate adverse selection and increase premiums across enrollees. Several commenters representing the insurance industry specifically noted that under the proposed policy, rates would be built with an assumption that some portion of enrollees would pay 9 months of premium for 12 months of full coverage.

Several alternatives were suggested, such as allowing QHP issuers to pend claims after the first 30 days of non-payment, which would allow the issuer to put a hold on claims until the end of the grace period, at which point such claims would be paid if the premiums were paid, or denied if the premiums were not paid. Another commenter suggested allowing QHP issuers to deny coverage for certain categories of services, such as elective, non-emergency procedures, additions of new household members, or new prescription drugs. Other commenters suggested that each Exchange be allowed to determine the payment policy, and some recommended that Exchanges be responsible for helping to pay outstanding premiums or for seeking payment of outstanding premiums from an individual.

Response: We did not accept the recommendation that each Exchange set its own standard. Advance payments of the premium tax credit are directly tied to the grace period. Thus the grace period's parameters will have an impact on potential Federal tax liability of consumers and on Federal administration of the advance payments ***18427** of the premium tax credit. As a result, it is critical that the Federal government establish a uniform grace period policy to balance the potential impacts on the consumer's tax liability, coverage liability for issuers and providers, and appropriate administration of advance payments of the premium tax credit.

However, we are persuaded that the proposed standards should be adjusted in this final rule to decrease the opportunities for risk manipulation, adverse selection, and premium increases. In § 156.270(d)(1) and (d)(2) of the final rule, we now direct QHP issuers to pay all appropriate claims for services provided during the first month of the grace period. We believe that the first month of non-payment is the month in which an enrollee is the most likely to resume timely payments, and thus is the time period in which it is most important to ensure seamless coverage. As such, issuers should adjudicate claims as they would for any enrollee that pays his or her premium in full. However, we acknowledge that as the amount owed by an enrollee increases

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during the 3-month grace period, the risk of non-payment increases as well. To decrease the financial risk to issuers, and to individuals as described below, the final rule now permits QHP issuers to pend claims in the second and third months. We note that QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third months could be denied. The grace period under this final rule represents an extended time for enrollees to catch up on premium payments before coverage is terminated. Several considerations informed this amended approach.

First, the statutory 3-month grace period is substantially longer than many current grace periods and only applies to recipients of advance payments of the premium tax credit, assuming they have paid at least one monthly premium. In light of this fact, a grace period policy that is significantly different from the rest of the market could produce markedly different premiums between the Exchange and non-Exchange markets. The final rule approach helps mitigate these concerns by aligning the grace period claims payment standards more closely with current industry practices.

Second, in accordance with section 36B of the Code, individuals may incur a tax liability for any advance payments of the premium tax credit that are paid on their behalf for a month that such individual did not pay his or her portion of the premium. Under the policy in the proposed rule, an individual would potentially be liable for three months of advance payments of the premium tax credit, which could be substantial in some instances. Given the potential for a large tax liability on the part of enrollees receiving advance premium tax credits that fail to pay their residual premiums to QHP issuers, we believe that a retroactive termination date is appropriate to mitigate excessive individual financial exposure. Under the final rule policy, an individual's financial exposure would be limited to the first month's advance payment of the premium tax credit if the individual did not pay his or her portion of the premium for that month. We have provided several examples below to illustrate how the new grace period policy would work:

Grace Period Examples:
Assumptions for a monthly premium:

—Premium: $500.

—Advance premium tax credit share of premium: $450.

—Enrollee share of premium: $50.

—First month of grace period: March.

—Individual pays enrollee share of premium for January and February coverage.
Example #1: Individual misses $50 payment that is due February 28 for March coverage. Individual realizes mistake and pays $100 on March 31st for March and April coverage, satisfying all obligations for premium payments through the end of March.

○ Issuer adjudicates claims for March consistent with normal practices (that is, for non-grace periods)

○ Individual will have full coverage for March and April

○ Individual has paid full premium for March and April as is eligible for premium tax credit for March and April.

Example #2: Individual misses $50 payment that is due February 28 for March coverage and misses $50 payment that is due March 31st for April coverage. Individual Pays $150 on April 30 for March, April and May coverage.

○ Issuer adjudicates claims for March

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○ Coverage continues for April and May (2nd and 3rd months of the grace period), but:

[ssquf] Providers are notified of the potential for a denied claim.

[ssquf] Issuer pends claims for services performed in April and May until individual pays outstanding premiums.

[ssquf] Individual has paid full premium for March, April and May as is eligible for premium tax credit for March, April and May.

Example #3: Same facts as Example #2 except that individual does not pay enrollee's share of premium for March, April or May.

○ Coverage terminated retroactively to March 31

○ Issuer can deny claims for services rendered during April and May. Providers could then seek payment directly from the individual for any services provided during that time.

○ Individual may have additional tax liability attributable to the $450 for the advance payment of the premium tax credit paid on his or her behalf for March's coverage. The exact amount of additional tax liability would be determined in accordance with the rules for tax credit reconciliation under section 36B of the Code.

Comment: Several commenters supported the proposed standards in § 156.270(d) that QHP issuers pay all appropriate claims during the 3-month grace period for enrollees receiving advance payments of the premium tax credit. Commenters said this would protect providers that render services to such enrollees during the grace period. A few commenters were also concerned about the timing of claims, and suggested that QHP issuers be obligated to pay claims based on the date the service was rendered, and not the date the claim was submitted.

Response: We understand that pended claims increase uncertainty for providers and increase the burden of uncompensated care. The obligation to pay all appropriate claims established in the proposed rule was intended to protect providers during an extended grace period. However, given the significant concerns regarding premium increases and the potential tax liability to consumers, we were concerned that this approach did not strike the right balance. Because we share providers' concerns about incurring claims during the grace period that are not ultimately paid, we now establish in § 156.270(d)(3) of the final rule that QHP issuers notify providers who submit claims for services rendered during the second and third months of the grace period that any such claims will be pended, and potentially not reimbursed by the QHP issuer if the individual does not settle outstanding premium payments. We believe that there are technology-based approaches to provide this notification. We also clarify in § 156.270(d)(1) that the application of the grace period to claims is based on the date the service was rendered, and not the date the claim was submitted.

Comment: Some commenters suggested that the 3-month grace period proposed in § 156.270(d) should be ***18428** shorter, and that HHS refrain from establishing additional rules. Other commenters suggested extending the grace period to 6 months, at least for the first few years.

Response: As stated in the proposed rule, section 1412(c)(2)(B)(iv)(II) of the Affordable Care establishes that QHP issuers "receiving advance payments of the premium tax credit with respect to an individual enrolled in the plan shall * * * allow a 3-month grace period for non-payment of premiums before discontinuing coverage" (76 FR 41902). We do not believe that the statute provides the flexibility to alter the grace period timeframe.

Comment: Several commenters requested clarification on whether the grace period described in proposed § 156.270(d) would be triggered by a full non-payment of premium or a partial non-payment of premium.

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Response: The 3-month grace period applies whenever the QHP issuer has received payment of less than the full amount of the enrollee's share of the premium for a given month. It is our understanding that issuers have varying practices related to the triggering of a grace period, with some issuers initiating a grace period for any payment that is not the full premium and others initiating a grace period only if the individual has not submitted an amount above some threshold. However, in order to be consistent with policy related to the advance payments of the premium tax credit, the enrollee must pay the full amount of his or her portion of the premium or the grace period would be triggered.

Comment: Several commenters voiced concerns about the potential for gaming during the grace period described in proposed § 156.270(d). Commenters suggested that we take action to prevent people from habitually paying 9 months of premiums, stopping premium payment for 3 months, and then enrolling in a new QHP to start the process over again. Commenter suggestions included: requiring payment of all outstanding premiums before enrollees can change issuers, enroll in a different QHP, or re-enroll in a QHP; establishing a 60-day waiting period for individuals who have been terminated for coverage due to non-payment of premiums but seeking re-enrollment in another QHP; allowing issuers to seek reimbursement for claims paid during the grace period from enrollee after termination; issuing a late enrollment penalty or establish a pre-existing condition exclusion period for individuals seeking re-enrollment after termination due to non-payment of premiums; prohibiting enrollment in a QHP until the following open enrollment period; prohibiting someone who has been terminated due to non-payment of premiums from qualifying for a special enrollment period later in the year; imposing penalties for repeat offenders, increasing premiums; allowing QHP issuers to collect the first and last month's premium at the time of application; and finally, limiting grace periods to one year. Other commenters recommended that States have the flexibility to establish their own protections against opportunistic consumer behavior.

Response: We did not adopt the recommendations regarding non-issuance of coverage for individuals who have outstanding premium payments for a previous QHP because we believe that there are implications for rescissions, guaranteed issue, and pre-existing condition policies. HHS will continue to explore options for incentivizing appropriate use of the grace period, either through future rulemaking or in the context of general insurance market reforms. We will also consider the implications for automatic redeterminations and reenrollment in instances where individuals have had their coverage terminated for non-payment of premiums. Gaming will not only affect issuers, but also represents potential for misuse of the advance payments of the premium tax credits. Given the compelling Federal financial stake in grace period, HHS will monitor this issue moving forward and will continue to work on the development of policies to prevent misuse of the grace period.

Comment: Many commenters voiced support of the continued issuance of advance payments of the premium tax credit on behalf of enrollees during the 3-month grace period, as proposed in § 156.270(e). Some commenters suggested that if QHP issuers were allowed to terminate coverage retroactively, then QHP issuers should be directed to return the advance payments of the premium tax credits.

Response: We have maintained the proposed rule policy that QHP issuers must continue to receive advance payments of the premium tax credit being paid on behalf of an enrollee in a grace period. In addition, we included in § 156.270(e)(2) an instruction for QHP issuers to return advance payments of the premium tax credit for the second and third months of the grace period for individuals who exhaust the grace period without paying outstanding premiums, because such individuals will have their coverage terminated retroactively to the end of the first month of the grace period. We note that, consistent with section 36B of the Code, individuals may owe a tax liability as a result of advance payments of the premium tax credit paid on their behalf during a month in which they did not pay their portion of the premium. Under the final rule, individuals will have a liability as a result of the advance payment of the premium tax credit for the first month of the grace period if they never pay their portion of the first month's premium. If an individual exhausts the grace period without paying all outstanding premiums, QHP issuers can terminate coverage retroactive to the end of the first month of the grace period and deny claims that were pended. An issuer who terminated coverage in this fashion would be obligated to return the advance payments of the premium tax credit made on behalf of the individual for the second and third months of the grace period.

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Comment: Some commenters requested clarification of the proposed policy in § 156.270(g) regarding whether a partial payment could extend the grace period once it has already been triggered, or if only full payment of all outstanding premiums would allow an individual to resolve a grace period. Commenters supported the resetting of the grace period only when all outstanding payments are made.

Response: The grace period may only be reset be if an individual has paid all outstanding premiums. We believe that a "rolling" grace period that moves the initial date of the grace period in correlation with any payment made by an individual would be not only confusing to consumers but administratively burdensome, particularly in light of the revised payment policy described in paragraph (d). Therefore, in this final rule, we have added language to clarify this policy in § 156.270(g). Once a grace period has been initiated by a QHP issuer, the individual has three months to settle all outstanding premium payments, at which time the grace period is either resolved and pended claims are paid or the individual's coverage is terminated.

Comment: Commenters requested clarification on the proposed policy in § 156.270(g) regarding whether a QHP issuer could terminate coverage retroactively to the last date of payment, or whether the termination was prospective from the end of the 3-month grace period. Commenters also requested clarification regarding how advance payments of the premium tax credit and payments to providers would be reconciled if the date of termination were retroactive.

***18429** Response: We clarify in final § 156.270(g) that if an individual exhausts the grace period without settling all outstanding premium payments, then the QHP issuer can terminate coverage retroactively to the first day of the second month in the grace period. We understand that many States allow issuers to terminate to the last paid date of coverage. In addition, HHS issued rules concerning rescissions of health insurance coverage, under which issuers are permitted to cancel coverage retroactively due to a failure to timely pay premiums (PHS Act section 2712; 45 CFR 147.128). However, the final Exchange standards for QHP issuers add more consumer protections than the generally applicable PHS Act's standards. During the first month, full coverage will be provided and the QHP issuer will be able to keep the advance payment of the premium tax credit. As a result, we treat the last day of the first month of the grace period as the "last paid date." We note that the enrollee may be obligated to repay the advance payment of the premium tax credit for the first month in the form of an additional tax liability if the individual does not pay the enrollee's portion of the premium. For purposes of claims payment, the QHP issuer must treat the first month of the grace period as if the full premium has been paid. However, the QHP issuer may pursue collection of the individual's portion of the premium; if the individual pays the unpaid enrollee portion of the premium, the individual would retain the potential to be eligible for the premium tax credit for that month.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.270 of the proposed rule, with the following modifications: We added paragraph (b)(1) to note that a QHP issuer must provide the enrollee with a notice of termination of coverage at least 30 days prior to effectuating termination. We added paragraph (b)(2) to clarify that the QHP issuer must give reason for termination in a notice. We have also amended the proposed policy regarding the statutory 3-month grace period for individuals receiving advance payments of the premium tax credit. As described in paragraphs (d) through (g), QHP issuers will now be directed to pay appropriate claims in the first month only of the grace period, and will be able to pend claims in the second and third months. QHP issuers must notify providers who submit claims that an enrollee is in the second or third month of the grace period and that a claim may be denied if the outstanding premiums are not paid in full. Finally, QHP issuers must retain advance payments of the premium tax credit made on behalf of an individual for the first month, and must return such payments for the second and third months to the Department of the Treasury. Finally, we redesignated proposed paragraphs (g) and (h) as (h) and (i), respectively, to accommodate other changes to this section.

m. Accreditation of QHP Issuers (§ 156.275)

In § 156.275, we proposed to codify the statutory provision that a QHP issuer be accredited on the basis of local performance in each of the nine categories listed in the Affordable Care Act, where "local performance" means performance of the QHP issuer in the State in which it is licensed. We further specified that a QHP issuer must be accredited by an entity recognized

by HHS. We also proposed that a QHP issuer must obtain its accreditation within a time period established by the Exchange under § 155.1045.

Comment: In general, commenters supported accreditation as a condition of QHP certification. One commenter voiced concern over the cost of private accreditation and the impact on participation of issuers in Exchanges. Commenters also suggested additional areas that HHS should include in standards for accreditation beyond those specified in the proposed rule, including specific clinical measure sets that should be included, among others. Another commenter asked that new accreditation models be reviewed that are specifically developed for the individual and small group market. One commenter asked for clarification if States would be able to establish more stringent accreditation standards beyond the Federal minimum.

Response: While we understand that accreditation can be a costly and resource-intensive process for issuers, it is established in the Affordable Care Act for certification of QHPs. At this time we are also not adding any additional standards for accreditation beyond what is specified in the Affordable Care Act. The Affordable Care Act is clear as to which criteria should be included in accreditation standards and we are codifying the statute in this regard. We clarify that Exchanges may impose accreditation standards that are more stringent than those contained in the Affordable Care Act.

Comment: Several commenters suggested specific entities that should be recognized by HHS and asked that more than one accrediting entity be recognized. Other commenters asked HHS to specify which accreditation entities would be selected and requested including both private and public entities.

Response: We will be issuing future rulemaking to establish a process by which accrediting entities will be recognized. Comments that requested specific products be considered for accreditation are beyond the scope of this rule.

Comment: A commenter did not support the proposal to direct issuers to authorize the release of their accreditation survey.

Response: We codify the obligation that issuers authorize the release of their accreditation survey to the Exchange and HHS. We believe that this is necessary to monitor the accreditation of QHP issuers beyond what can be learned from a simple reporting of accreditation status. We are also exploring the extent to which data submitted on the accreditation survey may be used to fulfill quality reporting standards, which may help alleviate potential reporting burden on Exchanges and issuers.

Comment: In general, commenters supported establishing a timeline for accreditation of QHP issuers under proposed § 156.275(b). However, several commenters disagreed with our proposal to allow Exchanges to set the timeline and requested that HHS establish a Federal timeline for accreditation that all Exchanges must follow. Commenters also provided recommendations on appropriate accreditation timelines for HHS to establish, ranging from one to several years. Other commenters suggested that there should be a transition period for new plans to become accredited.

Response: The Affordable Care Act, at section 1311(c)(1)(D)(ii) clearly provides for the Exchange to establish the timeframe. Consistent with the statute, we believe that Exchanges are in the best position to determine the accreditation timeline for QHP issuers operating in their States. Exchanges are familiar with local market conditions and the needs of their constituents. Therefore, we are maintaining the regulation text as proposed.

Summary of Regulatory Changes

We are finalizing § 156.275 as proposed.

n. Segregation of Funds for Abortion Services (§ 156.280)

In § 156.280, we proposed to implement section 1303 of the Affordable Care Act by codifying the statutory provisions. This codification includes the non-discrimination clause for providers and facilities, a voluntary ***18430** choice clause for issuers with respect to abortion services, the standards for the segregation of funds for QHP issuers that elect to cover abortion services

for which public funding is prohibited, and the associated communication standards related to such services. We solicited comment on the related model guidelines issued by HHS and the Office of Management and Budget on September 20, 2010, [FN14] noting that we intended the model guidelines to serve as the basis for the final rule.

Comment: A large number of commenters offered feedback on proposed § 156.280. Of these, many expressed general support for or opposition to abortion coverage in Exchanges. A number of commenters supported specific provisions of the proposed rule and recommended that they be finalized; for example, the voluntary choice provision for QHP issuers and the provision on the applicability of emergency services laws. Conversely, a few commenters recommended changes to the proposed provisions —such as that each Exchange be directed to include one QHP that covers non-excepted abortion services. A few commenters requested that HHS provide additional technical guidance on the provisions in section 1303 of the Affordable Care Act; for example, a few commenters suggested specific clarifications to the pre-regulatory model guidelines that describe high-level principles for QHP issuers' segregation plans, while other commenters recommended that Exchanges be directed to review the actuarial value of abortion coverage calculated by QHP issuers. Commenters also recommended that HHS clarify the provisions regarding separate payments for non-excepted abortion and all other services, specifically whether QHP issuers must collect separate payments from all enrollees or only from those receiving Federal financial assistance, whether QHP issuers may satisfy the separate payment provision by providing each enrollee with an itemized bill, and whether an enrollee's coverage would be terminated for failure to comply with the separate payment provision. A few commenters requested that HHS strengthen anti-discrimination protections for providers or expand the conscience protection. Finally, a few commenters raised concerns regarding provisions that HHS believes are addressed elsewhere in the final rule, such as privacy of individuals' QHP selections, and accessibility standards and other protections for QHP notices and plan information.

Response: We considered the comments received on this section, and are finalizing the provisions of proposed § 156.280 without modification, with the exception of finalizing the pre-regulatory model guidelines on issuer segregation plans released by HHS and the Office of Management and Budget.[FN15] Where future guidance is issued on this section, these comments will be taken into account.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.280 of the proposed rule, with the following modifications: we redesignated paragraph (e)(5)(ii) as (e)(5)(iv). In new paragraphs (e)(5)(ii) and (e)(5)(iii), we codified the pre-regulatory model guidelines on segregation of funds published by the Office of Management and Budget and the Assistant Secretary for Financial Resources as proposed.

o. Additional Standards Specific to the SHOP (§ 156.285)

In § 156.285, we proposed rating and premium payment standards for QHP issuers participating in the SHOP, including a proposal that the QHP issuer accept aggregated premiums, abide by the rate setting timeline established by the SHOP, and charge the same contract rate for a plan year. We also proposed that QHP issuers must accept and enroll applicants during the annual open enrollment period described in § 155.725 and the special enrollment periods described in § 155.420 (excluding paragraphs (d)(3) and (d)(6)), and they must ensure effective dates of coverage in accordance with § 155.410(c). We solicited comment on whether to direct QHPs in the SHOP to allow employers to offer dependent coverage.

We also proposed that QHP issuers abide by the SHOP enrollment timeline process standards, including the standards that QHP issuers must frequently accept electronic transmission of enrollment information from the SHOP, provide all new enrollees with the enrollment information package, and provide qualified employers and employees with the summary of cost and coverage document. We further proposed that QHP issuers reconcile enrollment files with the SHOP at least monthly. Additionally, we proposed that QHP issuers abide by the SHOP standards for acknowledgement of the receipt of enrollment information and issue qualified employees a policy that aligns with the qualified employer's plan year and contract.

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We also proposed general standards related to termination of coverage in the SHOP that are largely similar to the standards for the Exchange with respect to their enrollees from the individual market. We noted that the QHP issuer would be directed to provide the qualified employers and employees with a notice of termination of coverage of enrollees and QHP non-renewal to ensure that the qualified employer is aware of the changes in coverage for its employees and the availability of coverage in the SHOP. We indicated that a QHP issuer must terminate all enrolled qualified employees of the withdrawing employer if the employer chooses to stop participating in the SHOP.

Comment: In response to proposed § 156.285(b), one commenter recommended that the employer, and not the SHOP, establish the specific standards and dates for open enrollment and special enrollment periods.

Response: We believe that States should have the flexibility in establishing their enrollment periods based on the specific market and employer circumstances in the State, as it often does today for the small group market.

Comment: One commenter recommended that proposed § 156.285(b)(2) specify that employees who enroll during a special enrollment period should be allowed to purchase coverage at the same rates as those employees who enrolled during the annual open enrollment period for that plan year.

Response: We note that § 156.210 directs an issuer to set rates for an employer that will remain in effect for the employer's entire plan year.

Comment: One commenter suggested that the preamble text, which states that the rule would direct issuers to provide all new enrollees with an enrollment information package as described in § 156.265(e), is inconsistent with the proposed regulation text in § 156.285(c)(3), which states that the enrollment information package is described in § 156.265(f).

Response: We have modified the final rule to correctly reference § 156.265(e).

Comment: One commenter requested clarification of the definition of a QHP for the SHOP.

Response: We note that all of the standards in part 156, including definitions, pertaining to QHPs also apply to the QHPs offered through the ***18431** SHOP in the small group market unless the regulation text explicitly indicates that a specific standard pertains only to QHPs offered to qualified individuals, or are otherwise exempted.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.285 of the proposed rule, with the following modifications in conformance with changes to part 155 subpart H: in new paragraph (b)(3) we clarified that a SHOP must offer an enrollment period to a newly qualified employee who becomes qualified outside of the initial or annual open enrollment period. In new paragraph (b)(4) we established that a SHOP must conform to the effective dates of coverage described in § 156.260 and § 155.720. In new paragraph (e) we clarified that QHP issuers participating in the SHOP may not impose minimum participation rules with respect to a QHP unless the SHOP authorizes the minimum participation rule in accordance with 155.705(b)(10). Finally, we made a limited number of technical changes to clarify the language in this section.

p. Non-renewal and Decertification of QHPs (§ 156.290)

In § 156.290, we proposed standards for QHP issuers that voluntarily do not renew participation of a QHP in the Exchange, including notification, benefit coverage standards, and reporting standards. Specifically, we proposed to direct QHP issuers that do not renew QHP participation to provide written notice to each enrollee. We solicited comment on the potential content of the non-renewal notice and any other information that we should consider including. We also proposed that if an Exchange decertifies a QHP, the QHP issuer must terminate coverage for enrollees only after the Exchange has notified the QHP's enrollees

as described in § 155.1080 and enrollees have had the opportunity to enroll in other coverage. We requested comment on the extent to which enrollees should continue to receive coverage from a decertified plan.

Comment: One commenter recommended that HHS or Exchanges attach penalties to the decision not to seek recertification described in proposed § 156.290(a), such as barring the QHP from participating in the Exchange for one year following the non-renewal. Conversely, a few commenters requested that HHS prohibit Exchanges from imposing penalties or sanctions on plans that voluntarily non-renew.

Response: HHS lacks authority under the Affordable Care Act to impose any penalties for non-renewal of a QHP in an Exchange. Exchanges may take varied approaches to voluntary non-renewal; for example, some Exchanges may establish criteria for re-entry, while other Exchanges may utilize the standard certification process.

Comment: One commenter recommended that the final rule direct QHPs that choose not pursue recertification to complete data reporting 6 to 12 months after exiting the market.

Response: Obtaining data from non-renewing QHPs will be important for Exchanges. We note that § 156.290(a)(3) expressly obligates a non-renewing QHP to complete its reporting through the end of the plan or benefit year.

Comment: A few commenters suggested that HHS establish more advanced notice for non-renewal than the proposed deadline of September 15th.

Response: We believe that a deadline of September 15th is sufficiently far in advance of the annual open enrollment period to provide adequate notice for Exchanges and enrollees. Accordingly, we are finalizing that deadline as proposed.

Comment: Several commenters suggested that HHS direct QHPs to notify participating providers of a decision not to renew. These commenters further suggested that the QHP pay all incurred claims until participating providers have been notified.

Response: Section 156.290 of the final rule establishes that QHPs that choose not to pursue recertification must cover benefits for enrollees for the duration of the plan or benefit year. Similarly, QHPs must pay all claims incurred while certified and participating in the Exchange, subject to the terms and conditions of the QHP's contracts with providers. While participating providers have a significant interest in a QHP's decision not to seek recertification with the Exchange, we believe that establishing a standard for QHP issuers to notify participating providers would impose a significant burden on QHPs. Therefore, we are not adding such a standard in the final rule.

Summary of Regulatory Changes

We are finalizing § 156.290 as proposed.

q. Prescription Drug Distribution and Cost Reporting (§ 156.295)

In accordance with section 6005 of the Affordable Care Act, we proposed in § 156.295 that QHP issuers provide the following information related to prescription drug distribution—(1) The percentage of all prescriptions that were provided under the contract through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, that is paid by the QHP issuer or pharmacy benefit manager (PBM) under the contract; (2) the aggregate amount, and the type of rebates, discounts, or price concessions, with certain exceptions, that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed; and (3) the aggregate amount of the difference between the amount the QHP issuer pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed. We sought comment on how a QHP issuer whose contracted PBM operates its own mail

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order pharmacy can meaningfully report on element (3). We also requested comment on potential definitions for “rebates,” “discounts” and “price concessions”; and noted that we were considering using the term “direct and indirect remuneration,” to encompass these various arrangements. We also requested comment on our proposed definition of PBM and whether we should define PBMs as any entities that perform specific functions on behalf of a health insurance issuer. We sought comment on how to minimize the burden of these reporting standards.

Finally, we also proposed to codify the statutory penalties for noncompliance, including $10,000 per day that information is not provided; contract termination if the information is not reported within 90 days of the deadline; and $100,000 per piece of false information provided.

Comment: In response to proposed § 156.295(a)(1)—(3) and the discussion in the preamble to the proposed rule, many commenters requested clarification of key terms used in this section, such as “PBM,” “generic drug,” “bona fide service fees,” and “rebates, discounts, or price concessions.” One commenter requested that stakeholders have future opportunities to review and comment on the technical specifications of this section. Some commenters supported the proposed definition of “PBM,” while others recommended a broader definition that would encompass all entities that provide ***18432** management services but do not negotiate directly with manufacturers. A few commenters requested clarification of this definition with respect to medical benefit and physician-administered drugs. With respect to the definition of “generic drug,” commenters offered numerous alternate definitions that HHS could adopt, including the definition provided in the Social Security Act, single source versus multiple source drugs, or therapeutically and bioequivalent. Several commenters responded to HHS' request for comment on the definition of “rebates, discounts, or price concessions.” Some urged HHS to codify the statute as written, or proposed specific definitions for these terms. Other commenters recommended use of the term “direct and indirect remuneration” and recommended that CMS maintain consistent definitions across the Exchange and the Medicare program.

Response: Section 6005 of the Affordable Care Act includes similar standards for both the Medicare program and the Exchange. We believe that many of the entities and issuers that will report these data may participate in both programs. Therefore, we will align definitions with the Medicare program to the extent possible. We note that we are maintaining the proposed definition of “PBM”, which we believe encompasses a sufficiently broad spectrum of entities and activities. We are similarly maintaining the proposed interpretations of “generic drug” and “rebates, discounts, or price concessions.” Finally, we are revising the description of “bona fide service fees” to better align with the definition included by the Medicare program in a proposed rule released on October 11, 2011, and to provide for greater flexibility with respect to this definition, given that bona fide services are subject to change as new ones are developed or other bona fide services are discontinued. Accordingly, we are not finalizing the specific examples of bona fide service fees included in the proposed rule.

As we noted in the preamble to the proposed rule, we intend to clarify these standards through forthcoming guidance. We anticipate continuing to work with stakeholders to refine these standards.

Comment: One commenter requested that HHS clarify the standard in proposed § 156.295(a)(1) that QHP issuers report generic dispending rates “broken down by pharmacy type.”

Response: We clarify that paragraph (a)(1) directs QHP issuers to report generic dispensing rates separately for each of four types of pharmacies: mail order pharmacies, independent pharmacies, supermarket pharmacies, and mass merchandiser pharmacies.

Comment: In response to HHS' request for comment on how a QHP issuer whose contracted PBM operates its own mail order pharmacy can meaningfully report on the aggregate difference between what the issuer pays the PBM and what the PBM pays the pharmacy, several commenters suggested that mail order pharmacies owned by PBMs do not present unique challenges with respect to this reporting activity.

Response: As noted in the preamble to the proposed rule, we expect to issue further guidance on this section, and will continue to engage stakeholders to refine these reporting activities.

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Comment: In response to HHS' request for comment on how to minimize the burden associated with proposed § 156.295(a)(1)—(3), several commenters recommended that HHS limit the collection of information to those data elements listed in the Affordable Care Act. Commenters also suggested that HHS harmonize reporting standards across programs to the extent possible, such as by using the PDE reporting format currently used in the Medicare Part D program. Multiple commenters recommended that HHS monitor compliance with this section through audits only, either of QHP issuers or of PBMs.

Response: We clarify that HHS will only collect those data elements specified in the Affordable Care Act. We further intend to be consistent across programs to minimize burden and promote consistency, and are aligning the definitions of key terms used in this section with the Medicare Part D program. We expect to provide additional detail on the exact format and content of this reporting in future guidance.

Comment: In response to the reporting standards identified in proposed § 156.295(a), a few commenters requested more detailed information on why HHS needs to receive the data and how the data will be used. Conversely, some commenter favored greater transparency of prescription drug cost information and recommended that the information be reported to the Exchange.

Response: Section 6005 of the Affordable Care Act directs HHS to collect the data elements listed in the statute. We note that the Affordable Care Act limits the disclosure of these data, which we codify in paragraph (b). At this time we are still refining the process for reporting and uses for these data, and expect to provide additional guidance on this section in the future.

Comment: A few commenters raised concerns about QHP issuers' ability to comply with the reporting standards in proposed § 156.295(a)(1) through (3), noting that current contracts between issuers and PBMs do not typically cover these data elements.

Response: We believe that issuers and PBMs will have sufficient time to renegotiate or modify these contracts before reporting becomes necessary.

Comment: One commenter recommended that HHS establish some flexibility in the application of penalties to accommodate delays in the realization of price concessions and exceptional circumstances such as IT failure or human error.

Response: HHS intends to issue further guidance on these reporting standards, including how the statutory penalties may be applied.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.295 of the proposed rule, with the following modification: in paragraph (a)(2)(i) we revised the description of "bona fide service fees" to better align with the definition included by the Medicare program in a proposed rule released on October 11, 2011, published at 76 FR 63018, and to provide for greater flexibility with respect to this definition, given that bona fide services are subject to change as new ones are developed or other bona fide services are discontinued.

1. Subpart F—Consumer Operated and Oriented Plan Program

Definitions (§ 156.505)

Section 156.505 sets forth definitions for terms that are used throughout subpart F for the CO-OP program. In the final rule, "Establishment of Consumer Operated and Oriented Plan (CO-OP) Program (76 FR 77392), we revised the definitions of several terms to remove references to the "Establishment of Exchanges and QHPs" rule (76 FR 41866), because it had not yet been finalized. We also added definitions for several terms as they were proposed in the rule, "Establishment of Exchanges and QHPs" (76 FR 41866), because those terms were referred to within the revised definitions.

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In the CO-OP Program Final Rule, we stated that once the "Establishment of Exchanges and QHPs" rule (76 FR 77392) was finalized, we would revise the definitions in section 156.505 to incorporate the definitions adopted in the new part 155. Consistent with this intent, we have revised the definitions ***18433** for the terms "CO OP QHP," "Exchange," "individual market," "issuer," "small group market," "SHOP," and "State" from the CO-OP Program Final Rule to reference the definitions in the new part 155. As explained later in this preamble, the changes in this section are being issued on an interim basis. These revisions ensure that the definitions used in subpart F of section 156 are consistent with the definitions in the new part 155. We also removed the definitions of "group health plans," "health insurance coverage," "small employer," "qualified employer," and "QHP" because these terms are no longer referenced in the aforementioned definitions.

We made a technical change to section 156.510(b)(2)(ii). When referring to an applicant that "has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that is also a sponsor for a pre-existing issuer," we inadvertently used the defined term "sponsor." Our intent was to refer to an entity that sponsors a pre-existing issuer and not an entity that serves as a CO-OP's sponsor. Therefore, we revised this provision to refer to an applicant that "has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that also sponsors a pre-existing issuer."

C. Part 157—Employer Interactions with Exchange and SHOP Participation

In part 157, we proposed standards that address qualified employer participation in SHOP. Also, we briefly outlined employer interactions with Exchanges related to the verification of employees' eligibility for qualifying coverage in an eligible employer-sponsored plan.

1. Subpart A—General Provisions

Subpart A outlines the basis and scope for part 157 and defines terms used throughout part 157.

a. Basis and scope (§ 157.10)

In § 157.10, we proposed the general statutory authority for the proposed regulations and outlined the scope of part 157, which is to establish the standards for employers in connection with Exchanges. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Definitions (§ 157.20)

In § 157.20, we proposed definitions for terms used in part 157 that need clarification. The definitions presented in § 157.20 are taken directly from the statute or based on definitions we proposed in part 155 or part 156. For instance, we stated that the terms "qualified employer," "qualified employee" and "small employer" have the meaning given to the terms in § 155.20.

We did not receive specific comments on this section and are finalizing the provisions as proposed. Furthermore, we are finalizing the definitions proposed in § 157.20 of the proposed rule without modification.

2. Subpart C—Standards for Qualified Employers

Subpart C of this part outlines the general provisions for employer participation in SHOPs. As we noted in the preamble to the proposed rule, this subpart substantially mirrors and complements subpart H of part 155.

a. Eligibility of Qualified Employers to Participate in the SHOP (§ 157.200)

In § 157.200, we proposed the standards for an employer that seeks to offer health coverage to its employees through a SHOP. We proposed that only qualified employers may participate in a SHOP. In the preamble to the proposed rule, we noted that some small employers may have employees in multiple States or SHOP service areas, referencing proposed § 155.710, which would

allow multi-State employers flexibility in offering coverage to their employees. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Employer Participation Process in the SHOP (§ 157.205)

In § 157.205, we proposed the process for employer participation in the SHOP. Specifically, we proposed that a qualified employer make available QHPs to employees in accordance with the process developed by the SHOP pursuant to § 155.705, and that a qualified employer participating in a SHOP disseminate information to its employees about the methods for selecting and enrolling in a QHP. We also proposed that a qualified employer submit premium payments according to the process proposed in § 155.705. Additionally, we proposed that a qualified employer must provide an employee hired outside of the initial enrollment or annual open enrollment period with specific information.

We further proposed that a qualified employer provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed. We also proposed that a qualified employer adhere to the annual employer election period to change program participation for the next plan year. In § 155.725, we proposed that a qualified employer may begin participating in the SHOP at any time.

Finally, we proposed that if a qualified employer remains eligible for coverage and does not take action during the annual employer election period, the employer would continue to offer the same plan, coverage level or plans selected the previous year for the next plan year unless the QHP or QHPs are no longer available. We invited comments regarding the feasibility of the processes established in this section and the implications for small employers and their employees.

Comment: Some commenters requested that the final rule direct the SHOP to create a specific timeline for employers to notify their employees regarding their coverage options. Some commenters strongly supported the suggestion that the SHOP create a toolkit to help qualified employers explain the enrollment process and the choices available to employees.

Response: SHOPs may support employers through electronic means and through informational packages in communicating with their employees about available coverage options, and note that nothing in this section would preclude a SHOP from developing such resources. We do not codify an employer notification standard because we think it unnecessary.

Comment: One commenter stated that HHS should clarify that qualified employers offering coverage through the SHOP should be able to choose which QHPs they will offer their employees rather than allowing SHOPs to potentially decide employer offerings.

Response: Section 1311 of the Affordable Care Act directs a SHOP to, at a minimum, offer coverage to qualified employees as follows: qualified employers select a cost sharing level, within which qualified employees may select any available QHP. We recognize the need to balance the extent of employer and employee choice against the potential for risk selection resulting from those choices. As discussed more fully in the comment and response section of § 155.705(b)(2) and (3), we have neither specified nor restricted the range of additional employer options a SHOP may offer. Therefore, we are finalizing the provisions of this section as proposed with minor edits for better clarity and precision.

Summary of Regulatory Changes

We are finalizing the definitions proposed in § 157.205 of the proposed rule with the following modification: in paragraph (e)(1) we clarify that a SHOP ***18434** must offer an enrollment period to a newly qualified employee beginning on the first day of such employee becoming qualified.

IV. Waiver of Proposed Rulemaking

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We ordinarily publish a notice of proposed rulemaking in the Federal Register and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Based on the comments that we received on the Exchange establishment and eligibility proposed rules, we believe that there are new options and specific standards that should be implemented in connection with eligibility determinations. Specifically, we finalize here the ability of an Exchange to fulfill minimum functions without making eligibility determinations for Medicaid or CHIP, advance payments of premium tax credits, or cost-sharing reductions, provided that certain conditions and performance standards are met. As this option for a bifurcation of the responsibility to determine eligibility was not included in the proposed rule, the proposal also did not address the regulatory framework and standards necessary under this option to achieve a system of streamlined and coordinated eligibility and enrollment, the major goal underpinning our proposals in the Exchange eligibility proposed rule (76 FR 51204). In this rule, in part 155 subpart D in the sections identified below, we outline the options and approach to maintain the seamless consumer experience while allowing States to design the eligibility process to best match their current systems and capacity and State policy goals.

A compliant system for eligibility determination is critical to the establishment and implementation of Exchanges. In this final rule, we provide additional flexibility for how and by which eligibility for various insurance affordability programs will be made than was proposed in the Exchange proposed rules released in the summer of 2011. We also outline certain timeliness standards and agreements to permit a non-integrated approach to eligibility determination that still affords applicants a seamless path to enrollment in coverage but would not increase administrative burden and costs.

In addition, we finalize on an interim basis certain eligibility standards for cost-sharing reductions for multi-state households, Exchange timeliness standards for eligibility determinations, Exchange timeliness standards for administration of cost-sharing reduction and advance payments of premium tax credit, and a limited exception to the general verification rules for individuals in special circumstances. Although the proposed rule did not clearly and consistently address these timeliness provisions, commenters indicated the importance of such standards and we recognize the importance of providing finality for these standards at this time. We finalize an interim provision, at § 155.315(g), to provide a process by which the Exchange must complete verifications of information for applicants without documentation; this interim provision is also included in the Medicaid final rule. This provision was not proposed but several commenters raised the need for such a limited exception to the verification procedures otherwise required in subpart D. Further, HHS and CMS received comments in response to the Exchange Eligibility proposed rule and the Medicaid proposed rule related to better alignment of the Exchange and Medicaid and CHIP programs. Interim final provisions to set parameters for cooperation and coordination of these programs are included here at § 155.345(a) and (g).

The process for approval of State-based Exchanges must begin prior to January 1, 2013, a date by which HHS must approve (or conditionally-approve) States-based Exchanges for the 2014 coverage year. States that elect to establish an Exchange must make and implement critical decisions in order to seek approval of a State-based Exchange, including those about how eligibility determinations will be made. As they make these decisions, it is essential that States know the standards and necessary agreements associated with the new bifurcation alternatives for making eligibility determinations, the additional parameters for cooperation and alignment with Medicaid and CHIP programs, and the new rules governing Exchange eligibility determinations. Like the new bifurcation options described above, the new standards associated with Exchange determinations are also integral to developing and establishing an Exchange—and the systems to support it—in order to meet the January 1, 2013 deadline for HHS approval. For example, the timeliness and verification standards for Exchange eligibility determinations need to be part of the eligibility determination system that is developed. Similarly, the timeliness standards associated with administration of cost sharing reductions and premium tax credits are necessary to include in the initial establishment of Exchange systems. Accordingly, we believe we need to finalize these provisions as soon as possible to provide States the information they need for Exchange establishment.

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As a result, based on the comments to the 2011 Exchange proposed rules regarding these policies, we believe it would be contrary to the public interest to delay issuing new eligibility determination and timeliness standards rules. Further, providing public notice and additional comment periods for these policies would not provide States with sufficient lead time to take advantage of and incorporate these additional policies, prepare their State Exchange Blueprints, and complete the State Exchange readiness assessments process as set out in the proposed and this final rule. In light of the timing constraints, we are soliciting additional comment and issuing as interim final the following provisions:

• § 155.300(b)—Related to Medicaid and CHIP regulations;

• § 155.302—Related to options for conducting eligibility determinations;

• § 155.305(g)—Related to eligibility standards for cost-sharing reductions;

• § 155.310(e)—Related to timeliness standards for Exchange eligibility determinations;

• § 155.315(g)—Related to verification for applicants with special circumstances;

• § 155.340(d)—Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions; and

• § 155.345(a) and § 155.345(g)—Related to agreements between agencies administering insurance affordability programs.

We also received comments on the Exchanges establishment proposed rule regarding the need for performance and training standards that should be developed by HHS or required by HHS for agent and brokers who are assisting individuals with applications for insurance affordability programs. The proposed rule discussed and solicited comment about how to incorporate agents and brokers in the process of enrolling qualified individuals and qualified employers through the ***18435** Exchange; provisions to achieve that policy goal are finalized in this rule in light of the comments received to the proposed rule.[FN16] We did not propose or solicit comment on specific standards related to the provision of application assistance by agents and brokers. To provide useful assistance, agents and brokers should be fully aware of the complex eligibility and verification standards that will be used to determine eligibility for advance payment of premium tax credits and cost-sharing reductions. Also, in connection with this assistance, agents and brokers may gain access to a potential enrollee's income information, including access to sensitive tax data. Because the proposed rule did not apply training or performance standards to agents and brokers in connection with providing assistance to applicants, we did not address the regulatory framework supporting standards to ensure that agents and brokers are cognizant of the eligibility determination standards and process, maintain the confidentiality of such data, and operate in a manner that support their access to such data. In § 155.220, we describe these standards in more detail and outline their importance and connection to privacy and security standards described elsewhere in this rule.

Agent and brokers, where permitted to operate in a State, may serve an important role in assisting individuals in applying for coverage in the Exchange and with assisting individuals in gaining access to health insurance affordability programs. Because open enrollment for Exchanges will begin on October 1, 2013, and Exchanges require lead time to develop and implement privacy and security standards, agreements, training programs for agent and brokers, as well as systems to support agents and brokers working with Exchanges. As a result, we find that providing public notice and additional comment periods for these policies would not provide States with sufficient lead time to take advantage of and incorporate these additional policies prior to Exchange approval under the processes as set out in the proposed and this final rule. In light of the timing constraints, we are also soliciting additional comment and issuing as interim final the following provision:

• § 155.220(a)(3)—Related to the ability of a State 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.

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For the reasons stated above, we find good cause to waive the notice of proposed rulemaking and to issue these specific portions of this final rule on an interim basis. We are providing a 45-day public comment period in connection with these provisions.

Finally, this final rule makes a small number of technical changes to the provisions relating to CO-OPs, 45 CFR part 156 subpart F. We find there is good cause to waive notice and comment rulemaking for these changes because soliciting comment on them is unnecessary. These changes do not alter the substance of the CO-OP regulations and are therefore being finalized in this rule. As discussed the preamble above, they are being made principally to minimize duplicative definitions within parts 155 and 156.

IV. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

Changes to § 155.20

• Changes full definitions to statutory and regulatory definitions, where applicable, including the definitions of "applicant," "eligible employer-sponsored plan," "health plan," "plain language," "individual market," and "small group market."

• Added definitions for "application filer," "educated health care consumer," and "Exchange Blueprint."

Changes to § 155.105

• Adds that HHS would consult with other relevant Federal agencies in approval of State Exchanges.

• Establishes timeframe for review of significant changes to one where any change would receive written approved or denial within 60 days, or the approval would be automatic after 60 days (which may be extended by 30 days by HHS).

Changes to § 155.110

• Establishes that other State agencies are eligible contracting entities (such as departments of insurance).

• Establishes that Exchange boards must have at least one consumer representative on a governing board.

Changes to § 155.160

• Streamlines language regarding user fees, and removed policy that States announce user fees annually.

Changes to § 155.200

• Removes appeals of eligibility determinations as a minimum Exchange function.

• Adds a clarification that in carrying out its statutorily-required responsibilities, the Exchange is not construed to be acting on behalf of a QHP to convey that Exchanges are not automatically considered HIPAA business associates.

Changes to § 155.205

• Adds more detail regarding meaningful access standards.

• Clarifies standards for persons with disabilities, including the provision of auxiliary aids at no cost to the individual.

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• Outlines standards for limited English proficient individuals, including oral and written translations and the use of taglines on the Exchange Web site.

Changes to § 155.210

• Directs Exchanges to develop and publicly disseminate conflict of interest standards and training standards for entities to be awarded Navigator grants.

• Applies privacy and security standards to Navigators.

• Establishes that at least one Navigator entity must be a community and consumer-focused non-profit group.

• Clarifies entities that are not eligible to serve as Navigators.

• Prohibits Navigators from receiving compensation by issuers for enrollment into plans outside of the Exchange.

Changes to § 155.220

• Establishes standards related to the ability of a State to permit agents and brokers to assist qualified individuals enrolling in QHPs through an Exchange; as described elsewhere in this rule, this provision is being published as interim.

• Establishes participation standards for agents and brokers to facilitate QHP selection through a non-Exchange Web site.

Changes to § 155.230

• Aligns notices with expanded meaningful access standards in § 155.205.

• Maintains standard that the Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices, but removes the policy that this must occur "on an annual basis and in consultation with HHS in instances when significant changes are made."

• Adds that a notice must include a reason for intended action.

18436** ***Changes to § 155.240

• Removes duplicative standard for the Exchange to accept aggregated payments from qualified employers; § 155.705(b)(4) retains the premium aggregation function for the SHOP.

Changes to § 155.260

• Removed definition of "personally identifiable information."

• Includes more specific standards for privacy and security of personally identifiable information.

• Includes privacy and security principles based on the Fair Information Practice Principles (FIPPs) framework adopted by ONCHIT and a list of critical security outcomes.

• Clarifies that the privacy and security standards of this section apply only to information created or collected for the purposes of carrying out Exchange minimum functions.

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• Expands the scope of information to which the standards apply to information created, collected, used, or disclosed by an Exchange or other individual or entity that has an agreement with the Exchange.

• Adds the standard that the Exchange workforce complies with the privacy and security policies and procedures developed and implemented by the Exchange.

• Establishes that Exchanges must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

• Adds standards for data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP, or the BHP.

Changes to § 155.300

• Adds that references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with rules and procedures which are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.435(a), and as described elsewhere in this rule, this provision is being published as interim final.

Adds § 155.302

• Adds section outlining options for (1) the Exchange to conduct assessments of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP, and; (2) the Exchange to implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions for the Exchange, and as described elsewhere in this rule, this provision is being published as interim.

• Includes standards for such assessments and eligibility determinations, and as described elsewhere in this rule, this provision is being published as interim.

Changes to § 155.305

• Adds language throughout to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards for residency, in order to align with changes to Medicaid residency standards.

• Adds that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not currently employed), in order to align with changes to Medicaid residency standards.

• Adds language clarifying how to address cost-sharing reductions in situations in which multiple tax households are covered by a single policy, and as described elsewhere in this rule, this provision is being published as interim.

• Clarifies that cost-sharing reductions use the same household income and FPL definitions as advance payments of the premium tax credit.

Changes to § 155.310

• Adds language directing Exchanges to obtain attestations from a tax filer regarding advance payments of the premium tax credit, with flexibility to identify specific attestations in future guidance.

• Adds language clarifying that applicants must provide social security numbers.

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• Adds a standard that the Exchange must determine eligibility promptly and without undue delay, and as described elsewhere in this rule, this provision is being published as interim.

• Adds content, consistent with the statute, to the notice to an employer regarding an employee's eligibility for the advanced payment of tax credits.

• Adds the standard to provide employer with an indication the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable for the payment assessed under section 4980H of the Code if they have more than 50 full-time employees, and that the employer has the right to appeal the determination.

Changes to § 155.315

• Provides flexibility for the Exchange to accept attestation of residency or examine electronic data sources, regardless of the choices made by the State Medicaid or CHIP agencies.

• Adds provision specifying that the Exchange will validate all social security numbers with SSA.

• Allows applicants and application filers to submit documentation to resolve inconsistencies via channels available for submission of application.

• Includes a new provision which specifies that the Exchange will accept an applicant's attestation if documentation with which to resolve an inconsistency does not exist or is not reasonably available, with the exception of inconsistencies related to citizenship and immigration status, and as described elsewhere in this rule, this provision is being published as interim.

Changes to § 155.320

• Sets forth that if an applicant's attestation to projected annual household income is no more than ten percent below his or her prior tax data, the Exchange must rely on the attestation without further verification as part of the alternate verification process, and specifies that if his or her attestation is greater than ten percent below his or her prior tax data, the Exchange will conduct further verification.

• Allows the use of the alternate income verification process when a tax filer's filing status has changed, as directed by statute.

• Allows the use of the alternate income verification process when a tax filer's family composition has changed or is reasonably expected to change.

• Clarifies that if there is no tax data, the Exchange must discontinue advance payments of the premium tax credit and cost-sharing reductions at the end of the 90 day inconsistency period.

• Clarifies that the Exchange verify whether an applicant reasonably expects to be enrolled in employer-sponsored insurance the year for which he or she is seeking coverage, in addition to whether the applicant is currently enrolled.

Changes to § 155.330

• Allows the Exchange to establish a reasonable threshold for changes in income that an enrollee must report.

• Allows the Exchange to expand data matching during the benefit year within certain standards and without HHS approval.

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• Adds procedures for notifying and redetermining an enrollee's eligibility upon obtaining data via data matches; outlines different procedures for data related to income, family size, or family composition and data not related to ***18437** income, family size, or family composition.

• Allows the Exchange to align eligibility effective dates for redeterminations with coverage effective dates in subpart E.

Changes to § 155.335

• Adds timing standard for annual redetermination notice and provides that the annual redetermination notice be combined with the annual notice of open enrollment into a single, coordinated notice in the first two years.

• Provides flexibility to States on timing of notice starting with redeterminations of coverage effective on or after January 1, 2017, and sets forth standards for such flexibility.

• Clarifies effective dates of annual redetermination.

• Adds that the Exchange is authorized 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.

• Adds limitation to redetermination if an individual requests eligibility determination for insurance affordability programs but does not have an authorization for the Exchange to obtain tax data as part of annual redetermination process; Exchange must notify enrollee and not proceed with redetermination until authorization has been obtained or enrollee declines financial assistance.

Changes to § 155.340

• Replaces “Social Security number” with “taxpayer identification number,” in accordance with statute.

• Adds the standard that the Exchange must transmit promptly and without undue delay information to enable advance payments of the premium tax credits and cost-sharing reductions, and as described elsewhere in this rule, this provision is being published as interim.

Changes to § 155.345

• Adds standards for agreements between the Exchange and other insurance affordability programs, and as described elsewhere in this rule, this provision is being published as interim.

• Clarifies responsibilities of the Exchange when applicants are found potentially eligible for Medicaid based on factors other than MAGI which includes notifying the applicant; clarifies standards for providing advance payments of the premium tax credit and cost-sharing reductions to such individuals.

• Adds standards for the Exchange when accepting applications from other insurance affordability programs and sending applications to agencies administering other insurance affordability programs, and as described elsewhere in this rule, this provision is being published as interim.

• Adds a special rule providing that if the Exchange finds a tax filer's household income is less than 100 percent of the FPL and one or more applicant in the tax filer's household is found ineligible for Medicaid or CHIP, the Exchange follow the procedures in § 155.320(c)(3).

Changes to § 155.350

• Clarifies that an individual must be eligible for advance payments of the premium tax credit in order to be eligible for cost-sharing reductions, in accordance with statute.

• Clarifies that cost-sharing reductions use the same household income and FPL definitions as advance payments of the premium tax credit.

Changes to § 155.400

• Adds policy in § 155.400(b)(2) for Exchanges to submit eligibility and enrollment information to HHS and QHP issuers promptly and without undue delay.

• Removes policy from § 155.400(c) that the Exchange must submit enrollment information to HHS on a monthly basis.

• Adds policy in § 155.400(d) that the Exchange must reconcile enrollment information with HHS and QHP issuers on a monthly basis.

Changes to § 155.410

• Extends the initial open enrollment period from February 28, 2014 to March 31, 2014.

• Modifies the standards in this section such that an enrollment transaction must be received by the 15th of the month to secure an effective date of the first of the following month.

• Gives the Exchange flexibility to negotiate earlier effective dates and/or later plan selection cutoff dates, but notes that the Exchange must secure agreement from all participating QHP issuers. Further, an earlier effective date can only be offered to an individual who is not determined eligible for or forgoes advance payments of the premium tax credit/cost-sharing reductions for the first partial month of coverage.

• Gives the Exchange the option to automatically enroll individuals contingent upon demonstrating good cause to HHS.

Changes to § 155.420

• Aligns coverage effective dates for special enrollment periods with the new dates for the initial open enrollment periods as described in § 155.410, except in the case of marriage or loss of minimum essential coverage.

• Removes the limits on special enrollment periods formerly in § 155.420(f).

Changes to § 155.430

• Defines reasonable notice, for the purposes of effectuating a termination, as 14 days.

• Clarifies the effective dates of terminations for enrollees under various scenarios, including individuals newly eligible for Medicaid, or CHIP; and individuals receiving advance payments of the premium tax credit.

Changes to § 155.700

• Adds a definition for minimum participation rules.

Changes to § 155.705

• Permits the SHOP to impose minimum participation rules at the SHOP level.

• Adds a standard that the SHOP develop and offer a premium calculator.

Changes to § 155.715

• Clarifies that SHOPs may not use section 1411(b)(2) or 1411(c) verification processes for the SHOP eligibility determination process.

• Clarifies that for eligibility determination purposes, the SHOP may collect only the minimum information necessary to make such a determination.

Changes to § 155.720

• Adds a standard that the SHOP must report to the IRS employer participation and employee enrollment information in a form and manner specified by HHS.

Changes to § 155.725

• Adds a standard that the SHOP offer the same special enrollment periods as the individual Exchange, with the exception of changes in citizenship status or eligibility for insurance affordability programs.

• Clarifies that the annual election/open enrollment periods for employers/employees must be at least 30 days.

• Clarifies that the SHOP provide newly qualified employees with a specified enrollment period.

Changes to § 155.730

• Adds safeguards to protect information collected on application.

Changes to § 155.1010

• Clarifies that multi-State plans and CO-OPs are recognized as QHPs.

***18438** • Allows Exchanges to certify QHPs during the plan/benefit year if necessary.

Changes to § 155.1020

• Clarifies that multi-State plans are exempt from the Exchange process for receiving and considering rate increase justifications, and from the Exchange process for receiving annual rate and benefit information.

• Establishes that the Exchange must post rate increase justifications on its Web site.

Changes to § 155.1040

• Clarifies that multi-State plans must submit transparency data in a time and manner determined by the U.S. Office of Personnel Management.

Changes to § 155.1045

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• Clarifies that the U.S. Office of Personnel Management will establish the accreditation timeline for multi-State plans.

Changes to § 155.1050

• Clarifies that the U.S. Office of Personnel Management will ensure compliance with network adequacy standards by multi-State plans.

• Clarifies that a QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under § 156.235(c).

Changes to § 155.1065

• Clarifies that stand-alone dental plans must meet most QHP certification standards, including § 155.1020(c) and that stand-alone dental plans must offer the pediatric dental essential health benefit without annual and lifetime limits as applied to the essential health benefits in section 1302(b) of the Affordable Care Act.

• Adds a standard for the Exchange to ensure sufficient access to pediatric dental coverage.

Changes to § 155.1075

• Exempts multi-State plans and CO-OPs from the Exchange recertification process.

Changes to § 155.1080

• Exempts multi-State plans and CO-OPs from the Exchange decertification process.

Changes to § 156.50

• Clarifies that participating issuers must remit user fees, as defined by an Exchange, and other assessments, if applicable, to a State-based or Federally-facilitated Exchange.

Changes to § 156.225

• Codifies the statutory prohibition against QHP benefit designs that have the effect of discouraging enrollment by higher-need individuals.

Changes to § 156.230

• Expands the proposed standard such that a QHP must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay.

Changes to § 156.235

• Sets minimum standards that a QHP must have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range such providers for low-income, medically underserved individuals in the QHP's service area.

• Clarifies the definition of essential community provider to include providers that met the criteria to be an essential community provider on the publication date of this regulation unless the provider lost its status as an essential community provider as a result of violating Federal law.

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• Establishes an alternate standard for integrated delivery systems and staff model plans.

• Clarifies payment policy with respect to FQHCs and all other essential community providers.

Changes to § 156.255
• Removes provision related to covering specific rating categories or groups.

Changes to § 156.265
• Clarifies the role of the QHP issuer in the enrollment process for enrollment through the Exchange.

Changes to § 156.270
• Adds a standard that the QHP issuer must notify the affected individual 30 days in advance of a termination.

• Clarifies that for individuals receiving advance payments of the premium tax credit who are terminated for non-payment, the QHP issuer must pay all claims for the first month of the grace period. The issuer may pend claims during the second and third months, but must notify providers. Finally, the issuer must return to Treasury any advance payment of the premium tax credit for the second and third months at the conclusion of the grace period and effectuate termination of coverage at the end of the first month of the grace period.

Changes to § 156.280
• Codifies the pre-regulatory model guidelines on issuer segregation plans.

Changes to § 156.285
• Clarifies that QHP issuers must provide newly qualified employees with a specified enrollment period.

• Clarifies that QHP issuers participating in the SHOP may not set minimum participation rules for offering health coverage in connection with a QHP.

Changes to § 156.295
• Modifies definition of “bona fide service fees.”

Changes to § 157.205
• Removes requirement for SHOP to continue coverage if employer fails to take action during election period.

V. Collection of Information Requirements

Paperwork Reduction Act
As noted above, this final rule incorporates provisions originally published as two proposed rules, the July 15, 2011 rule titled Establishment of Exchanges and Qualified Health Plans, and the August 17, 2011 rule titled Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers. These proposed rules are referred to collectively as the Exchange establishment and eligibility proposed rules. In the Exchange establishment proposed rule published on July 15, 2011, we sought comment on certain information collection requirements associated with that proposed rule. We received one comment that stated a concern regarding the adequacy of the burden estimates stated in the Collection

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of Information Requirements section. We considered the commenter's concern and plan to issue more detail regarding the collection of information requirements in this rule.

In the Exchange establishment proposed rule, we explained that we would seek comments on the standards associated with § 155.105, which are finalized in this rule as the standards for the Exchange Blueprint. On November 10, 2011, we issued a 60-day Federal Register Notice seeking comments on a template for the Exchange Blueprint. For more information, please see page 70418 of Vol. 76, No. 218 of the Federal Register.

In the Exchange eligibility proposed rule published on August 17, 2011, we did not seek comment on the associated ***18439** information collection requirements. In accordance with the Paperwork Reduction Act (PRA), we will issue a Federal Register Notice in the coming weeks to seek public comments on these provisions.

In addition, this final rule includes certain regulatory provisions that differ from those included in the Exchange establishment proposed rule. Some of those provisions involve changes from the information collection requirements described in the Exchange establishment proposed rule. These changes include the following:

• Exchange up-to-date Internet Web site (§ 155.205);

• Standard for Exchanges to maintain records of enrollment (§ 155.400);

• Standard for Exchanges to submit eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay and reconcile enrollment information with QHP issuers and HHS on at least a monthly basis (§ 155.400);

• Notice of eligibility to applicant (§ 155.405);

• Notice of annual open enrollment period to applicant (§ 155.410);

• Standard for Exchanges to maintain records of coverage terminations (§ 155.430);

• Notice to employers (§ 155.715);

• Notice to individual of inability to substantiate employee status (§ 155.715);

• Notice of employer eligibility (§ 155.715);

• Notice of employee eligibility (§ 155.715);

• Notice of employer withdrawal from SHOP (§ 155.715);

• Notice of effective date to employees (§ 155.720);

• Notice of employee termination of coverage to employer (§ 155.720);

• Standard for the SHOP to maintain records of enrollment (§ 155.720);

• Standard for the SHOP to reconcile enrollment information (§ 155.720);

• Notice of annual employer election period (§ 155.725);

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• Notice to employee of open enrollment period (§ 155.725);

• Standard for Exchanges to collect QHP issuer reports on covered benefits, rates, and cost sharing requirements (§ 155.1020);

• Notice to the QHP issuer, enrollees, HHS, and the State insurance department of the decertification of a QHP (§ 155.1080);

• Issuer reporting of benefit and rate information (§ 156.210);

• Issuer reporting of rate increase justifications (§ 156.210);

• Issuer reporting of transparency in coverage information (§ 156.220);

• Standard for QHP issuers to make available enrollee cost sharing information (§ 156.220);

• Notice to applicants and enrollees that includes the provider directory (§ 156.230);

• Notice of effective date of coverage to individuals (§ 156.260);

• Standard for QHP issuers to collect enrollment information and submit the enrollment information to the Exchange (§ 156.265);

• Standard for QHP issuers to provide an enrollment package to enrollee (§ 156.265);

• Summary of cost and coverage document(§ 156.265);

• Standard for QHP issuers to reconcile enrollment information with the Exchange (§ 156.265);

• Notice to the enrollee of the termination of coverage (§ 156.270);

• Notice to the enrollee of payment delinquency (§ 156.270);

• Standard for QHP issuers to maintain records of coverage terminations (§ 156.270);

• Standard for QHP issuers to provide enrollment information package to SHOP enrollees (§ 156.285);

• Summary of cost and coverage document for employees and employers (§ 156.285);

• Standard for QHP issuers to reconcile enrollment information with the SHOP (§ 156.285);

• Notice to SHOP enrollee of the termination of coverage (§ 156.285);

• Notice of QHP issuer non-renewal of certification to Exchange (§ 156.290);

• Notice of QHP issuer non-renewal of certification to enrollees (§ 156.290); and

• Standard for QHP issuers to submit prescription drug distribution and cost reporting (§ 156.295);

This final rule also includes some information collection requirements for which we did not seek comment in the Exchange establishment proposed rule. In accordance with the Paperwork Reduction Act (PRA), we will issue a Federal Register Notice in the coming weeks to seek public comments on these provisions.

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Finally, this final rule describes some information collections for which CMS plans to seek approval at a later date. For these information collections, CMS will issue future Federal Register notices to seek comments on those information collections, as required by the PRA. This includes, among other collections:

• Navigator standards (§ 155.210);

• Single streamlined application to determine eligibility and collect information for enrollment (§ 155.405);

• SHOP single employer application (§ 155.715);

• SHOP single employee application (§ 155.715);

• Alternative employer application (§ 155.730);

• Collection of rates, covered benefits, and cost sharing information (§ 155.200);

• Collection of transparency of coverage information (§ 155.1040);

• Evaluation of service area (§ 155.1055);

• Standards for the certification of stand-alone dental plans (§ 155.1065);

• Submission of rates, covered benefits, and cost sharing information (§ 156.210); and

• Submission of transparency of coverage information (§ 156.220).

VI. Summary of Regulatory Impact Analysis

The summary analysis of benefits and costs included in this rule is drawn from the detailed Regulatory Impact Analysis. That impact analysis evaluates the impacts of this rule and a second rule, "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The second final rule will be published separately. The following summary focuses on the benefits and costs of this final rule.

A. Introduction

HHS has examined the impacts of this final rule under Executive Orders 12866 and 13563, the Regulatory Flexibility Act (5 U.S.C. 601-612), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and the Executive Order 13132 on Federalism. Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits (both quantitative and qualitative) of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an "economically" significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Using the Small Business Administration (SBA) definitions of small entities for issuers, agents and brokers, and employers, HHS concludes ***18440** that a significant number of firms affected by this final rule are not small businesses.

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Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before promulgating "any rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year." The current threshold after adjustment for inflation is approximately $136 million, using the most current (2011) Implicit Price Deflator for the Gross Domestic Product. HHS does not expect this final rule to result in one-year expenditures that would meet or exceed this amount.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Specifically, an agency must act in strict accordance with the governing law, consult with State officials, and address their concerns.

B. Need for This Regulation

This final rule implements standards related to the Establishment of Exchanges and Qualified Health Plans and standards for Qualified Employers consistent with the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small business the same purchasing power as large businesses.

C. Summary of Costs and Benefits of the Regulation

This summary focuses on the benefits and costs of the requirements in this Exchange final rule that combines the policies in the Exchange establishment proposed rule and the Exchange eligibility proposed rule.

Benefits in Response to the Regulation

The Exchanges and their associated policies, according to CBO's letter to Evan Bayh from November 30, 2009, reduce premiums for the same benefits compared to prior law. CBO estimated that, in 2016, people purchasing non-group coverage through the Exchanges would pay 7 to 10 percent less due to the healthier risk pool that results from the coverage expansion. An additional 7 to 10 percent in savings would result from gains in economies of scale in purchasing insurance and lower administrative costs from elimination of underwriting, decreased marketing costs, and the Exchanges' simpler system for finding and enrolling individuals in health insurance plans.[FN17]

CBO also estimates that premiums for small businesses purchasing through the Exchanges would be up to 2 percent lower than they would be without the Affordable Care Act, for comparable reasons. CBO estimated that the administrative costs to health plans (described in greater detail below) would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, and end underwriting. Premium savings to individuals and small businesses allow for alternative uses of income and resources, such as increasing retirement savings for families or investing in new jobs for small businesses.

Simplified eligibility processes will increase take-up of health insurance leading to improved health. In a recent study, compared to the uninsured group, the insured received more hospital care, more outpatient care, had lower medical debt, better self-reported health, and other health related benefits. The evaluation concluded that for low-income uninsured adults, coverage has the following benefits: (1) Significantly higher utilization of preventive care (mammograms, cholesterol monitoring, blood tests for high blood sugar related to diabetes, etc.); (2) a significant increase in the probability of having a regular office or clinic for primary care; and, (3) significantly better self-reported health. In addition, the use of electronic records among State and Federal agencies with information to verify eligibility will minimize the transaction costs associated with purchasing health insurance improving market efficiency and minimizing time cost for enrollees on enrollment.

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Costs in Response to the Regulation

Meeting the requirements of this rule will have costs affecting Exchanges and issuers of qualified health plans (QHPs). The administrative costs of operating an Exchange will almost certainly vary by the number of enrollees in the Exchange due to economies of scale, variation in the scope of the Exchange's activities, and variation in average premium in the Exchange service areas. However, we believe major cost components for Exchanges will include: IT infrastructure, Navigators, notifications, enrollment standards, application process, SHOP, certification of QHPs, and quality reporting. The major costs on issuers of QHPs will include: accreditation, network adequacy standards, and quality improvement strategy reporting. CBO estimates that the administrative costs to QHP issuers would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, prohibit "riders," and end under-writing.

To support the new eligibility structure, States are expected to build new or modify existing information technology systems. How each State constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. Administrative costs to support the vision for a streamlined and coordinated eligibility and enrollment process will also vary for each State depending on the specific approaches taken regarding the integration between programs and its decision to build a new system or use existing systems; while the Affordable Care Act requires a high level of integration, States have the option to go beyond the requirements of the Act.

We also believe that overall administrative costs may increase in the short term as States build information technology systems; however, in the long-term States will see savings through the use of more efficient systems. As noted in the preamble, we believe the approach we are taking to supporting the verification of applicant information with SSA, IRS, and DHS reduces administrative complexity and associated costs. Administrative costs to States incurred in the development of information technology infrastructure to support the Exchange are funded wholly through State Exchange Planning and Establishment Grants. Costs for information technology infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a time-limited 90 percent Federal matching rate to assist in development.

Methods of Analysis

This impact analysis references both estimates from the Congressional Budget Office (CBO), as well as Center for ***18441** Medicare & Medicaid Services (CMS) estimates from the FY 2013 President's Budget. The CBO estimate remains the most comprehensive accounting of all the interacting provisions pertaining to the Affordable Care Act, and contains cost estimates of some provisions that have not been independently estimated by CMS. Based on our review, we expect that the requirements in these final rules will not significantly alter CBO's estimates of the budget impact of Exchanges or enrollment. The requirements are well within the parameters used in the modeling of the Affordable Care Act. Our review and analysis of the requirements indicate that the impacts are within the model's margin of error. In the regulatory impact analysis that accompanied the proposed Exchange establishment rule, we displayed CBO estimates of Exchange grant outlays. The estimates in this analysis reflect the most up-to-date estimates from the FY 2013 President's Budget for State Planning and Establishment Grants.

Table 1 includes the estimates of grants to States for Exchange start up from 2012 to 2016. It does not include costs related to reduced Federal revenues from refundable premium tax credits, which are administered by the Department of the Treasury subject to IRS rulemaking, the Medicaid effects, which are subject to separate rulemaking, or the policies whose offsets led CBO to estimate that the Affordable Care Act would reduce the Federal budget deficit by over $100 billion over the next 10 years. As this is a summary of the final impact analysis, for further information on the expected benefits and costs of this rule, please see the final regulatory impact analysis.

Table 1—Estimated Outlays for the Affordable Insurance Exchanges FY 2012-FY2016

[In billions of dollars]

Year	2012	2013	2014	2015	2016	2012-2016
Part II						
Grant Authority for Exchange Start up [a]	0.9	1.1	0.8	0.4	0.1	3.4

Regulatory Options Considered

In addition to a baseline, HHS has identified three regulatory options for this final rule as required by Executive Order 12866 for Exchange establishment and eligibility.

(1) Uniform Standard for Operations of an Exchange. Under this alternative HHS would require a single standard for State operations of Exchanges. The regulation offers States the choice of whether to establish an Exchange, how to structure governance of the Exchange, whether to join with other States to form a regional Exchange, and how much education and outreach to engage in, among other factors. This alternative model would restrict State flexibility, requiring a more uniform standard that States must enact in order to achieve approval of an Exchange.

(2) Uniform Standard for Health Insurance Coverage. Under this alternative, there would be a single uniform standard for certifying QHPs. QHPs would need to meet a single standard in terms of benefit packages, network adequacy, premiums, etc. HHS would set these standards in advance of the certification process and QHPs would either meet those standards and thereby be certified or would fail to meet those standards and therefore would not be available to enrollees.

(3) Require a Paper-Driven Process for Conducting Eligibility Determinations. In this final rule, to verify applicant information used to support an eligibility determination, we generally require the Exchange first use electronic data, where available, prior to requesting paper documentation. Under this rule, individuals will be asked to provide only the minimum amount of information necessary to complete an eligibility determination, and will only be required to submit paper if electronic data cannot be used to complete the verification process. Under this alternative, the Exchange would require individuals to submit paper documentation to verify information necessary for an eligibility determination. This would not only increase the amount of burden placed on individuals to identify and collect this information, which may not be readily available to the applicant, but would also necessitate additional time and resources for Exchanges to accept and verify the paper documentation needed for an eligibility determination.

Summary of Costs for Each Option

HHS notes that Option 1, which promotes uniformity, could produce a benefit of reduced Federal oversight cost; however this option would reduce innovation and therefore limit diffusion of successful policies and furthermore interfere with Exchange functions and needs. HHS also notes that while Option 2 could produce administrative burdens on Exchanges, this approach could reduce Exchanges' and QHP issuers' ability to innovate. These costs and benefits are discussed more fully in the detailed Regulatory Impact Analysis.

The paper-driven process in option 3 would ultimately increase the amount of time it would take for an individual to receive health coverage, would reduce the number of States likely to operate an Exchange due to increased administrative costs, and would dissuade individuals from seeking coverage through the Exchange. We believe using technology to minimize burden on individuals and States will help increase access to coverage by streamlining the eligibility process, and will reduce administrative burden on Exchanges, while increasing accuracy by relying on trusted data for eligibility.

VIII. Accounting Statement

Category	Estimates	Units

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	Primary estimate	Low estimate $estimate	High	Year dollar	Discount rate	Period covered
Benefits						
Annualized Monetized ($millions/year)	Not Estimated	$	$	2011	7%	2012-2016
	Not Estimated	$	$	2011	3%	2012-2016
Qualitative (05)The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including earlier treatment and improved morbidity, fewer bankruptcies and decreased use of uncompensated care. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience.						
Costs						
Annualized Monetized ($millions/year)	$690.55	Not Estimated	Not Estimated	2011	7%	2012-2016
	$673.50	Not Estimated	Not Estimated	2011	3%	2012-2016
Qualitative (05)These costs include grant outlays to States to establish Exchanges.						
Transfers						
Federal Annualized Monetized ($millions/year)	0	$	$	2011	7%	2012-2016
	0	$0.00	$0.00	2011	3%	2012-2016
From/To	From:		....	To:		

Other Annualized Monetized ($millions/year)		0.0	0.0	0.0
		0.0	0.0	0.0
From/To	From:		....	To:

***18442 VII. Regulatory Flexibility Act**

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) A proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this final rule is necessary to implement standards related to the Establishment of Exchanges and Qualified Health Plans as authorized by the Affordable Care Act. For purpose of the Regulatory Flexibility Analysis, we expect the following types of entities to be affected by this final rule: (1) QHP issuers; (2) agents and brokers; (3) employers. We believe that health insurers and agents and brokers would be classified under the North American Industry Classification System (NAICS) Codes 524114 (Direct Health and Medical Insurance Carriers) and 524210 (Insurance Agencies and Brokers). According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities for both of these NAICS codes. Health issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $10 million or less.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the SBA (currently $7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).[FN18]

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical ***18443** coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

This rule finalizes Exchange standards related to offering the QHPs. These standards and the associated certification process will impose costs on issuers, but these costs will vary depending on a number of factors, including the operating model chosen by the Exchange, their current accreditation status, and the variation between these standards and current practice. Some QHP issuers will be more prepared to meet the standards than others and will incur fewer costs. For example, if data reporting functions required for certification already exist at the QHP issuer, there would be no additional cost. Exchanges also have the flexibility in some cases to set requirements. For example, the rule provides discretion for Exchanges in setting network adequacy standards for participating health insurance issuers. The cost to the issuer will depend on whether the Exchange determines that compliance with relevant State law and licensure requirements is sufficient for a QHP issuer to participate in the Exchange or whether they decide to set additional standards in accordance with current provider market characteristics and consumer needs.

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The cost of participating in an Exchange is an investment for QHP issuers, with benefits expected to accrue to QHP issuers. The Exchange will function as an important distribution channel for QHPs. QHP issuers currently fund their own sales and marketing efforts. As a centralized outlet to attract and enroll consumers, the Exchanges will supplement and reduce incremental health plan sales and marketing costs with their consumer assistance, education and outreach functions.

We anticipate that the agent and broker industry, which is comprised of large brokerage organizations, small groups, and independent agents, will play a critical role in enrolling qualified individuals in QHPs. We are codifying section 1312(e) of the Affordable Care Act, which gives States the option to permit agents or brokers to assist individuals in enrolling in QHPs through the Exchange. If a State chooses to allow agents and brokers to assist individuals in enrolling in QHPs through the Exchange, we establish standards that would apply for such enrollment. Agents and brokers must meet these standards and any conditions imposed by the State and, as a result, could incur costs. In addition, agents and brokers who become Navigators will also agree to comply with associated requirements and are likely to incur some costs. Because the States and the Exchanges will make these determinations, we cannot provide an estimate of the potential number of small entities that will be affected or the costs associated with these decisions.

This final rule establishes requirements on employers that choose to participate in a SHOP. As discussed above, the SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would meet the SBA Standard for Small entities. We do not believe that the regulation imposes requirements on employers offering health insurance through SHOP that are more restrictive than the current requirements on employers offering employer sponsored health insurance. For this reason, we also believe the processes that we have established constitute the minimum amount of requirements necessary to implement statutory mandates and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to lessen the compliance burden. We also expect that for some employers, risk pooling and economies of scale will reduce the administrative cost of offering coverage through the SHOP and that they will, therefore, benefit from participation.

VIII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any one year by a State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. Because States are not required to set up an Exchange, and because grants are available for funding of the establishment of an Exchange by a State, we anticipate that this final rule would not impose costs above that $136 million UMRA threshold on State, local, or tribal governments.

IX. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, pre-empts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an approved Exchange. For States electing to create an Exchange, much of the initial costs to the creation of Exchanges will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In the Department's view, while this final rule does not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each State electing to establish an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this final rule, or have in effect a State law or regulation

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that implements these Federal standards. However, the Department anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require States to establish an Exchange; if a State elects not to establish an Exchange or the State's Exchange is not approved, HHS, either directly or through agreement with a non-profit entity, must establish and operate an Exchange in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, the Department has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

Throughout the process of developing this rule, the Department has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is the Department's view that we have ***18444** complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached regulation in a meaningful and timely manner.

List of Subjects

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

45 CFR Part 157

Employee benefit plans, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below:

Subchapter B—Requirements Relating to Health Care Access

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

1. The authority citation for part 155 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413.

2. Revise the part 155 heading to read as set forth above.

3. Add subparts A through E to read as follows:

Subpart A—General Provisions

Sec.

155.10 Basis and scope.

155.20 Definitions.

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

155.100 Establishment of a State Exchange.

155.105 Approval of a State Exchange.

155.106 Election to operate an Exchange after 2014.

155.110 Entities eligible to carry out Exchange functions.

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

155.130 Stakeholder consultation.

155.140 Establishment of a regional Exchange or subsidiary Exchange.

155.150 Transition process for existing State health insurance exchanges.

155.160 Financial support for continued operations.

Subpart C—General Functions of an Exchange

155.200 Functions of an Exchange.

155.205 Consumer assistance tools and programs of an Exchange.

155.210 Navigator program standards.

155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

155.230 General standards for Exchange notices.

155.240 Payment of premiums.

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155.260 Privacy and security of personally identifiable information.

155.270 Use of standards and protocols for electronic transactions.

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

155.300 Definitions and general standards for eligibility determinations.

155.302 Options for conducting eligibility determinations.

155.305 Eligibility standards.

155.310 Eligibility process.

155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

155.320 Verification process related to eligibility for insurance affordability programs.

155.330 Eligibility redetermination during the benefit year.

155.335 Annual eligibility redetermination.

155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

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

155.350 Special eligibility standards and process for Indians.

155.355 Right to appeal.

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

155.400 Enrollment of qualified individuals into QHPs.

155.405 Single streamlined application.

155.410 Initial and annual open enrollment periods.

155.420 Special enrollment periods.

155.430 Termination of coverage.

Subpart A—General Provisions.
45 CFR § 155.10

§ 155.10 Basis and scope.
(a) Basis. This part is based on the following sections of title I of the Affordable Care Act:

(1) 1301. Qualified health plan defined

(2) 1302. Essential health benefits requirements

(3) 1303. Special rules

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(4) 1304. Related definitions

(5) 1311. Affordable choices of health benefit plans.

(6) 1312. Consumer choice

(7) 1313. Financial integrity.

(8) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(9) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(10) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(11) 1334. Multi-State plans.

(12) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(13) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(14) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(15) 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

(b) Scope. This part establishes minimum standards for the establishment of an Exchange, minimum Exchange functions, eligibility determinations, enrollment periods, minimum SHOP functions, ***18445** certification of QHPs, and health plan quality improvement.
45 CFR § 155.20

§ 155.20 Definitions.
The following definitions apply to this part:

Advance payments of the premium tax credit means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer.

Annual open enrollment period means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange.

Applicant means:

(1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

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(i) Enrollment in a QHP through the Exchange; or

(ii) Medicaid, CHIP, and the BHP, if applicable.

(2) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

Benefit year means a calendar year for which a health plan provides coverage for health benefits.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Educated health care consumer has the meaning given the term in section 1304(e) of the Affordable Care Act.

Eligible employer-sponsored plan has the meaning given the term in section 5000A(f)(2) of the Code.

Employee has the meaning given to the term in section 2791 of the PHS Act.

Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code are treated as one employer.

Employer contributions means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee means a qualified individual or qualified employee enrolled in a QHP.

Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

Exchange Blueprint means information submitted by a State, an Exchange, or a regional Exchange that sets forth how an Exchange established by a State or a regional Exchange meets the Exchange approval standards established in § 155.105(b) and demonstrates operational readiness of an Exchange as described in § 155.105(c)(2).

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the standards specified in subpart B of this part.

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Grandfathered health plan has the meaning given the term in § 147.140.

Group health plan has the meaning given to the term in § 144.103.

Health insurance issuer or issuer has the meaning given to the term in § 144.103.

Health insurance coverage has the meaning given to the term in § 144.103.

Health plan has the meaning given to the term in section 1301(b)(1) of the Affordable Care Act.

Individual market has the meaning given the term in section 1304(a)(2) of the Affordable Care Act.

Initial open enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define large employer by substituting "51 employees" for "101 employees."

Lawfully present has the meaning given the term in § 152.2.

Minimum essential coverage has the meaning given in section 5000A(f) of the Code.

Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in § 155.210.

Plan year means a consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Plain language has the meaning given to the term in section 1311(e)(3)(B) of the Affordable Care Act.

Qualified employee means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified health plan issuer or QHP issuer means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange.

***18446** Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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SHOP means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting “50 employees” for “100 employees.”

Small group market has the meaning given to the term in section 1304(a)(3) of the Affordable Care Act.

Special enrollment period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

State means each of the 50 States and the District of Columbia.

Subpart B—General Standards Related to the Establishment of an Exchange
45 CFR § 155.100

§ 155.100 Establishment of a State Exchange.
(a) General requirements. Each State may elect to establish an Exchange that facilitates the purchase of health insurance coverage in QHPs and provides for the establishment of a SHOP.

(b) Eligible Exchange entities. The Exchange must be a governmental agency or non-profit entity established by a State, consistent with § 155.110.
45 CFR § 155.105

§ 155.105 Approval of a State Exchange.
(a) State Exchange approval requirement. Each State Exchange must be approved by HHS by no later than January 1, 2013 to offer QHPs on January 1, 2014, and thereafter required in accordance with § 155.106. HHS may consult with other Federal Government agencies in determining whether to approve an Exchange.

(b) State Exchange approval standards. HHS will approve the operation of an Exchange established by a State provided that it meets the following standards:

(1) The Exchange is able to carry out the required functions of an Exchange consistent with subparts C, D, E, H, and K of this part;

(2) The Exchange is capable of carrying out the information reporting requirements in accordance with section 36B of the Code;

(3) The entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with § 155.140(b).

(c) State Exchange approval process. In order to have its Exchange approved, a State must:

(1) Elect to establish an Exchange by submitting, in a form and manner specified by HHS, an Exchange Blueprint that sets forth how the Exchange meets the standards outlined in paragraph (b) of this section; and

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(2) Demonstrate operational readiness to execute its Exchange Blueprint through a readiness assessment conducted by HHS.

(d) State Exchange approval. Each Exchange must receive written approval or conditional approval of its Exchange Blueprint and its performance under the operational readiness assessment consistent with paragraph (c) of this section in order to be considered an approved Exchange.

(e) Significant changes to Exchange Blueprint. The State must notify HHS in writing before making a significant change to its Exchange Blueprint; no significant change to an Exchange Blueprint may be effective until it is approved by HHS in writing or 60 days after HHS receipt of a completed request. For good cause, HHS may extend the review period by an additional 30 days to a total of 90 days. HHS may deny a request for a significant change to an Exchange Blueprint within the review period.

(f) HHS operation of an Exchange. If a State is not an electing State under § 155.100(a) or an electing State does not have an approved or conditionally approved Exchange by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State. In the case of a Federally-facilitated Exchange, the requirements in § 155.130 and subparts C, D, E, H, and K of this part will apply.
45 CFR § 155.106

§ 155.106 Election to operate an Exchange after 2014.
(a) Election to operate an Exchange after 2014. A State electing to seek approval of its Exchange later than January 1, 2013 must:

(1) Comply with the State Exchange approval requirements and process set forth in § 155.105;

(2) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 12 months prior to the Exchange's first effective date of coverage; and

(3) Develop a plan jointly with HHS to facilitate the transition from a Federally-facilitated Exchange to a State Exchange.

(b) Transition process for State Exchanges that cease operations. A State that ceases operations of its Exchange after January 1, 2014 must:

(1) Notify HHS that it will no longer operate an Exchange at least 12 months prior to ceasing operations; and

(2) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.
45 CFR § 155.110

§ 155.110 Entities eligible to carry out Exchange functions.
(a) Eligible contracting entities. The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are:

(1) An entity:

(i) Incorporated under, and subject to the laws of, one or more States;

(ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

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(b) Responsibility. To the extent that an Exchange establishes such agreements, the Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met.

(c) Governing board structure. If the Exchange is an independent State agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:

(1) Is administered under a formal, publicly-adopted operating charter or by-laws;

(2) Holds regular public governing board meetings that are announced in advance;

(3) Represents consumer interests by ensuring that overall governing board membership:

***18447** (i) Includes at least one voting member who is a consumer representative;

(ii) Is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(d) Governance principles. (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

(e) SHOP independent governance. (1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

(f) HHS review. HHS may periodically review the accountability structure and governance principles of a State Exchange.
45 CFR § 155.120

§ 155.120 Non-interference with Federal law and non-discrimination standards.
(a) Non-interference with Federal law. An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) Non-interference with State law. Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.

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

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

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(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.
45 CFR § 155.130

§ 155.130 Stakeholder consultation.
The Exchange must regularly consult on an ongoing basis with the following stakeholders:

(a) Educated health care consumers who are enrollees in QHPs;

(b) Individuals and entities with experience in facilitating enrollment in health coverage;

(c) Advocates for enrolling hard to reach populations, which include individuals with mental health or substance abuse disorders;

(d) Small businesses and self-employed individuals;

(e) State Medicaid and CHIP agencies;

(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange's geographic area;

(g) Public health experts;

(h) Health care providers;

(i) Large employers;

(j) Health insurance issuers; and

(k) Agents and brokers.
45 CFR § 155.140

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.
(a) Regional Exchange. A State may participate in a regional Exchange if:

(1) The Exchange spans two or more States, regardless of whether the States are contiguous; and

(2) The regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with § 155.105(c).

(b) Subsidiary Exchange. A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) Exchange standards. Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its service area in accordance with subpart H of this part; and

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(ii) If a State elects to operate its individual market Exchange and SHOP under two governance or administrative structures as described in § 155.110(e), the SHOP must encompass a geographic area that matches the geographic area of the regional or subsidiary Exchange.
45 CFR § 155.150

§ 155.150 Transition process for existing State health insurance exchanges.
(a) Presumption. Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State exchange meets the standards under this part if:

(1) The exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act, according to the Congressional Budget Office estimates for projected coverage in 2016 that were published on March 30, 2011.

(b) Process for determining non-compliance. Any State described in paragraph (a) of this section must work with HHS to identify areas of non-compliance with the standards under this part.
45 CFR § 155.160

§ 155.160 Financial support for continued operations.
(a) Definition. For purposes of this section, participating issuers has the meaning provided in § 156.50.

(b) Funding for ongoing operations. A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) States may generate funding, such as through user fees on participating issuers, for Exchange operations; and

(2) No Federal grants under section 1311 of the Affordable Care Act will be awarded for State Exchange establishment after January 1, 2015.

Subpart C—General Functions of an Exchange
45 CFR § 155.200

§ 155.200 Functions of an Exchange.
(a) General requirements. The Exchange must perform the minimum functions described in this subpart and in subparts D, E, H, and K of this part.

(b) Certificates of exemption. The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.

(c) Oversight and financial integrity. The Exchange must perform required functions related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.

(d) Quality activities. The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, ***18448** assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

(e) Clarification. In carrying out its responsibilities under this subpart, an Exchange is not operating on behalf of a QHP.

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45 CFR § 155.205

§ 155.205 Consumer assistance tools and programs of an Exchange.

(a) Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section.

(b) Internet Web site. The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:

(1) Provides standardized comparative information on each available QHP, including at a minimum:

(i) Premium and cost-sharing information;

(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with § 155.1040; and

(viii) The provider directory made available to the Exchange in accordance with § 156.230.

(2) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;

(iv) Administrative costs of such Exchange; and

(v) Monies lost to waste, fraud, and abuse.

(3) Provides applicants with information about Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.

(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.

(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

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(c) Accessibility. Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including

(i) Oral interpretation;

(ii) Written translations; and

(iii) Taglines in non-English languages indicating the availability of language services.

(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.

(d) Consumer assistance. The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.

(e) Outreach and education. The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.
45 CFR § 155.210

§ 155.210 Navigator program standards.
(a) General Requirements. The Exchange must establish a Navigator program consistent with this section through which it awards grants to eligible public or private entities or individuals described in paragraph (c) of this section.

(b) Standards. The Exchange must develop and publicly disseminate—

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity or individuals to be awarded a Navigator grant and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure expertise in:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) The range of QHP options and insurance affordability programs; and,

(iv) The privacy and security standards applicable under § 155.260.

(c) Entities and individuals eligible to be a Navigator. (1) To receive a Navigator grant, an entity or individual must—

(i) Be capable of carrying out at least those duties described in paragraph (e) of this section;

(ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable;

(iv) Not have a conflict of interest during the term as Navigator; and,

(v) Comply with the privacy and security standards adopted by the Exchange as required in accordance with § 155.260.

(2) The Exchange must include an entity as described in paragraph (c)(2)(i) of this section and an entity from at least one of the other following categories for receipt of a Navigator grant:

(i) Community and consumer-focused nonprofit groups;

(ii) Trade, industry, and professional associations;

(iii) Commercial fishing industry organizations, ranching and farming organizations;

(iv) Chambers of commerce;

(v) Unions;

(vi) Resource partners of the Small Business Administration;

(vii) Licensed agents and brokers; and

(viii) Other public or private entities or individuals that meet the requirements of this section. Other entities may include but are not limited ***18449** to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

(d) Prohibition on Navigator conduct. The Exchange must ensure that a Navigator must not—

(1) Be a health insurance issuer;

(2) Be a subsidiary of a health insurance issuer;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry; or,

(4) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or a non-QHP.

(e) Duties of a Navigator. An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;

(2) Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs;

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(3) Facilitate selection of a QHP;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(f) Funding for Navigator grants. Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange.
45 CFR § 155.220

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.
(a) General rule. A State may permit agents and brokers to—

(1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;

(2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and

(3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

(b) Web site disclosure. The Exchange may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange.

(c) Enrollment through the Exchange. A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if—

(1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Web site as described in § 155.405;

(2) The Exchange transmits enrollment information to the QHP issuer as provided in § 155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.

(3) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:

(i) Meet all standards for disclosure and display of QHP information contained in § 155.205(b)(1) and (c);

(ii) Provide consumers the ability to view all QHPs offered through the Exchange;

(iii) Not provide financial incentives, such as rebates or giveaways;

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(iv) Display all QHP data provided by the Exchange;

(v) Maintain audit trails and records in an electronic format for a minimum of ten years; and

(vi) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in § 155.205(b) instead at any time.

(d) Agreement. An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with the terms of an agreement between the agent or broker and the Exchange under which the agent or broker at least:

(1) Registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;

(2) Receives training in the range of QHP options and insurance affordability programs; and

(3) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260.

(e) Compliance with State law. An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with applicable State law related to agents and brokers, including applicable State law related to confidentiality and conflicts of interest.
45 CFR § 155.230

§ 155.230 General standards for Exchange notices.
(a) General requirement. Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees must be written and include:

(1) Contact information for available customer service resources;

(2) An explanation of appeal rights, if applicable; and

(3) A citation to or identification of the specific regulation supporting the action, including the reason for the intended action.

(b) Accessibility and readability requirements. All applications, forms, and notices, including the single, streamlined application described in § 155.405 and notice of annual redetermination described in § 155.335(c), must conform to the standards outlined in § 155.205(c).

(c) Re-evaluation of appropriateness and usability. The Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices.
45 CFR § 155.240

§ 155.240 Payment of premiums.
(a) Payment by individuals. The Exchange must allow a qualified individual to pay any applicable premium owed by such individual directly to the QHP issuer.

(b) Payment by tribes, tribal organizations, and urban Indian organizations. The Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, including aggregated payment, subject to terms and conditions determined by the Exchange.

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(c) Payment facilitation. The Exchange may establish a process to facilitate through electronic means the collection and payment of premiums to QHP issuers.

(d) Required standards. In conducting an electronic transaction with a QHP ***18450** issuer that involves the payment of premiums or an electronic funds transfer, the Exchange must comply with the privacy and security standards adopted in accordance with § 155.260 and use the standards and operating rules referenced in § 155.270.
45 CFR § 155.260

§ 155.260 Privacy and security of personally identifiable information.
(a) Creation, collection, use and disclosure. (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in 155.20; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary to carry out the functions described in § 155.200 of this subpart.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information while the Exchange is fulfilling its responsibilities in accordance with § 155.200 of this subpart unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) Individual access. Individuals should be provided with a simple and timely means to access and obtain their personally identifiable health information in a readable form and format;

(ii) Correction. Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable health information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) Openness and transparency. There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable health information;

(iv) Individual choice. Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable health information;

(v) Collection, use, and disclosure limitations. Personally identifiable health information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) Data quality and integrity. Persons and entities should take reasonable steps to ensure that personally identifiable health information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) Safeguards. Personally identifiable health information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) Accountability. These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

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(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) Application to non-Exchange entities. Except for tax return information, which is governed by section 6103 of the Code, when collection, use or disclosure is not otherwise required by law, an Exchange must require the same or more stringent privacy and security standards (as § 155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that:

(1) Gain access to personally identifiable information submitted to an Exchange; or

(2) Collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

(c) Workforce compliance. The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) Written policies and procedures. Policies and procedures regarding the collection, use, and disclosure of personally identifiable information must, at minimum:

(1) Be in writing, and available to the Secretary of HHS upon request; and

(2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.

(e) Data sharing. Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:

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(1) Meet any applicable requirements described in this section;

(2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;

(3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and

(4) For those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

(f) Compliance with the Code. Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.

(g) Improper use and disclosure of information. Any person who knowingly and willfully uses or discloses information in violation of ***18451** section 1411(g) of the Affordable Care Act will be subject to a civil penalty of not more than $25,000 per person or entity, per use or disclosure, in addition to other penalties that may be prescribed by law.
45 CFR § 155.270

§ 155.270 Use of standards and protocols for electronic transactions.
(a) HIPAA administrative simplification. To the extent that the Exchange performs electronic transactions with a covered entity, the Exchange must use standards, implementation specifications, operating rules, and code sets adopted by the Secretary in 45 CFR parts 160 and 162.

(b) HIT enrollment standards and protocols. The Exchange must incorporate interoperable and secure standards and protocols developed by the Secretary in accordance with section 3021 of the PHS Act. Such standards and protocols must be incorporated within Exchange information technology systems.

Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs
45 CFR § 155.300

§ 155.300 Definitions and general standards for eligibility determinations.
(a) Definitions. In addition to those definitions in § 155.20, for purposes of this subpart, the following terms have the following meaning:

Adoption taxpayer identification number has the same meaning as it does in 26 CFR 301.6109-3(a).

Applicable Children's Health Insurance Program (CHIP) MAGI-based income standard means the applicable income standard as defined at 42 CFR 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

Applicable Medicaid modified adjusted gross income (MAGI)-based income standard has the same meaning as "applicable modified adjusted gross income standard," as defined at 42 CFR 435.911(b), as applied under the State plan adopted in accordance with title XIX of the Act, or waiver of such plan, and as certified by the State Medicaid agency in accordance with 42 CFR 435.1200(b)(2) for determining eligibility for Medicaid.

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Federal poverty level or FPL means the most recently published Federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in § 155.410.

Indian means any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

Insurance affordability program has the same meaning as "insurance affordability program," as specified in 42 CFR 435.4.

MAGI-based income has the same meaning as it does in 42 CFR 435.603(e).

Minimum value, when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in section 36B(c)(2)(C)(ii) of the Code.

Modified Adjusted Gross Income (MAGI) has the same meaning as it does in section 36B(d)(2)(B) of the Code.

Non-citizen means an individual who is not a citizen or national of the United States, in accordance with section 101(a)(3) of the Immigration and Nationality Act.

Qualifying coverage in an eligible employer-sponsored plan means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in section 36B(c)(2)(C) of the Code.

State CHIP Agency means the agency that administers a separate child health program established by the State under title XXI of the Act in accordance with implementing regulations at 42 CFR 457.

State Medicaid Agency means the agency established or designated by the State under title XIX of the Act that administers the Medicaid program in accordance with implementing regulations at 42 CFR parts 430 through 456.

Tax dependent has the same meaning as the term dependent under section 152 of the Code.

Tax filer means an individual, or a married couple, who indicates that he, she or they expects—

(1) To file an income tax return for the benefit year, in accordance with 26 U.S.C. 6011, 6012, and implementing regulations;

(2) If married (within the meaning of 26 CFR 1.7703-1), to file a joint tax return for the benefit year;

(3) That no other taxpayer will be able to claim him, her or them as a tax dependent for the benefit year; and

(4) That he, she, or they expects to claim a personal exemption deduction under section 151 of the Code on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

(b) Medicaid and CHIP. In general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with rules and procedures which are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.345(a).

(c) Attestation. (1) Except as specified in paragraph (c)(2) of this section, for the purposes of this subpart, an attestation may be made by the application filer.

(2) The attestations specified in § 155.310(d)(2)(ii) and § 155.315(f)(4)(ii) must be provided by the tax filer.

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(d) Reasonably compatible. For purposes of this subpart, the Exchange must consider information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant'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.
45 CFR § 155.302

§ 155.302 Options for conducting eligibility determinations.
(a) Options for conducting eligibility determinations. The Exchange may satisfy the requirements of this subpart—

(1) Directly or through contracting arrangements in accordance with § 155.110(a); or

(2) Through a combination of the approach described in paragraph (a)(1) of this section and one or both of the options described in paragraph (b) or (c) of this section, subject to the standards in paragraph (d) of this section.

(b) Medicaid and CHIP. Notwithstanding the requirements of this subpart, the Exchange may conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP, provided that—

(1) The Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented ***18452** by the State Medicaid and CHIP agencies.

(2) Notices and other activities required in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law.

(3) Applicants found potentially eligible for Medicaid or CHIP. When the Exchange assesses an applicant as potentially eligible for Medicaid or CHIP consistent with the standards in subparagraph (b)(1) of this section, the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface, promptly and without undue delay.

(4) Applicants not found potentially eligible for Medicaid and CHIP. (i) If the Exchange conducts an assessment in accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions and must notify such applicant, and provide him or her with the opportunity to—

(A) Withdraw his or her application for Medicaid and CHIP; or

(B) Request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies.

(ii) To the extent that an applicant described in paragraph (b)(4)(i) of this section requests a full determination of eligibility for Medicaid and CHIP, the Exchange must—

(A) Transmit all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency and CHIP agency via secure electronic interface, promptly and without undue delay; and

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(B) Consider such an applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP.

(5) The Exchange adheres to the eligibility determination for Medicaid or CHIP made by the State Medicaid or CHIP agency;

(6) The Exchange and the State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP.

(c) Advance payments of the premium tax credit and cost-sharing reductions. Notwithstanding the requirements of this subpart, the Exchange may implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS, provided that—

(1) Verifications, notices, and other activities required in connection with an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (c)(4) of this section;

(2) The Exchange transmits all information provided as a part of the application, update, or renewal that initiated the eligibility determination, and any information obtained or verified by the Exchange, to HHS via secure electronic interface, promptly and without undue delay;

(3) The Exchange adheres to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions made by HHS; and

(4) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions.

(d) Standards. To the extent that assessments of eligibility for Medicaid and CHIP based on MAGI or eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) or (c) of this section, the Exchange must ensure that—

(1) Eligibility processes for all insurance affordability programs are streamlined and coordinated across HHS, the Exchange, the State Medicaid agency, and the State CHIP agency, as applicable;

(2) Such arrangement does not increase administrative costs and burdens on applicants, enrollees, beneficiaries, or application filers, or increase delay; and

(3) Applicable requirements under 45 CFR 155.260, 155.270, and 155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, and use of information are met.

45 CFR § 155.305

§ 155.305 Eligibility standards.

(a) Eligibility for enrollment in a QHP through the Exchange. The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange if he or she meets the following requirements:

(1) Citizenship, status as a national, or lawful presence. Is a citizen or national of the United States, or is a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(2) Incarceration. Is not incarcerated, other than incarceration pending the disposition of charges; and

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(3) Residency. Meets the applicable residency standard identified in this paragraph (a)(3).

(i) For an individual who is age 21 and over, is not living in an institution as defined in 42 CFR 435.403(b), is capable of indicating intent, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and—

(A) Intends to reside, including without a fixed address; or

(B) Has entered with a job commitment or is seeking employment (whether or not currently employed).

(ii) For an individual who is under the age of 21, is not living in an institution as defined in 42 CFR 435.403(b), is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act as addressed in 42 CFR 435.403(g), is not emancipated, is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the Exchange service area of the individual—

(A) Is the service area of the Exchange in which he or she resides, including without a fixed address; or

(B) Is the service area of the Exchange of a parent or caretaker, established in accordance with paragraph (a)(3)(i) of this section, with whom the individual resides.

(iii) Other special circumstances. In the case of an individual who is not described in paragraphs (a)(3)(i) or (ii) of this section, the Exchange must apply the residency requirements described in 42 CFR 435.403 with respect to the service area of the Exchange.

(iv) Special rule for tax households with members in multiple Exchange ***18453** service areas. (A) Except as specified in paragraph (a)(3)(iv)(B) of this section if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in paragraphs (a)(3)(i), (ii), and (iii) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(B) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may only enroll in a QHP through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard described in paragraphs (a)(3)(i), (ii), or (iii) of this section.

(b) Eligibility for QHP enrollment periods. The Exchange must determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in §§ 155.410 and 155.420.

(c) Eligibility for Medicaid. The Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) and—

(1) Is a pregnant woman, as defined in the Medicaid State Plan in accordance with 42 CFR 435.4;

(2) Is under age 19;

(3) Is a parent or caretaker relative of a dependent child, as defined in the Medicaid State plan in accordance with 42 CFR 435.4; or

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(4) Is not described in paragraph (c)(1), (2), or (3) of this section, is under age 65 and is not entitled to or enrolled for benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of the Social Security Act.

(d) Eligibility for CHIP. The Exchange must determine an applicant eligible for CHIP if he or she meets the requirements of 42 CFR 457.310 through 457.320 and has a household income, as defined in 42 CFR 435.603(d), at or below the applicable CHIP MAGI-based income standard.

(e) Eligibility for BHP. If a BHP is operating in the service area of the Exchange, the Exchange must determine an applicant eligible for the BHP if he or she meets the requirements specified in section 1331(e) of the Affordable Care Act and regulations implementing that section.

(f) Eligibility for advance payments of the premium tax credit. (1) In general. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she is expected to have a household income, as defined in section 36B(d)(2) of the Code, of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(ii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section; and

(B) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of the Code.

(2) Special rule for non-citizens who are lawfully present and who are ineligible for Medicaid by reason of immigration status. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she meets the requirements specified in paragraph (f)(1) of this section, except for paragraph (f)(1)(i);

(ii) He or she is expected to have a household income, as defined in section 36B(d)(2) of the Code, of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with section 36B(c)(1)(B) of the Code.

(3) Enrollment required. The Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP through the Exchange.

(4) Compliance with filing requirement. The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that advance payments of the premium tax credit were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and

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the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

(5) Calculation of advance payments of the premium tax credit. The Exchange must calculate advance payments of the premium tax credit in accordance with section 36B of the Code.

(6) Collection of Social Security numbers. The Exchange must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.

(g) Eligibility for cost-sharing reductions. (1) Eligibility criteria. (i) The Exchange must determine an applicant eligible for cost-sharing reductions if he or she—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section;

(B) Meets the requirements for advance payments of the premium tax credit, as specified in paragraph (f) of this section; and

(C) Is expected to have a household income that does not exceed 250 percent of the FPL, for the benefit year for which coverage is requested.

(ii) The Exchange may only provide cost-sharing reductions to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.

(2) Eligibility categories. The Exchange must use the following eligibility categories for cost-sharing reductions when making eligibility determinations under this section—

(i) An individual who is expected to have a household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for advance payments of the premium tax credit under paragraph (f)(2) of this section, a household income less than 100 percent of the FPL ***18454** for the benefit year for which coverage is requested;

(ii) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; and

(iii) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.

(3) Special rule for multiple tax households. To the extent that an enrollment in a QHP under a single policy covers individuals who are expected to be in different tax households for the benefit year for which coverage is requested, the Exchange must apply only the first category of cost-sharing reductions listed below for which the Exchange has determined that one of the applicants in the tax households is eligible.

(i) § 155.350(b);

(ii) Paragraph (g)(2)(iii) of this section;

(iii) Paragraph (g)(2)(ii) of this section;

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(iv) Paragraph (g)(3)(i) of this section;

(v) § 155.350(a).

(4) For the purposes of paragraph (g) of this section, "household income" means household income as defined in section 36B(d)(2) of the Code.
45 CFR § 155.310

§ 155.310 Eligibility process.
(a) Application. (1) Accepting applications. The Exchange must accept applications from individuals in the form and manner specified in § 155.405.

(2) Information collection from non-applicants. The Exchange may not request information regarding citizenship, status as a national, or immigration status for an individual who is not seeking coverage for himself or herself on any application or supplemental form.

(3) Collection of Social Security numbers. (i) The Exchange must require an applicant who has a Social Security number to provide such number to the Exchange.

(ii) The Exchange may not require an individual who is not seeking coverage for himself or herself to provide a Social Security number, except as specified in § 155.305(f)(6).

(b) Applicant choice for Exchange to determine eligibility for insurance affordability programs. The Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange; however, the Exchange may not permit an applicant to request an eligibility determination for less than all insurance affordability programs.

(c) Timing. The Exchange must accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(d) Determination of eligibility. (1) The Exchange must determine an applicant's eligibility, in accordance with the standards specified in § 155.305.

(2) Special rules relating to advance payments of the premium tax credit. (i) The Exchange must permit an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible.

(ii) The Exchange may authorize advance payments of the premium tax credit on behalf of a tax filer only if the Exchange first obtains necessary attestations from the tax filer regarding advance payments of the premium tax credit, including, but not limited to attestations that—

(A) He or she will file an income tax return for the benefit year, in accordance with 26 U.S.C. 6011, 6012, and implementing regulations;

(B) If married (within the meaning of 26 CFR 1.7703-1), he or she will file a joint tax return for the benefit year;

(C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the tax filer and his or her spouse, in accordance with § 155.320(c)(3)(i).

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(3) Special rule relating to Medicaid and CHIP. To the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the State Medicaid or CHIP agency and transmit all information from the records of the Exchange to the State Medicaid or CHIP agency, promptly and without undue delay, that is necessary for such agency to provide the applicant with coverage.

(e) Timeliness standards. (1) The Exchange must determine eligibility promptly and without undue delay.

(2) The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable.

(f) Effective dates for eligibility. Upon making an eligibility determination, the Exchange must implement the eligibility determination under this section for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions as follows—

(1) For an initial eligibility determination, in accordance with the dates specified in § 155.410(c) and (f) and § 155.420(b), as applicable,

(2) For a redetermination, in accordance with the dates specified in § 155.330(f) and § 155.335(i), as applicable.

(g) Notification of eligibility determination. The Exchange must provide timely written notice to an applicant of any eligibility determination made in accordance with this subpart.

(h) Notice of an employee's eligibility for advance payments of the premium tax credit and cost-sharing reductions to an employer. The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions upon determination that an employee is eligible for advance payments of the premium tax credit or cost-sharing reductions. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and

(4) Notify the employer of the right to appeal the determination.

(i) Duration of eligibility determinations without enrollment. To the extent that an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment period in accordance with subpart E, and seeks a new enrollment period—

(1) Prior to the date on which his or her eligibility would have been redetermined in accordance with § 155.335 had he or she enrolled in a QHP, the Exchange must require the applicant to attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for an enrollment period, and must process any changes reported in accordance with the procedures specified in § 155.330.

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(2) On or after the date on which his or her eligibility would have been redetermined in accordance with § 155.335 had he or she enrolled in a QHP, the Exchange must apply the ***18455** procedures specified in § 155.335 before determining his or her eligibility for an enrollment period.
45 CFR § 155.315

§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.
(a) General requirement. Unless a request for modification is granted in accordance with paragraph (h) of this section, the Exchange must verify or obtain information as provided in this section in order to determine that an applicant is eligible for enrollment in a QHP through the Exchange.

(b) Validation of Social Security number. (1) For any individual who provides his or her Social Security number to the Exchange, the Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

(c) Verification of citizenship, status as a national, or lawful presence. (1) Verification with records from the Social Security Administration. For an applicant who attests to citizenship and has a Social Security number, the Exchange must transmit the applicant's Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) Verification with the records of the Department of Homeland Security. For an applicant who has documentation that can be verified through the Department of Homeland Security and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the Department of Homeland Security for verification.

(3) Inconsistencies and inability to verify information. For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the Social Security Administration or the Department of Homeland Security, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security, as applicable. The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period.

(d) Verification of residency. The Exchange must verify an applicant's attestation that he or she meets the standards of § 155.305(a)(3) as follows—

(1) Except as provided in paragraphs (d)(3) and (4) of this section, accept his or her attestation without further verification; or

(2) Examine electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

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(3) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange the Exchange must examine information in data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate.

(4) If the information in such data sources is not reasonably compatible with the information provided by the applicant, the Exchange must follow the procedures specified in paragraph (f) of this section. Evidence of immigration status may not be used to determine that an applicant is not a resident of the Exchange service area.

(e) Verification of incarceration status. The Exchange must verify an applicant's attestation that he or she meets the requirements of § 155.305(a)(2) by—

(1) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and offer less administrative complexity than paper verification; or

(2) Except as provided in paragraph (e)(3) of this section, if an approved data source is unavailable, accepting his or her attestation without further verification.

(3) To the extent that an applicant's attestation is not reasonably compatible with information from approved data sources described in paragraph (e)(1) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

(f) Inconsistencies. Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but not available, the Exchange:

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, must—

(i) Provide notice to the applicant regarding the inconsistency; and

(ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in § 155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

(3) May extend the period described in paragraph (f)(2)(ii) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

(4) During the period described in paragraph (f)(2)(ii) of this section, must:

(i) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the ***18456** extent that an applicant is otherwise qualified; and

(ii) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests

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to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

(5) If, after the period described in paragraph (f)(2)(ii) of this section, the Exchange remains unable to verify the attestation, must—

(i) Determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph (i) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation; and

(ii) Effectuate the determination specified in paragraph (f)(5)(i) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in paragraph (f)(5)(i) of this section is sent.

(g) Exception for special circumstances. For an applicant who does not have documentation with which to resolve the inconsistency through the process described in paragraph (f)(2) of this section because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, with the exception of an inconsistency related to citizenship or immigration status, the Exchange must provide an exception, on a case-by-case basis, to accept an 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.

(h) Flexibility in information collection and verification. HHS may approve an Exchange Blueprint in accordance with § 155.105(d) or a significant change to the Exchange Blueprint in accordance with § 155.105(e) to modify the methods to be used for collection of information and verification of information as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable requirements under § 155.260, § 155.270, paragraph (i) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

(i) Applicant information. The Exchange must not require an applicant to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, described in this subpart.

45 CFR § 155.320

§ 155.320 Verification process related to eligibility for insurance affordability programs.

(a) General requirements. (1) The Exchange must verify information in accordance with this section only for an applicant or tax filer who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b).

(2) Unless a request for modification is granted in accordance with § 155.315(h), the Exchange must verify or obtain information in accordance with this section before making an eligibility determination for insurance affordability programs, and must use such information in such determination.

(b) Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan. (1) The Exchange must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the BHP, using information obtained by transmitting identifying information specified by HHS to HHS.

(2) The Exchange must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, within the State or States in which the Exchange operates using information obtained from the agencies administering such programs.

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(c) Verification of household income and family/household size. (1) Data. (i) Tax return data. (A) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with section 36B(d)(2) of the Code, or an applicant's household income, in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number or an adoption taxpayer identification number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury by transmitting identifying information specified by HHS to HHS.

(B) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed in accordance with section 6103(l)(21) of the Code and its accompanying regulations, the Exchange must proceed in accordance with § 155.315(f)(1).

(ii) Data regarding MAGI-based income. For all individuals whose income is counted in calculating a tax filer's household income, in accordance with section 36B(d)(2) of the Code, or an applicant's household income, in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

(2) Verification process for Medicaid and CHIP. (i) Household size. (A) The Exchange must verify household size in accordance with 42 CFR 435.945(a) or through other reasonable verification procedures consistent with the requirements in 42 CFR 435.952.

(B) The Exchange must verify the information in paragraph (c)(2)(i)(A) of this section by accepting an applicant's attestation without further verification, unless the Exchange finds that an applicant's attestation to the individuals that comprise his or her household for Medicaid and CHIP is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, in which case the Exchange must utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in 42 CFR 435.952.

(ii) Verification process for MAGI-based household income. The Exchange must verify MAGI-based income, within the meaning of 42 CFR 435.603(d), for the household described in paragraph (c)(2)(i) in accordance with the procedures specified in Medicaid regulations 42 CFR 435.945, 42 CFR 435.948, and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380.

(3) Verification process for advance payments of the premium tax credit and cost-sharing reductions. (i) Family size. (A) The Exchange must require an applicant to attest to the individuals that comprise a tax filer's family for advance payments of the premium tax credit and cost-sharing reductions.

***18457** (B) To the extent that the applicant attests that the information described in paragraph (c)(1)(i) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the family size data in paragraph (c)(1)(i) of this section.

(C) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must verify the tax filer's family size for advance payments of the premium tax credit and cost-sharing reductions by accepting an applicant's attestation without further verification, except as specified in paragraph (c)(3)(i)(D) of this section.

(D) If Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (c)(1)(i) of this section, the Exchange must utilize data obtained through other electronic data sources to verify

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the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in § 155.315(f).

(ii) Basic verification process for annual household income. (A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the tax return data described in paragraph (c)(1)(i) of this section;

(B) The Exchange must require the applicant to attest regarding a tax filer's projected annual household income;

(C) To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(ii)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(ii)(A) of this section.

(D) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must require the applicant to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

(iii) Verification process for increases in household income. (A) If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, except as provided in paragraph (c)(3)(iii)(B) of this section.

(B) If the Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, the Exchange must utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation using the procedures specified in § 155.315(f).

(iv) Eligibility for alternate verification process for decreases in annual household income and situations in which tax return data is unavailable. The Exchange must determine a tax filer's annual household income for advance payments of the premium tax credit and cost-sharing reductions based on the alternate verification procedures described in paragraph (c)(3)(v) of this section, if an applicant attests to projected annual household income in accordance with paragraph (c)(3)(ii)(B) of this section, the tax filer does not meet the criteria specified in paragraph (c)(3)(iii) of this section, the applicants in the tax filer's family have not established MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section that is within the applicable Medicaid or CHIP MAGI-based income standard, and one of the following conditions is met—

(A) The Secretary of the Treasury does not have tax return data that may be disclosed under section 6103(l)(21) of the Code for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which advance payments of the premium tax credit or cost-sharing reductions would be effective;

(B) The applicant attests that the tax filer's applicable family size has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage, or the members of the tax filer's family have changed or are reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage;

(C) The applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so the tax filer's annual household income has decreased or is reasonably expected to decrease from the data described in paragraph (c)(1)(i) of this section for the benefit year for which the applicants in his or her family are requesting coverage;

(D) The applicant attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage; or

(E) An applicant in the tax filer's family has filed an application for unemployment benefits.

(v) Alternate verification process. If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is no more than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the Exchange must accept the applicant's attestation without further verification.

(vi) Alternate verification process for decreases in annual household income and situations in which tax return data is unavailable. If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than ten percent below the ***18458** annual household income computed in accordance with paragraph (c)(3)(ii)(A), or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income for the tax filer by—

(A) Using annualized data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section;

(B) Using other electronic data sources that have been approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(C) If electronic data are unavailable or do not support an applicant's attestation, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4).

(D) If, following the 90-day period described in paragraph (c)(3)(vi)(C) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.

(E) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(C) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and implement such determination in accordance with the effective dates specified in § 155.330(f).

(F) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(C) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in § 155.330(f).

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(vii) For the purposes of this paragraph (c)(3), "household income" means household income as specified in section 36B(d)(2) of the Code.

(viii) For purposes of paragraph (c)(3) of this section, "family size" means family size as specified in section 36B(d)(1) of the Code.

(4) The Exchange must provide education and assistance to an applicant regarding the process specified in this paragraph.

(d) Verification related to enrollment in an eligible employer-sponsored plan. (1) Except as provided in paragraph (d)(2) of this section, the Exchange must verify whether an applicant who requested an eligibility determination for insurance affordability programs is enrolled in an eligible employer-sponsored plan or reasonably expects to be enrolled in an eligible employer-sponsored plan for the benefit year for which coverage is requested by accepting an applicant's attestation without further verification.

(2) If the Exchange finds that an applicant's attestation regarding enrollment in an eligible employer-sponsored plan is not reasonably compatible with other information provided by the applicant or in the records of the Exchange, the Exchange must utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in § 155.315(f).

(e) Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan. (1) The Exchange must require an applicant to attest to an applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, and to provide information identified in section 1411(b)(4) of the Affordable Care Act.

(2) The Exchange must verify whether an applicant is eligible for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(f) Additional verification related to immigration status for Medicaid and CHIP. (1) For purposes of determining eligibility for Medicaid, the Exchange must verify whether an applicant who does not attest to being a citizen or a national has satisfactory immigration status to be eligible for Medicaid, as required by 42 CFR 435.406 and, if applicable under the State Medicaid plan, section 1903(v)(4) of the Act.

(2) For purposes of determining eligibility for CHIP, the Exchange must verify whether an applicant who does not attest to being a citizen or a national has satisfactory immigration status to be eligible for CHIP, in accordance with 42 CFR 457.320(b) and if applicable under the State Child Health Plan, section 2107(e)(1)(J) of the Act.
45 CFR § 155.330

§ 155.330 Eligibility redetermination during a benefit year.
(a) General requirement. The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (d) of this section.

(b) Requirement for individuals to report changes. (1) Except as specified in paragraphs (b)(2) and (3) of this section, the Exchange must require an enrollee to report any change with respect to the eligibility standards specified in § 155.305 within 30 days of such change.

(2) The Exchange must not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs.

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(3) The Exchange may establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such change.

(4) The Exchange must allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in § 155.405(c).

(c) Verification of reported changes. The Exchange must—

(1) Verify any information reported by an enrollee in accordance with the processes specified in §§ 155.315 and 155.320 prior to using such information in an eligibility redetermination; and

(2) Provide periodic electronic notifications regarding the requirements for reporting changes and an enrollee's opportunity to report any changes as described in paragraph (b)(3) of this section, to an enrollee who has elected to receive electronic notifications, ***18459** unless he or she has declined to receive notifications under this paragraph (c)(2).

(d) Periodic examination of data sources. (1) The Exchange must periodically examine available data sources described in § 155.315(b)(1) and § 155.320(b) to identify the following changes:

(i) Death; and

(ii) Eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange.

(2) Flexibility. The Exchange may make additional efforts to identify and act on changes that may affect an enrollee's eligibility for enrollment in a QHP through the Exchange or for insurance affordability programs, provided that such efforts—

(i) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable requirements under §§ 155.260, 155.270, 155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met; and

(ii) Comply with the standards specified in paragraphs (e)(2) and (3) of this section.

(e) Redetermination and notification of eligibility. (1) Enrollee-reported data. If the Exchange verifies updated information reported by an enrollee, the Exchange must—

(i) Redetermine the enrollee's eligibility in accordance with the standards specified in § 155.305;

(ii) Notify the enrollee regarding the determination in accordance with the requirements specified in § 155.310(g); and

(iii) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in § 155.310(h).

(2) Data matching not regarding income, family size and family composition. If the Exchange identifies updated information through the data matching taken in accordance with paragraph (d)(1) or through other data matching under paragraph (d)(2) of this section, with the exception of data matching related to income, the Exchange must—

(i) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;

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(ii) Allow an enrollee 30 days from the date of the notice to notify the Exchange that such information is inaccurate; and

(iii) If the enrollee responds contesting the updated information, proceed in accordance with § 155.315(f).

(iv) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(ii), proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(3) Data matching regarding income, family size and family composition. If the Exchange identifies updated information regarding income, family size and composition through the data matching taken in accordance with paragraph (c)(2) of this section, the Exchange must—

(i) Follow procedures described in paragraph (e)(2)(i) and (ii) of this section; and

(ii) If the enrollee responds confirming the updated information or providing more up to date information, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(iii) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(ii) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(f) Effective dates. (1) Except as specified in paragraphs (f)(2) or (3) of this section, the Exchange must implement changes resulting from a redetermination under this section on the first day of the month following the date of the notice described in paragraph (e)(1)(ii) of this section.

(2) The Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month specified in paragraph (f)(1) of this section. Such reasonable point in a month must be no earlier than the date described in § 155.420(b)(2).

(3) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions, in accordance with the effective dates described in § 155.430(d)(3).
45 CFR § 155.335

§ 155.335 Annual eligibility redetermination.
(a) General requirement. Except as specified in paragraph (l) of this section, the Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange on an annual basis.

(b) Updated income and family size information. In the case of an enrollee who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b), the Exchange must request updated tax return information, if the enrollee has authorized the request of such tax return information, and data regarding MAGI-based income as described in § 155.320(c)(1) for use in the enrollee's eligibility redetermination.

(c) Notice to enrollee. The Exchange must provide an enrollee with an annual redetermination notice including the following:

(1) The data obtained under paragraph (b) of this section, if applicable; and

(2) The data used in the enrollee's most recent eligibility determination; and

(3) The enrollee's projected eligibility determination for the following year, after considering any updated information described in paragraph (c)(1) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions or eligibility for Medicaid, CHIP or BHP.

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(d) Timing. (1) For redeterminations under this section for coverage effective January 1, 2015, the Exchange must satisfy the notice provisions of paragraph (c) of this section and § 155.410(d) through a single, coordinated notice.

(2) For redeterminations under this section for coverage effective on or after January 1, 2017, the Exchange may send the notice specified in paragraph (c) of this section separately from the notice of annual open enrollment specified in § 155.410(d), provided that—

(i) The Exchange sends the notice specified in paragraph (c) of this section no earlier than the date of the notice of annual open enrollment specified in § 155.410(d); and

(ii) The timing of the notice specified in paragraph (c) of this section allows a reasonable amount of time for the enrollee to review the notice, provide a timely response, and for the Exchange to implement any changes in coverage elected during the annual open enrollment period.

(e) Changes reported by enrollees. (1) The Exchange must require an enrollee to report any changes with respect to the information listed in the notice described in paragraph (c) of this section within 30 days from the date of the notice.

(2) The Exchange must allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2).

***18460** (f) Verification of reported changes. The Exchange must verify any information reported by an enrollee under paragraph (e) of this section using the processes specified in § 155.315 and § 155.320, including the relevant provisions in those sections regarding inconsistencies, prior to using such information to determine eligibility.

(g) Response to redetermination notice. (1) The Exchange must require an enrollee, or an application filer, on behalf of the enrollee, to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that an enrollee does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (e) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

(h) Redetermination and notification of eligibility. (1) After the 30-day period specified in paragraph (e) of this section has elapsed, the Exchange must—

(i) Redetermine the enrollee's eligibility in accordance with the standards specified in § 155.305 using the information provided to the individual in the notice specified in paragraph (c), as supplemented with any information reported by the enrollee and verified by the Exchange in accordance with paragraphs (e) and (f) of this section;

(ii) Notify the enrollee in accordance with the requirements specified in § 155.310(g); and

(iii) If applicable, notify the enrollee's employer, in accordance with the requirements specified in § 155.310(h).

(2) If an enrollee reports a change with respect to the information provided in the notice specified in paragraph (c) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (e) of this section, the Exchange must redetermine the enrollee's eligibility after completing verification, as specified in paragraph (f) of this section.

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(i) Effective date of annual redetermination. The Exchange must ensure that a redetermination under this section is effective on the first day of the coverage year following the year in which the Exchange provided the notice in paragraph (c) of this section, or in accordance with the rules specified in § 155.330(f) regarding effective dates, whichever is later.

(j) Renewal of coverage. If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee will remain in the QHP selected the previous year unless such enrollee terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with § 155.430.

(k) Authorization of the release of tax data to support annual redetermination. (1) The Exchange must have authorization from an enrollee in order to obtain updated tax return information described in paragraph (b) of this section for purposes of conducting an annual redetermination.

(2) The Exchange is authorized to obtain the updated tax return information described in paragraph (b) of this section for a period of no more than five years based on a single authorization, provided that—

(i) An individual may decline to authorize the Exchange to obtain updated tax return information; or

(ii) An individual may authorize the Exchange to obtain updated tax return information for fewer than five years; and

(iii) The Exchange must allow an individual to discontinue, change, or renew his or her authorization at any time.

(l) Limitation on redetermination. To the extent that an enrollee has requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange must notify the enrollee in accordance with the timing described in paragraph (d) of this section. The Exchange may not proceed with the redetermination process described in paragraphs (c) and (e) through (j) of this section until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability programs in accordance with § 155.310(b).
45 CFR § 155.340

§ 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.
(a) Requirement to provide information to enable advance payments of the premium tax credit and cost-sharing reductions. In the event that the Exchange determines that a tax filer is eligible for advance payments of the premium tax credit, an applicant is eligible for cost-sharing reductions, or that such eligibility for such programs has changed, the Exchange must, simultaneously—

(1) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change advance payments of the premium tax credit or cost-sharing reductions; and

(2) Notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of advance payments of the premium tax credit or cost-sharing reductions, as applicable, including:

(i) The dollar amount of the advance payment; and

(ii) The cost-sharing reductions eligibility category.

(b) Requirement to provide information related to employer responsibility. (1) In the event that the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, within the standard of section 36B(c)(2)(C)(i) of the Code, or does not meet the minimum value requirement specified in section 36B(c)(2)(C)(ii) of the Code, the Exchange must transmit the individual's name and taxpayer identification number to HHS.

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(2) If an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he or she has changed employers, the Exchange must transmit the enrollee's name and taxpayer identification number to HHS.

(3) In the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year, the Exchange must—

(i) Transmit the individual's name and taxpayer identification number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and,

(ii) Transmit the individual's name and the effective date of the termination of coverage to his or her employer.

(c) Requirement to provide information related to reconciliation of advance payments of the premium tax credit. The Exchange must comply with the requirements specified in section 36B(f)(3) of the Code regarding reporting to the IRS and to taxpayers.

(d) Timeliness standard. The Exchange must transmit all information required in accordance with paragraphs (a) and (b) of this section promptly and without undue delay.
45 CFR § 155.345

§ 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.
***18461** (a) Agreements. The Exchange must enter into agreements with agencies administering Medicaid, CHIP, and the BHP as are necessary to fulfill the requirements of this subpart and provide copies of any such agreements to HHS upon request. Such agreements must include a clear delineation of the responsibilities of each program to—

(1) Minimize burden on individuals;

(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to or redetermination is initiated by the agency administering Medicaid, CHIP, or the BHP, or to the Exchange; and

(3) Ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

(b) Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups. For an applicant who is not eligible for Medicaid based on the standards specified in § 155.305(c), the Exchange must assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors not otherwise considered in this subpart.

(c) Individuals requesting additional screening. The Exchange must notify an applicant of the opportunity to request a full determination of eligibility for Medicaid based on eligibility criteria that are not described in § 155.305(c), and provide such an opportunity. The Exchange must also make such notification to an enrollee and provide an enrollee such opportunity in any determination made in accordance with § 155.330 or § 155.335.

(d) Notification of applicant and State Medicaid agency. If an Exchange identifies an applicant as potentially eligible for Medicaid under paragraph (b) of this section or an applicant requests a full determination for Medicaid under paragraph (c) of this section, the Exchange must—

(1) Transmit all information provided on the application and any information obtained or verified by, the Exchange to the State Medicaid agency, promptly and without undue delay; and

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(2) Notify the applicant of such transmittal.

(e) Treatment of referrals to Medicaid on eligibility for advance payments of the premium tax credit and cost-sharing reductions. The Exchange must consider an applicant who is described in paragraph (d) of this section and has not been determined eligible for Medicaid based on the standards specified in § 155.305(c) as ineligible for Medicaid for purposes of eligibility for advance payments of the premium tax credit or cost-sharing reductions until the State Medicaid agency notifies the Exchange that the applicant is eligible for Medicaid.

(f) Special rule. If the Exchange verifies that a tax filer's household income, as defined in section 36B(d)(2) of the Code, is less than 100 percent of the FPL for the benefit year for which coverage is requested, determines that the tax filer is not eligible for advance payments of the premium tax credit based on § 155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income, the Exchange must—

(1) Provide the applicant with any information regarding income used in the Medicaid and CHIP eligibility determination; and

(2) Follow the procedures specified in § 155.320(c)(3).

(g) Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP. The Exchange, in consultation with the agencies administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange 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, if a BHP is operating in the service area of the Exchange, for the individual, and not require submission of another application;

(2) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart;

(3) Not request information of documentation from the individual already provided to another insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other program;

(4) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart; and

(5) Provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application.

(h) Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP, and the BHP. (1) The Exchange must utilize a secure electronic interface to exchange data with the agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, including to verify whether an applicant for insurance affordability programs has been determined eligible for Medicaid, CHIP, or the BHP, as specified in § 155.320(b)(2), and for other functions required under this subpart.

(2) Model agreements. The Exchange may utilize any model agreements as established by HHS for the purpose of sharing data as described in this section.

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(i) Transition from the Pre-existing Condition Insurance Plan (PCIP). The Exchange must follow procedures established in accordance with 45 CFR 152.45 to transition PCIP enrollees to the Exchange to ensure that there are no lapses in health coverage.
45 CFR § 155.350

§ 155.350 Special eligibility standards and process for Indians.
(a) Eligibility for cost-sharing reductions. (1) The Exchange must determine an applicant who is an Indian eligible for cost-sharing reductions if he or she—

(i) Meets the requirements specified in § 155.305(a) and § 155.305(f);

(ii) Is expected to have a household income, as defined in section 36B(d)(2) of the Code, that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP through the Exchange.

(b) Special cost-sharing rule for Indians regardless of income. The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination for insurance affordability programs in accordance with § 155.310(b) in order to qualify for this rule.

(c) Verification related to Indian status. To the extent that an applicant attests that he or she is an Indian, the ***18462** Exchange must verify such attestation by—

(1) Utilizing any relevant documentation verified in accordance with § 155.315(f);

(2) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation, the Exchange must follow the procedures specified in § 155.315(f) and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.
45 CFR § 155.355

§ 155.355 Right to appeal.
Individual appeals. The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any eligibility determination notice issued to the applicant in accordance with § 155.310(g), § 155.330(e)(1)(ii), or § 155.335(h)(1)(ii).

Subpart E—Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans
45 CFR § 155.400

§ 155.400 Enrollment of qualified individuals into QHPs.
(a) General requirements. The Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with subpart D, and must—

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(1) Notify the issuer of the applicant's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the applicant.

(b) Timing of data exchange. The Exchange must:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay; and

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information.

(c) Records. The Exchange must maintain records of all enrollments in QHP issuers through the Exchange.

(d) Reconcile files. The Exchange must reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.
45 CFR § 155.405

§ 155.405 Single streamlined application.
(a) The application. The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) Advance payments of the premium tax credit;

(3) Cost-sharing reductions; and

(4) Medicaid, CHIP, or the BHP, where applicable.

(b) Alternative application. If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

(c) Filing the single streamlined application. The Exchange must—

(1) Accept the single streamlined application from an application filer;

(2) Provide the tools to file an application—

(i) Via an Internet Web site;

(ii) By telephone through a call center;

(iii) By mail; and

(iv) In person, with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act.
45 CFR § 155.410

§ 155.410 Initial and annual open enrollment periods.
(a) General requirements. (1) The Exchange must provide an initial open enrollment period and annual open enrollment periods consistent with this section, during which qualified individuals may enroll in a QHP and enrollees may change QHPs.

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(2) The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period specified in paragraph (b) of this section, the annual open enrollment period specified in paragraph (e) of this section, or a special enrollment period described in § 155.420 of this subpart for which the qualified individual has been determined eligible.

(b) Initial open enrollment period. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Effective coverage dates for initial open enrollment period. (1) Regular effective dates. For a QHP selection received by the Exchange from a qualified individual—

(i) On or before December 15, 2013, the Exchange must ensure a coverage effective date of January 1, 2014;

(ii) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; and

(iii) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) Option for earlier effective dates. Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraphs (c)(1)(ii) and (iii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (c)(1)(ii) or (iii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month for any month between December 2013 and March 31, 2014, the Exchange may provide a coverage effective date of the first of the following month.

(d) Notice of annual open enrollment period. Starting in 2014, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than September 1, and no later than September 30.

(e) Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.

(f) Effective date for coverage after the annual open enrollment period. The Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

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(g) Automatic enrollment. The Exchange may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Exchange demonstrating to HHS that it has good ***18463** cause to perform such automatic enrollments.
45 CFR § 155.420

§ 155.420 Special enrollment periods.
(a) General requirements. The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(b) Effective dates. (1) Regular effective dates. Except as specified in paragraphs (b)(2) and (3) of this section, for a QHP selection received by the Exchange from a qualified individual—

(i) Between the first and the fifteenth day of any month, the Exchange must ensure a coverage effective date of the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) Special effective dates. (i) In the case of birth, adoption or placement for adoption, the Exchange must ensure that coverage is effective on the date of birth, adoption, or placement for adoption, but advance payments of the premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure coverage is effective on the first day of the following month.

(3) Option for earlier effective dates. Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(c) Length of special enrollment periods. Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(d) Special enrollment periods. The Exchange must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

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(1) A qualified individual or dependent loses minimum essential coverage;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

(7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

(8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(e) Loss of minimum essential coverage. Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to—

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128.
45 CFR § 155.430

§ 155.430 Termination of coverage.
(a) General requirements. The Exchange must determine the form and manner in which coverage in a QHP may be terminated.

(b) Termination events. (1) The Exchange must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

(2) The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage, in the following circumstances:

(i) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(ii) Non-payment of premiums for coverage of the enrollee, and

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(A) The 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted as described in § 156.270(g); or,

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The enrollee's coverage is rescinded in accordance with § 147.128 of this subtitle;

(iv) The QHP terminates or is decertified as described in § 155.1080; or

(v) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with § 155.410 or § 155.420.

(c) Termination of coverage tracking and approval. The Exchange must—

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of coverage;

***18464** (2) Send termination information to the QHP issuer and HHS, promptly and without undue delay, at such time and in such manner as HHS may specify, in accordance with § 155.400(b).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage. (1) For purposes of this section, reasonable notice is defined as fourteen days from the requested effective date of termination.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is—

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(iii) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than fourteen days and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of coverage is the day before such coverage begins.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of coverage is the last day of the month following the month in which the notice described in § 155.330(e)(1)(ii) is sent by the Exchange unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of coverage will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of coverage should be consistent with existing State laws regarding grace periods.

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(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

4. Add subpart H to read as follows:

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

Sec.

155.700 Standards for the establishment of a SHOP.

155.705 Functions of a SHOP.

155.710 Eligibility standards for SHOP.

155.715 Eligibility determination process for SHOP.

155.720 Enrollment of employees into QHPs under SHOP.

155.725 Enrollment periods under SHOP.

155.730 Application standards for SHOP.

Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)
45 CFR § 155.700

§ 155.700 Standards for the establishment of a SHOP.
(a) General requirement. An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(b) Definition. For the purposes of this subpart:

Group participation rule means 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.
45 CFR § 155.705

§ 155.705 Functions of a SHOP.
(a) Exchange functions that apply to SHOP. The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, and K of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with § 155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) Unique functions of a SHOP. The SHOP must also provide the following unique functions:

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(1) Enrollment and eligibility functions. The SHOP must adhere to the requirements outlined in §§ 155.710, 155.715, 155.720, 155.725, and 155.730.

(2) Employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(4) Premium aggregation. The SHOP must perform the following functions related to premium payment administration:

(i) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer;

(ii) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees; and

(iii) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

(5) QHP Certification. With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in § 156.285 of this subchapter.

(6) Rates and rate changes. The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually; and

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) QHP availability in merged markets. If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting the following requirements of the small group market:

(i) Deductible maximums described in section 1302(c) of the Affordable Care Act; and

(ii) Levels of coverage described in section 1302(d) of the Affordable Care Act.

(8) QHP availability in unmerged markets. If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) SHOP expansion to large group market. If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market ***18465** through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) Participation rules. The SHOP may authorize uniform group participation rules for the offering of health insurance coverage in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(11) Premium calculator. In the SHOP, the premium calculator described in § 155.205(b)(6) must facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost-sharing reductions.
45 CFR § 155.710

§ 155.710 Eligibility standards for SHOP.
(a) General requirement. The SHOP must permit qualified employers to purchase coverage for qualified employees through the SHOP.

(b) Employer eligibility requirements. An employer is a qualified employer eligible to purchase coverage through a SHOP if such employer—

(1) Is a small employer;

(2) Elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and

(3) Either—

(i) Has its principal business address in the Exchange service area and offers coverage to all its full-time employees through that SHOP; or

(ii) Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

(c) Participating in multiple SHOPs. If an employer meets the criteria in paragraph (b) of this section and makes the election described in (b)(3)(ii) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

(d) Continuing eligibility. The SHOP must treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees of such employer as a qualified employer until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

(e) Employee eligibility requirements. An employee is a qualified employee eligible to enroll in coverage through a SHOP if such employee receives an offer of coverage from a qualified employer.
45 CFR § 155.715

§ 155.715 Eligibility determination process for SHOP.
(a) General requirement. Before permitting the purchase of coverage in a QHP, the SHOP must determine that the employer or individual who requests coverage is eligible in accordance with the requirements of § 155.710.

(b) Applications. The SHOP must accept a SHOP single employer application form from employers and the SHOP single employee application form from employees wishing to elect coverage through the SHOP, in accordance with the relevant standards of § 155.730.

(c) Verification of eligibility. For the purpose of verifying employer and employee eligibility, the SHOP—

(1) Must verify that an individual applicant is identified by the employer as an employee to whom the qualified employer has offered coverage and must otherwise accept the information attested to within the application unless the information is inconsistent with the employer-provided information;

(2) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the applicable application;

(3) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in § 155.710; and

(4) May not perform individual eligibility determinations described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act.

(d) Eligibility adjustment period. (1) When the information submitted on the SHOP single employer application is inconsistent with the eligibility standards described in § 155.710, the SHOP must—

(i) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(ii) Notify the employer of the inconsistency;

(iii) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (d)(1)(ii) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(1)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must—

(A) Notify the employer of its denial of eligibility in accordance with paragraph (e) of this section and of the employer's right to appeal such determination; and

(B) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the notice is sent.

(2) For an individual requesting eligibility to enroll in a QHP through the SHOP for whom the SHOP receives information on the application inconsistent with the employer provided information, the SHOP must—

(i) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(ii) Notify the individual of the inability to substantiate his or her employee status;

(iii) Provide the employee with a period of 30 days from the date on which the notice described in paragraph (d)(2)(ii) of this section is sent to the employee to either present satisfactory documentary evidence to support the employee's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(2)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must notify the employee of its denial of eligibility in accordance with paragraph (f) of this section.

(e) Notification of employer eligibility. The SHOP must provide an employer requesting eligibility to purchase coverage with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination.

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(f) Notification of employee eligibility. The SHOP must notify an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the individual is eligible in accordance with § 155.710 and the employee's right to appeal such determination.

(g) Notification of employer withdrawal from SHOP. If a qualified employer ceases to purchase coverage through the SHOP, the SHOP must ensure that—

(1) Each QHP terminates the coverage of the employer's qualified employees enrolled in the QHP through the SHOP; and

(2) Each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the termination of coverage prior to such termination. Such notification must also provide information about other potential sources of coverage, including access to ***18466** individual market coverage through the Exchange.
45 CFR § 155.720

§ 155.720 Enrollment of employees into QHPs under SHOP.
(a) General requirements. The SHOP must process the SHOP single employee applications of qualified employees to the applicable QHP issuers and facilitate the enrollment of qualified employees in QHPs. All references to QHPs in this section refer to QHPs offered through the SHOP.

(b) Enrollment timeline and process. The SHOP must establish a uniform enrollment timeline and process for all QHP issuers and qualified employers to follow, which includes the following activities that must occur before the effective date of coverage for qualified employees:

(1) Determination of employer eligibility for purchase of coverage in the SHOP as described in § 155.715;

(2) Qualified employer selection of QHPs offered through the SHOP to qualified employees, consistent with § 155.705(b)(2) and (3);

(3) Provision of a specific timeframe during which the qualified employer can select the level of coverage or QHP offering, as appropriate;

(4) Provision of a specific timeframe for qualified employees to provide relevant information to complete the application process;

(5) Determination and verification of employee eligibility for enrollment through the SHOP;

(6) Processing enrollment of qualified employees into selected QHPs; and

(7) Establishment of effective dates of employee coverage.

(c) Transfer of enrollment information. In order to enroll qualified employees of a qualified employer participating in the SHOP, the SHOP must—

(1) Transmit enrollment information on behalf of qualified employees to QHP issuers in accordance with the timeline and process described in paragraph (b) of this section; and

(2) Follow requirements set forth in § 155.400(c) of this part.

(d) Payment. The SHOP must—

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(1) Follow requirements set forth in § 155.705(b)(4) of this part; and

(2) Terminate participation of qualified employers that do not comply with the process established in § 155.705(b)(4).

(e) Notification of effective date. The SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of coverage consistent with § 156.260(b).

(f) Records. The SHOP must receive and maintain for at least 10 years records of enrollment in QHPs, including identification of—

(1) Qualified employers participating in the SHOP; and

(2) Qualified employees enrolled in QHPs.

(g) Reconcile files. The SHOP must reconcile enrollment information and employer participation information with QHPs on no less than a monthly basis.

(h) Employee termination of coverage from a QHP. If any employee terminates coverage from a QHP, the SHOP must notify the employee's employer.

(i) Reporting requirement for tax administration purposes. The SHOP must report to the IRS employer participation, employer contribution, and employee enrollment information in a time and format to be determined by HHS.
45 CFR § 155.725

§ 155.725 Enrollment periods under SHOP.
(a) General requirements. The SHOP must—

(1) Adhere to the start of the initial open enrollment period set forth in § 155.410;

(2) Ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with § 156.260 of this subchapter; and

(3) Provide the special enrollment periods described in § 155.420 excluding paragraphs (d)(3) and (6).

(b) Rolling enrollment in the SHOP. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

(c) Annual employer election period. The SHOP must provide qualified employers with a period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(1) The method by which the qualified employer makes QHPs available to qualified employees pursuant to § 155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in § 155.705(b)(2) and (3); and

(4) The QHP or QHPs offered to qualified employees in accordance with § 155.705.

(d) Annual employer election period notice. The SHOP must provide notification to a qualified employer of the annual election period in advance of such period.

(e) Annual employee open enrollment period. The SHOP must establish a standardized annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(f) Annual employee open enrollment period notice. The SHOP must provide notification to a qualified employee of the annual open enrollment period in advance of such period.

(g) Newly qualified employees. The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an enrollment period to seek coverage in a QHP beginning on the first day of becoming a qualified employee.

(h) Effective dates. The SHOP must establish effective dates of coverage for qualified employees consistent with the effective dates of coverage described in § 155.720.

(i) Renewal of coverage. If a qualified employee enrolled in a QHP through the SHOP remains eligible for coverage, such employee will remain in the QHP selected the previous year unless—

(1) The qualified employee terminates coverage from such QHP in accordance with standards identified in § 155.430;

(2) The qualified employee enrolls in another QHP if such option exists; or

(3) The QHP is no longer available to the qualified employee.
45 CFR § 155.730

§ 155.730 Application standards for SHOP.
(a) General requirements. Application forms used by the SHOP must meet the requirements set forth in this section.

(b) Single employer application. The SHOP must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following—

(1) Employer name and address of employer's locations;

(2) Number of employees;

(3) Employer Identification Number (EIN); and

(4) A list of qualified employees and their taxpayer identification numbers.

(c) Single employee application. The SHOP must use a single application for eligibility determination, QHP selection and enrollment for qualified employees and their dependents.

(d) Model application. The SHOP may use the model single employer application and the model single employee application provided by HHS.

(e) Alternative employer and employee application. The SHOP may use an alternative application if such ***18467** application is approved by HHS and collects the following:

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(1) In the case of the employer application, the information in described in paragraph (b); and

(2) In the case of the employee application, the information necessary to establish eligibility of the employee as a qualified employee and to complete the enrollment of the qualified employee and any dependents to be enrolled.

(f) Filing. The SHOP must allow an employer to file the SHOP single employer application and employees to file the single employee application in the form and manner described in § 155.405(c).

(g) Additional safeguards. The SHOP may not provide to the employer any information collected on the employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.

5. Subpart K is added to read as follows:

Subpart K—Exchange Functions: Certification of Qualified Health Plans

Sec.

155.1000 Certification standards for QHPs.

155.1010 Certification process for QHPs.

155.1020 QHP issuer rate and benefit information.

155.1040 Transparency in coverage.

155.1045 Accreditation timeline.

155.1050 Establishment of Exchange network adequacy standards.

155.1055 Service area of a QHP.

155.1065 Stand-alone dental plans.

155.1075 Recertification of QHPs.

155.1080 Decertification of QHPs.

Subpart K—Exchange Functions: Certification of Qualified Health Plans
45 CFR § 155.1000

§ 155.1000 Certification standards for QHPs.
(a) Definition. The following definition applies in this subpart:

Multi-State plan means a health plan that is offered in accordance with section 1334 of the Affordable Care Act.

(b) General requirement. The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise.

(c) General certification criteria. The Exchange may certify a health plan as a QHP in the Exchange if—

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(1) The health insurance issuer provides evidence during the certification process in § 155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156, as applicable; and

(2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan—

(i) On the basis that such plan is a fee-for-service plan;

(ii) Through the imposition of premium price controls; or

(iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.
45 CFR § 155.1010

§ 155.1010 Certification process for QHPs.
(a) Certification procedures. The Exchange must establish procedures for the certification of QHPs consistent with § 155.1000(c).

(1) Completion date. The Exchange must complete the certification of the QHPs that will be offered during the open enrollment period prior to the beginning of such period, as outlined in § 155.410.

(2) Ongoing compliance. The Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in § 155.1000(c).

(b) Exchange recognition of plans deemed certified for participation in an Exchange. Notwithstanding paragraph (a) of this section, an Exchange must recognize as certified QHPs:

(1) A multi-State plan certified by and under contract with the U.S. Office of Personnel Management.

(2) A CO-OP QHP as described in subpart F of part 156 and deemed as certified under § 156.520(e).
45 CFR § 155.1020

§ 155.1020 QHP issuer rate and benefit information.
(a) Receipt and posting of rate increase justification. The Exchange must ensure that a QHP issuer submits a justification for a rate increase for a QHP prior to the implementation of such an increase, except for multi-State plans, for which the U.S. Office of Personnel Management will provide a process for the submission of rate justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site as required under § 156.210. To ensure consumer transparency, the Exchange must also provide access to the justification on its Internet Web site described in § 155.205(b).

(b) Rate increase consideration. (1) The Exchange must consider rate increases in accordance with section 1311(e)(2) of the Affordable Care Act, which includes consideration of the following:

(i) A justification for a rate increase prior to the implementation of the increase;

(ii) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act; and

(iii) Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

(2) This paragraph does not apply to multi-State plans for which the U.S. Office of Personnel Management will provide a process for rate increase consideration.

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(c) Benefit and rate information. The Exchange must receive the information described in this paragraph, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS. Information about multi-State plans may be provided in a form and manner determined by the U.S. Office of Personnel Management. The information identified in this paragraph is:

(1) Rates;

(2) Covered benefits; and

(3) Cost-sharing requirements.
45 CFR § 155.1040

§ 155.1040 Transparency in coverage.
(a) General requirement. The Exchange must collect information relating to coverage transparency as described in § 156.220 of this subtitle from QHP issuers, and from multi-State plans in a time and manner determined by the U.S. Office of Personnel Management.

(b) Use of plain language. The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) Transparency of cost-sharing information. The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle.
45 CFR § 155.1045

§ 155.1045 Accreditation timeline.
The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.
45 CFR § 155.1050

§ 155.1050 Establishment of Exchange network adequacy standards.
(a) An Exchange must ensure that the provider network of each QHP meets the ***18468** standards specified in § 156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in § 156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under § 156.235(c) of this subtitle.
45 CFR § 155.1055

§ 155.1055 Service area of a QHP.
The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of 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.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.
45 CFR § 155.1065

§ 155.1065 Stand-alone dental plans.
(a) General requirements. The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including § 155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) Offering options. The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) Sufficient capacity. An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) QHP Certification standards. If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.
45 CFR § 155.1075

§ 155.1075 Recertification of QHPs.
(a) Recertification process. Except with respect to multi-State plans and CO-OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review of the general certification criteria as outlined in § 155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.

(b) Timing. The Exchange must complete the QHP recertification process on or before September 15 of the applicable calendar year.
45 CFR § 155.1080

§ 155.1080 Decertification of QHPs.
(a) Definition. The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) Decertification process. Except with respect to multi-State plans and CO-OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meet the requirements in this section.

(c) Decertification by the Exchange. The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c).

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(d) Appeal of decertification. The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) Notice of decertification. Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in § 155.420;

(3) HHS; and

(4) The State department of insurance.

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

6. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, Sections 1301-1304, 1311-1312, 1321, 1322, 1324, 1334, 1341-1343, and 1401-1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18042).

7. Revise the part 156 heading to read as set forth above.

8. Add subpart A to read as follows:

Subpart A—General Provisions

Sec.

156.10 Basis and scope.

156.20 Definitions.

156.50 Financial support.

Subpart A—General Provisions

45 CFR § 156.10

§ 156.10 Basis and scope.

(a) Basis. (1) This part is based on the following sections of title I of the Affordable Care Act:

(i) 1301. QHP defined.

(ii) 1302. Essential health benefits requirements.

(iii) 1303. Special rules.

(iv) 1304. Related definitions.

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(v) 1311. Affordable choices of health benefit plans.

(vi) 1312. Consumer choice.

(vii) 1313. Financial integrity.

(viii) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(ix) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(xi) 1334. Multi-State plans.

(xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) Scope. This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements. 45 CFR § 156.20

§ 156.20 Definitions.
The following definitions apply to this part, unless the context indicates otherwise:

Applicant has the meaning given to the term in § 155.20 of this subchapter.

***18469** Benefit design standards means coverage that provides for all of the following:

(1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in § 155.20 of this subtitle.

Group health plan has the meaning given to the term in § 144.103 of this subtitle.

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Health insurance coverage has the meaning given to the term in § 144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in § 144.103 of this subtitle.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(2) of the Affordable Care Act of plan coverage.

Plan year has the meaning given to the term in § 155.20 of this subchapter.

Qualified employer has the meaning given to the term in § 155.20 of this subchapter.

Qualified health plan has the meaning given to the term in § 155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in § 155.20 of this subchapter.

Qualified individual has the meaning given to the term in § 155.20 of this subchapter.
45 CFR § 156.50

§ 156.50 Financial support.
(a) Definitions. The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.

(b) Requirement for Exchanges user fees. A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by the Federally-facilitated Exchange under 31 U.S.C. 9701 or a State-based Exchange under § 155.160 of this subchapter.

9. Add subpart C to read as follows:

Subpart C—Qualified Health Plan Minimum Certification Standards

Sec.

156.200 QHP issuer participation standards.

156.210 QHP rate and benefit information.

156.220 Transparency in coverage.

156.225 Marketing and Benefit Design of QHPs.

156.230 Network adequacy standards.

156.235 Essential community providers.

156.245 Treatment of direct primary care medical homes.

156.250 Health plan applications and notices.

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156.255 Rating variations.

156.260 Enrollment periods for qualified individuals.

156.265 Enrollment process for qualified individuals.

156.270 Termination of coverage for qualified individuals.

156.275 Accreditation of QHP issuers.

156.280 Segregation of funds for abortion services.

156.285 Additional standards specific to SHOP.

156.290 Non-renewal and decertification of QHPs.

156.295 Prescription drug distribution and cost reporting.

Subpart C—Qualified Health Plan Minimum Certification Standards
45 CFR § 156.200

§ 156.200 QHP issuer participation standards.
(a) General requirement. In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) QHP issuer requirement. A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.

(c) Offering requirements. A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,

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(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) State requirements. A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.

(e) Non-discrimination. A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.
45 CFR § 156.210

§ 156.210 QHP rate and benefit information.
(a) General rate requirement. A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

(b) Rate and benefit submission. A QHP issuer must submit rate and benefit information to the Exchange.

(c) Rate justification. A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.
45 CFR § 156.220

§ 156.220 Transparency in coverage.
(a) Required information. A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

***18470** (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.

(b) Reporting requirement. A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) Use of plain language. A QHP issuer must make sure that the information submitted under paragraph (b) is provided in plain language as defined under § 155.20 of this subtitle.

(d) Enrollee cost sharing transparency. A QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely

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manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.
45 CFR § 156.225

§ 156.225 Marketing and Benefit Design of QHPs.
A QHP issuer and its officials, employees, agents and representatives must—

(a) State law applies. Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) Non-discrimination. Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.
45 CFR § 156.230

§ 156.230 Network adequacy standards.
(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—

(1) Includes essential community providers in accordance with § 156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.
45 CFR § 156.235

§ 156.235 Essential community providers.
(a) General requirement. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

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(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.
45 CFR § 156.245

§ 156.245 Treatment of direct primary care medical homes.
A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.
45 CFR § 156.250

§ 156.250 Health plan applications and notices.
QHP issuers must provide all applications and notices to enrollees in accordance with the standards described in § 155.230(b) of this subtitle.
45 CFR § 156.255

§ 156.255 Rating variations.
(a) Rating areas. A QHP issuer, including an issuer of a multi-State plan, may vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS Act.

(b) Same premium rates. A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.
45 CFR § 156.260

§ 156.260 Enrollment periods for qualified individuals.
(a) Individual market requirement. A QHP issuer must:

(1) Enroll a qualified individual during the initial and annual open enrollment periods described in § 155.410(b) and (e) of this subchapter, and abide by the effective dates of coverage established by the Exchange in accordance with § 155.410(c) and (f) of this subchapter; and

***18471** (2) Make available, at a minimum, special enrollment periods described in § 155.420(d) of this subchapter, for QHPs and abide by the effective dates of coverage established by the Exchange in accordance with § 155.420(b) of this subchapter.

(b) Notification of effective date. A QHP issuer must notify a qualified individual of his or her effective date of coverage.
45 CFR § 156.265

§ 156.265 Enrollment process for qualified individuals.
(a) General requirement. A QHP issuer must process enrollment in accordance with this section.

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(b) Enrollment through the Exchange for the individual market. (1) A QHP issuer must enroll a qualified individual only if the Exchange—

(i) Notifies the QHP issuer that the individual is a qualified individual; and

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter.

(2) If an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange, the QHP issuer must either—

(i) Direct the individual to file an application with the Exchange in accordance with § 155.310, or

(ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

(c) Acceptance of enrollment information. A QHP issuer must accept enrollment information consistent with the privacy and security requirements established by the Exchange in accordance with § 155.260 and in an electronic format that is consistent with § 155.270.

(d) Premium payment. A QHP issuer must follow the premium payment process established by the Exchange in accordance with § 155.240.

(e) Enrollment information package. A QHP issuer must provide new enrollees an enrollment information package that is compliant with accessibility and readability standards established in § 155.230(b).

(f) Enrollment reconciliation. A QHP issuer must reconcile enrollment files with the Exchange no less than once a month in accordance with § 155.400(d).

(g) Enrollment acknowledgement. A QHP issuer must acknowledge receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards established in accordance with § 155.400(b)(2) of this subchapter.
45 CFR § 156.270

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

(b) Termination of coverage notice requirement. If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer must:

(1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with § 155.430(d) of this subchapter.

(2) Notify the Exchange of the termination effective date and reason for termination.

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Effective date of termination of coverage. QHP issuers must abide by the termination of coverage effective dates described in § 155.430(d) of this subchapter.
45 CFR § 156.275

§ 156.275 Accreditation of QHP issuers.
(a) General requirement. A QHP issuer must:

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

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

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

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(iii) Consumer access;

(iv) Utilization management;

(v) Quality assurance;

(vi) Provider credentialing;

(vii) Complaints and appeals;

(viii) Network adequacy and access; and

(ix) Patient information programs, and

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

(b) Timeframe for accreditation. A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.
45 CFR § 156.280

§ 156.280 Segregation of funds for abortion services.
***18472** (a) State opt-out of abortion coverage. A QHP issuer must comply with a State law that prohibits abortion coverage in QHPs.

(b) Termination of opt out. A QHP issuer may provide coverage of abortion services through the Exchange in a State described in paragraph (a) of this section if the State repeals such law.

(c) Voluntary choice of coverage of abortion services. Notwithstanding any other provision of title I of the Affordable Care Act (or any other amendment made under that title):

(1) Nothing in title I of the Affordable Care Act (or any amendments by that title) shall be construed to require a QHP issuer to provide coverage of services described in paragraph (d) of this section as part of its essential health benefits, as described in section 1302(b) of the Affordable Care Act, for any plan year.

(2) Subject to paragraphs (a) and (b) of this section, the QHP issuer must determine whether or not the QHP provides coverage of services described in paragraph (d) of this section as part of such benefits for the plan year.

(d) Abortion services. (1) Abortions for which public funding is prohibited. The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is not permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(2) Abortions for which public funding is allowed. The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(e) Prohibition on the use of Federal funds. (1) If a QHP provides coverage of services described in paragraph (d)(1) of this section, the QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

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(i) The credit under section 36B of the Code and the amount (if any) of the advance payment of the credit under section 1412 of the Affordable Care Act;

(ii) Any cost-sharing reduction under section 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under section 1412 of the Affordable Care Act.

(2) Establishment of allocation accounts. In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:

(i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

(ii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(3) Segregation of funds. (i) The QHP issuer to which paragraph (e)(1) of this section applies must establish allocation accounts described in paragraph (e)(3)(ii) of this section for enrollees receiving the amounts described in paragraph (e)(1) of this section.

(ii) Allocation accounts. The QHP issuer to which paragraph (e)(1) of this section applies must deposit:

(A) All payments described in paragraph (e)(2)(i)(A) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services other than the services described in paragraph (d)(1) of this section;

(B) All payments described in paragraph (e)(2)(i)(B) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (d)(1) of this section.

(4) Actuarial value. The QHP issuer must estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the QHP of services described in paragraph (d)(1) of this section. In making such an estimate, the QHP issuer:

(i) May take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) Must estimate such costs as if such coverage were included for the entire population covered; and

(iii) May not estimate such a cost at less than one dollar per enrollee, per month.

(5) Ensuring compliance with segregation requirements. (i) Subject to paragraph (e)(5)(iv) of this section, the QHP issuer must comply with the efforts or direction of the State health insurance commissioner to ensure compliance with this section through the segregation of QHP funds in accordance with applicable provisions of generally accepted accounting requirements, circulars

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on funds management of the Office of Management and Budget and guidance on accounting of the Government Accountability Office.

(ii) Each QHP issuer that participates in an Exchange and offers coverage for services described in paragraph (d)(1) of this section should, as a condition of participating in an Exchange, submit a plan that details its process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) (hereinafter, "segregation plan") to the State health insurance commissioner. The segregation plan should describe the QHP issuer's financial accounting systems, including appropriate accounting documentation and internal controls, that would ensure the segregation of funds required by section 1303(b)(2)(C), (D), and (E), and should include:

(A) The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of services described in paragraph (d)(1) of this section from those received for coverage of all other services;

(B) The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for services described in paragraph (d)(1) of this section are reimbursed from the appropriate account; and

(C) An explanation of how the QHP issuer's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.

(iii) Each QHP issuer participating in the Exchange must provide to the State insurance commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations.

(iv) Nothing in this clause shall prohibit the right of an individual or QHP issuer to appeal such action in courts of competent jurisdiction.

(f) Rules relating to notice. (1) Notice. A QHP that provides for coverage of services in paragraph (d)(1) of this section, must provide a notice to enrollees, only as part of the summary ***18473** of benefits and coverage explanation, at the time of enrollment, of such coverage.

(2) Rules relating to payments. The notice described in paragraph (f)(1) of this section, any advertising used by the QHP issuer with respect to the QHP, any information provided by the Exchange, and any other information specified by HHS must provide information only with respect to the total amount of the combined payments for services described in paragraph (d)(1) of this section and other services covered by the QHP.

(g) No discrimination on basis of provision of abortion. No QHP offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(h) Application of State and Federal laws regarding abortions. (1) No preemption of State laws regarding abortion. Nothing in the Affordable Care Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) No effect on Federal laws regarding abortion. Nothing in the Affordable Care Act shall be construed to have any effect on Federal laws regarding:

(i) Conscience protection;

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(ii) Willingness or refusal to provide abortion; and

(iii) Discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) No effect on Federal civil rights law. Nothing in section 1303(c) of the Affordable Care Act shall alter the rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964.

(i) Application of emergency services laws. Nothing in the Affordable Care Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Act (popularly known as "EMTALA").
45 CFR § 156.285

§ 156.285 Additional standards specific to SHOP.
(a) SHOP rating and premium payment requirements. QHP issuers offering a QHP through a SHOP must:

(1) Accept payment from the SHOP on behalf of a qualified employer or an enrollee in accordance with § 155.705(b)(4) of this subchapter;

(2) Adhere to the SHOP timeline for rate setting as established in § 155.705(b)(6) of this subchapter; and

(3) Charge the same contract rate for a plan year.

(b) Enrollment periods for the SHOP. QHP issuers offering a QHP through the SHOP must:

(1) Enroll a qualified employee in accordance with the qualified employer's annual employee open enrollment period described in § 155.725 of this subchapter;

(2) Provide special enrollment periods described in § 155.420 excluding paragraphs (d)(3) and (6);

(3) Provide an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period as described in § 155.725(g) of this subchapter; and

(4) Adhere to effective dates of coverage in accordance with § 156.260 and those established through § 155.720 of this subchapter.

(c) Enrollment process for the SHOP. A QHP issuer offering a QHP through the SHOP must:

(1) Adhere to the enrollment timeline and process for the SHOP as described in § 155.720(b) of this subchapter;

(2) Receive enrollment information in an electronic format, in accordance with the requirements in §§ 155.260 and 155.270 of this subchapter, from the SHOP as described in § 155.720(c);

(3) Provide new enrollees with the enrollment information package as described in § 156.265(e);

(4) Reconcile enrollment files with the SHOP at least monthly;

(5) Acknowledge receipt of enrollment information in accordance with SHOP standards; and

(6) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

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(d) Termination of coverage in the SHOP. QHP issuers offering a QHP through the SHOP must:

(1) Comply with the following requirements with respect to coverage termination of enrollees in the SHOP:

(i) General requirements regarding termination of coverage established in § 156.270(a);

(ii) Requirements for notices to be provided to enrollees and qualified employers in § 156.270(b) and § 156.290(b); and

(iii) Requirements regarding termination of coverage effective dates as set forth in § 156.270(i).

(2) If a qualified employer chooses to withdraw from participation in the SHOP, the QHP issuer must terminate coverage for all enrollees of the withdrawing qualified employer.

(e) Participation rules. QHP issuers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP only if and to the extent authorized by the SHOP in accordance with § 155.705 of this subchapter.

45 CFR § 156.290

§ 156.290 Non-renewal and decertification of QHPs.

(a) Non-renewal of recertification. If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must—

(1) Notify the Exchange of its decision prior to the beginning of the recertification process and procedures adopted by the Exchange in accordance with § 155.1075 of this subchapter;

(2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year;

(3) Fulfill data reporting obligations from the last plan or benefit year of the certification;

(4) Provide notice to enrollees as described in paragraph (b) of this section; and

(5) Terminate coverage for enrollees in the QHP in accordance with § 156.270, as applicable.

(b) Notice of QHP non-renewal. If a QHP issuer elects not to seek recertification with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.

(c) Decertification. If a QHP is decertified by the Exchange, the QHP issuer must terminate coverage for enrollees only after:

(1) The Exchange has made notification as described in § 155.1080 of this subchapter; and

(2) Enrollees have an opportunity to enroll in other coverage.

45 CFR § 156.295

§ 156.295 Prescription drug distribution and cost reporting.

(a) General requirement. In a form, manner, and at such times specified by HHS, a QHP issuer must provide to HHS the following information:

(1) The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all

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drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public, that is paid by the QHP issuer or the QHP issuer's contracted PBM;

***18474** (2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding bona fide service fees) that the QHP issuer or its contracted PBM negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed.

(i) Bona fide service fees means fees paid by a manufacturer to an entity that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

(ii) [Reserved]

(3) The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(b) Confidentiality. Information disclosed by a QHP issuer or a PBM under this section is confidential and shall not be disclosed by HHS or by a QHP receiving the information, except that HHS may disclose the information in a form which does not disclose the identity of a specific PBM, QHP, or prices charged for drugs, for the following purposes:

(1) As HHS determines to be necessary to carry out section 1150A or part D of title XVIII of the Act;

(2) To permit the Comptroller General to review the information provided;

(3) To permit the Director of the Congressional Budget Office to review the information provided; or

(4) To States to carry out section 1311 of the Affordable Care Act.

(c) Penalties. A QHP issuer that fails to report the information described in paragraph (a) of this section to HHS on a timely basis or knowingly provides false information will be subject to the provisions of subsection (b)(3)(C) of section 1927 of the Act.
45 CFR § 156.505
9. Section 156.505 is amended by—

A. Revising the definitions of "CO-OP qualified health plan," "Exchange," Individual market," "Issuer," "SHOP," "Small group market," and "State."

B. Removing the definitions of "Group health plan," "Health insurance coverage," "Qualified employer," "Qualified health plan," and "Small employer."

The revisions read as follows:
45 CFR § 156.505

§ 156.505 Definitions.
* * * * *
CO-OP qualified health plan means a health plan that has in effect a certification that it meets the standards described in subpart C of this part, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in § 156.520(e).

Exchange has the meaning given to the term in § 155.20 of this subchapter.

* * * * *

Individual market has the meaning given to the term in § 155.20 of this subchapter.

Issuer has the meaning given to the term in § 155.20 of this subchapter.

* * * * *

SHOP has the meaning given to the term in § 155.20 of this subchapter.

Small group market has the meaning given to the term in § 155.20 of this subchapter.

* * * * *

State has the meaning given to the term in § 155.20 of this subchapter.

45 CFR § 156.510

10. Section 156.510 is amended by revising paragraph (b)(2)(i) to read as follows:

45 CFR § 156.510

§ 156.510 Eligibility.

* * * * *

(b) * * *

(2) * * *

(i) Has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that also sponsors a pre-existing issuer but is not an issuer, a foundation established by a pre-existing issuer, a holding company that controls a pre-existing issuer, or a trade association comprised of pre-existing issuers and whose purpose is to represent the interests of the health insurance industry, provided that the pre-existing issuer sponsored by the nonprofit organization does not share any of its board or the same chief executive with the applicant; or

* * * * *45 CFR § 156.520

§ 156.520 [Amended]

45 CFR § 156.520

11. Section 156.520 is amended by removing paragraph (e)(1), and redesignating paragraphs (e)(2), (3), and (4) as paragraphs (e)(1), (2), and (3) respectively.

12. Part 157 is added to read as follows:

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

Subpart A—General Provisions

Sec.

157.10 Basis and scope.

157.20 Definitions.

Subpart B—[Reserved]

Subpart C—Standards for Qualified Employers

157.200 Eligibility of qualified employers to participate in a SHOP.

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157.205 Qualified employer participation process in a SHOP.
Authority: Title I of the Affordable Care Act, Sections 1311, 1312, 1321, 1411, 1412, Pub. L. 111-148, 124 Stat. 199.

Subpart A—General Provisions
45 CFR § 157.10

§ 157.10 Basis and scope.
(a) Basis. This part is based on the following sections of title I of the Affordable Care:

(1) 1311. Affordable choices of health benefits plans.

(2) 1312. Consumer Choice.

(3) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(4) 1411. Procedures for determining eligibility for Exchange participation, advance payments of the premium tax credit and cost-sharing reductions, and individual responsibility exemptions.

(5) 1412. Advance determination and payment of the premium tax credit and cost-sharing reductions.

(b) Scope. This part establishes the requirements for employers in connection with the operation of Exchanges.
45 CFR § 157.20

§ 157.20 Definitions.
The following definitions apply to this part, unless otherwise indicated:

Qualified employee has the meaning given to the term in § 155.20 of this subchapter.

Qualified employer has the meaning given to the term in § 155.20 of this subchapter.

Small employer has the meaning given to the term in § 155.20 of this subchapter.

Subpart B—[Reserved]

Subpart C—Standards for Qualified Employers
45 CFR § 157.200

§ 157.200 Eligibility of qualified employers to participate in a SHOP.
(a) General requirement. Only a qualified employer may participate in the SHOP in accordance with § 155.710 of this subchapter.

(b) Continuing participation for growing small employers. A qualified employer may continue to participate in the SHOP if it ceases to be a small employer in accordance with § 155.710 of this subchapter.

(c) Participation in multiple SHOPs. A qualified employer may participate in multiple SHOPs in accordance with § 155.710 of this subchapter.
45 CFR § 157.205

§ 157.205 Qualified employer participation process in a SHOP.

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***18475** (a) General requirements. When joining the SHOP, a qualified employer must comply with the requirements, processes, and timelines set forth by this part and must remain in compliance for the duration of the employer's participation in the SHOP.

(b) Selecting QHPs. During an election period, a qualified employer may make coverage in a QHP available through the SHOP in accordance with the processes developed by the SHOP in accordance with § 155.705 of this subchapter.

(c) Information dissemination to employees. A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.

(d) Payment. A qualified employer must submit any contribution towards the premiums of any qualified employee according to the standards and processes described in § 155.705 of this subchapter.

(e) Employees hired outside of the initial or annual open enrollment period. Qualified employers must provide employees hired outside of the initial or annual open enrollment period with:

(1) A period to seek coverage in a QHP beginning on the first day of becoming a qualified employee; and

(2) Information about the enrollment process in accordance with § 155.725 of this subchapter.

(f) New employees and changes in employee eligibility. Qualified employers participating in the SHOP must provide the SHOP with information about dependents or employees whose eligibility status for coverage purchased through the employer in the SHOP has changed, including:

(1) Newly eligible dependents and employees; and

(2) Loss of qualified employee status.

(g) Annual employer election period. Qualified employers must adhere to the annual employer election period to change their program participation for the next plan year described in § 155.725(c) of this subchapter.

Dated: March 1, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 2, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012-6125 Filed 3-12-12; 11:15 am]

BILLING CODE 4120-01-P

Footnotes

1 State Exchange Implementation Questions and Answers, published November 29, 2011: http://cciio.cms.gov/resources/files/Files2/11282011/exchange—q—and—a.pdf.pdf.

2 Guidance for Exchange and Medicaid Information Technology (IT) Systems 1.0 published in November 2010: http://cciio.cms.gov/resources/files/joint—cms—ociio—guidance.pdf.

3 Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information: http://healthit.hhs.gov/portal/server.pt/community/healthit—hhs—gov—privacy—security—framework/1173.

4 http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

5 http://www.healthcare.gov/law/resources/reports/premiums01282011a.pdf.

6 http://cciio.cms.gov/resources/files/Files2/11282011/exchange—q—and—a.pdf.pdf.

7 Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods. February 9, 2012: http://www.dol.gov/ebsa/newsroom/tr12-01.html.

8 This provision is proposed in the Exchange proposed rule at 76 FR 41866 (July 15, 2011) and is addressed in this final rule at § 155.330(d)(2).

9 Exhibit 4.2: Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2011, Employer Health Benefits 2011 Annual Survey. Kaiser Family Foundation.

10 HCFA Insurance Standards Bulletin Series No. 99-03 (September 1999), posted online at https://www.cms.gov/HealthInsReformforConsume/downloads/HIPAA-99-03.pdf.
FN11 Notice of Proposed Rulemaking for Health Coverage Portability: Tolling Certain Time Periods and Interaction with the Family and Medical Leave Act Under HIPAA Titles I and IV, 69 CFR 78000-78825.

12 Available at: http://www.hrsa.gov/grants/apply/assistance/NAP/forms/9needforassistance.pdf.

13 Available at: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

14 Available at: http://www.whitehouse.gov/sites/default/files/omb/assets/financial—pdf/segregation—2010-09-20.pdf.

15 Available at: http://www.whitehouse.gov/sites/default/files/omb/assets/financial—pdf/segregation—2010-09-20.pdf.

16 We direct attention to § 155.220(a)(2) and the preamble for that section for a more detailed discussion.

17 Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act " (Washington, 2009).
a FY 2013 President's Budget, Analytical Perspectives, Table 32-1.

18 'Table of Size Standards Matched To North American Industry Classification System Codes," effective November 5, 2010, U.S. Small Business Administration, available at http://www.sba.gov.

End of Document

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82 FR 18346-01, 2017 WL 1374271(F.R.)
RULES and REGULATIONS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Parts 147, 155, and 156
[CMS-9929-F]
RIN 0938-AT14

Patient Protection and Affordable Care Act; Market Stabilization

Tuesday, April 18, 2017

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

***18346** ACTION: Final rule.

SUMMARY: This rule finalizes changes that will help stabilize the individual and small group markets and affirm the traditional role of State regulators. This final rule amends standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements.
DATES: These regulations are effective on June 19, 2017.

FOR FURTHER INFORMATION CONTACT: Jeff Wu, (301) 492-4305, Lindsey Murtagh, (301) 492-4106, or Michelle Koltov, (301) 492-4225, for general information.
Rachel Arguello, (301) 492-4263, for matters related to Exchange special enrollment periods and annual open enrollment periods.

Erika Melman, (301) 492-4348, for matters related to network adequacy, and essential community providers.

Allison Yadsko, (410) 786-1740, for matters related to actuarial value.

David Mlawsky, (410) 786-6851, for matters related to guaranteed availability.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

Affordable Health Benefit Exchanges, or "Exchanges" are competitive marketplaces through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive advance payments of the premium tax credit to reduce their costs for health insurance premiums, and receive reductions in cost-sharing payments to reduce out-of-pocket expenses for healthcare services.

The stability and competitiveness of the Exchanges, as well as that of the individual and small group markets in general, have recently been threatened by issuer exits and increasing rates in many geographic areas. Some issuers have had difficulty attracting and retaining the healthy consumers necessary to provide for a stable risk pool that will support stable rates. In particular, some issuers have cited special enrollment periods and grace periods as potential sources of adverse selection that have contributed to this problem. Concerns over the risk pool have led some issuers to cease offering coverage on the Exchanges in particular States and counties, and other issuers have increased their rates.

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A stabilized individual and small group insurance market will depend on greater choice to draw consumers to the market and vibrant competition to ensure consumers have access to competitively priced, affordable, and quality coverage. Higher rates, particularly for consumers who are not receiving advance payments of the premium tax credit (APTC) or claiming the premium tax credit, resulting from minimal choice and competition, can cause healthier individuals to drop out of the market, further damaging the risk pool and risking additional issuer attrition from the market. This final rule takes steps to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improve the risk pool and bring stability and certainty to the individual and small group markets, while increasing the options for patients and providers.

To improve the risk pool and promote stability in the individual insurance markets, we are taking several steps to increase the incentives for individuals to maintain enrollment in health coverage and decrease the incentives for individuals to enroll only after they discover they require medical services. First, we are changing the dates for open enrollment in the individual markets for the benefit year starting January 1, 2018, from November 1, 2017 through January 31, 2018 (the previously established open enrollment period for 2018), to extend from November 1 through December 15, 2017. This change requires individuals to enroll in coverage prior to the beginning of the year, unless eligible for a special enrollment period, and is consistent with the open enrollment period previously established for the benefit years starting January 1, 2019, and beyond. This change will improve individual market risk pools by reducing opportunities for adverse selection by those who learn they will need medical services in late December and January; and will encourage healthier individuals who might have previously enrolled in partial year coverage after December 15th to instead enroll in coverage for the full year.

Second, we are responding to concerns from issuers about potential misuse and abuse of special enrollment periods in the individual market Exchanges that enables individuals who are not entitled to special enrollment periods to enroll in coverage after they realize they will need medical services. We are increasing pre-enrollment verification of all applicable individual market special enrollment periods for all States served by the HealthCare.gov platform from 50 to 100 percent of new consumers who seek to enroll in Exchange coverage through these special enrollment periods. We are also making several additional changes to our regulations regarding special enrollment periods that we believe could improve the risk pool, improve market stability, promote continuous coverage, and increase options for patients.

Third, we are revising our interpretation of the Federal guaranteed availability requirement to allow issuers, subject to applicable State law, to apply a premium payment to an individual's past debt owed for coverage from the same issuer or a different issuer in the same controlled group within the prior 12 months before applying the payment toward a new enrollment. We believe this interpretation will have a positive impact on the risk pool by removing economic incentives individuals may have had to pay premiums only when they were in need of healthcare services, particularly toward the end of the benefit year. We also believe this policy is an important means of encouraging individuals to maintain continuous coverage throughout the year.

Fourth, we are finalizing an increase in the de minimis variation in the actuarial values (AVs) used to determine metal levels of coverage for the 2018 plan year and beyond. This change is intended to allow issuers greater flexibility in designing new plans and to provide additional options for issuers to keep cost sharing the same from year to year, while helping stabilize premiums for consumers.

We believe these changes are critical to improving the risk pool, and will together promote more competitive markets with increased choice for consumers.

We are also finalizing policies intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The modified ***18347** approach we are finalizing for network adequacy, which includes deferring to States with sufficient network adequacy review (or relying on accreditation or an access plan), will not only lessen the regulatory burden on issuers, but also will recognize the primary role of States in regulating this area. We are also finalizing changes that will allow issuers to continue to use a write-in process to identify essential community providers (ECPs) who are not on the HHS list of available ECPs for the 2018 plan year; and will lower

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the ECP standard to 20 percent (rather than 30 percent) for the 2018 plan year, which we believe will make it easier for a QHP issuer to build provider networks that comply with the ECP standard.

Robust issuer participation in the individual and small group markets is critical for ensuring consumers have access to affordable, quality coverage, and have real choice in coverage. Continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited. The changes in this rule are intended to promote issuer participation in these markets and to address concerns raised by issuers, States, and consumers. We believe these changes will result in broader choices and more affordable coverage.

II. Background

A. Legislative and Regulatory Overview

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

The PPACA reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 2702 of the PHS Act, as added by the PPACA, requires health insurance issuers that offer non-grandfathered health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage, unless an exception applies.

Section 2703 of the PHS Act, as added by the PPACA, and sections 2712 and 2742 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[FN1] require health insurance issuers that offer health insurance coverage in the group or individual market to renew or continue in force such coverage at the option of the plan sponsor or individual, unless an exception applies.

Section 1302(d) of the PPACA describes the various metal levels of coverage based on AV. Consistent with section 1302(d)(2)(A) of the PPACA, AV is calculated based on the provision of essential health benefits (EHB) to a standard population. Section 1302(d)(3) of the PPACA directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations. Section 2707(a) of the PHS Act directs health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes the EHB package, which includes the requirement to offer coverage at the metal levels of coverage described in section 1302(d) of the PPACA.

Section 1311(c)(1)(B) of the PPACA requires the Secretary to establish minimum QHP certification criteria for provider network adequacy that a health plan must meet.

Section 1311(c)(1)(C) of the PPACA requires the Secretary to establish minimum QHP certification criteria for the inclusion of essential community providers.

Section 1311(c)(6)(B) of the PPACA states that the Secretary is to set annual open enrollment periods for Exchanges for calendar years after the initial enrollment period.

Section 1311(c)(6)(C) of the PPACA states that the Secretary is to provide for special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 (the Code) and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act (the Act) for the Exchanges.

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Section 1321(a) of the PPACA provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the PPACA.

1. Market Rules

A proposed rule relating to the 2014 Health Insurance Market Rules was published in the November 26, 2012 Federal Register (77 FR 70584). A final rule implementing the Health Insurance Market Rules was published in the February 27, 2013 Federal Register (78 FR 13406) (2014 Market Rules).

A proposed rule relating to Exchanges and Insurance Market Standards for 2015 and Beyond was published in the March 21, 2014 Federal Register (79 FR 15808) (2015 Market Standards Proposed Rule). A final rule implementing the Exchange and Insurance Market Standards for 2015 and Beyond was published in the May 27, 2014 Federal Register (79 FR 30240) (2015 Market Standards Rule).

2. Exchanges

We published a request for comment relating to Exchanges in the August 3, 2010 Federal Register (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010.[FN2] We issued a proposed rule in the July 15, 2011 Federal Register (76 FR 41865) to implement components of the Exchanges, and a proposed rule in the August 17, 2011 Federal Register (76 FR 51201) regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers. A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges was published in the March 27, 2012 Federal Register (77 FR 18309) (Exchange Establishment Rule).

In the March 8, 2016 Federal Register (81 FR 12203), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 final rule (2017 Payment Notice), and established additional Exchange standards, including requirements for network adequacy and essential community providers; and established the timing of annual open enrollment periods.

In the September 6, 2016 Federal Register (81 FR 61456), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 proposed rule (proposed 2018 Payment Notice). In the December 22, 2016 Federal Register (81 FR 94058), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 final rule (2018 Payment Notice) and established additional Exchange standards, including requirements for network ***18348** adequacy and essential community providers.

3. Special Enrollment Periods

In the July 15, 2011 Federal Register (76 FR 41865), we published a proposed rule establishing special enrollment periods for the Exchange. We implemented these special enrollment periods in the Exchange Establishment Rule (77 FR 18309). In the January 22, 2013 Federal Register (78 FR 4594), we published a proposed rule amending certain special enrollment periods, including the special enrollment periods described in § 155.420(d)(3) and (7). We finalized these rules in the July 15, 2013 Federal Register (78 FR 42321).

In the June 19, 2013 Federal Register (78 FR 37032), we proposed to add a special enrollment period when the Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity. We finalized this proposal in the October 30, 2013 Federal Register (78 FR 65095). In the March 21, 2014 Federal Register (79 FR 15808), we proposed to amend various special enrollment periods. In particular, we proposed to clarify that later coverage effective dates for birth, adoption, placement for adoption, or placement for foster care would be effective the first of the month. The rule also proposed to clarify that earlier effective dates would be allowed if all issuers in an Exchange agree to effectuate coverage only on the first day of the specified month. Finally, this rule proposed adding that consumers may report a move in advance of the date of the move and established a special enrollment period for individuals losing medically

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needy coverage under the Medicaid program even if the medically needy coverage is not recognized as minimum essential coverage (individuals losing medically needy coverage that is recognized as minimum essential coverage already were eligible for a special enrollment period under the regulation). We finalized these provisions in the May 27, 2014 Federal Register (79 FR 30348). In the October 1, 2014 Federal Register (79 FR 59137), we published a correcting amendment related to codifying the coverage effective dates for plan selections made during a special enrollment period and clarifying a consumer's ability to select a plan 60 days before and after a loss of coverage.

In the November 26, 2014 Federal Register (79 FR 70673), we proposed to amend effective dates for special enrollment periods, the availability and length of special enrollment periods, the specific types of special enrollment periods, and the option for consumers to choose a coverage effective date of the first of the month following the birth, adoption, placement for adoption, or placement in foster care. We finalized these provisions in the February 27, 2015 Federal Register (80 FR 10866). In the July 7, 2015 Federal Register (80 FR 38653), we issued a correcting amendment to include those who become newly eligible for a QHP due to a release from incarceration. In the December 2, 2015 Federal Register (80 FR 75487) (proposed 2017 Payment Notice), we sought comment and data related to existing special enrollment periods, including data relating to the potential abuse of special enrollment periods. In the 2017 Payment Notice, we stated that in order to review the integrity of special enrollment periods, the Federally-facilitated Exchange (FFE) will conduct an assessment by collecting and reviewing documents from some consumers to confirm their eligibility for the special enrollment periods under which they enrolled.

In an interim final rule with comment published in the May 11, 2016 Federal Register (81 FR 29146), we amended the parameters of certain special enrollment periods.

In the 2018 Payment Notice, we established additional Exchange standards, including requirements for certain special enrollments.

4. Actuarial Value

On February 25, 2013, we established the requirements relating to EHBs and AVs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the Federal Register (78 FR 12833) (EHB Rule), implementing section 1302 of the PPACA and 2707 of the PHS Act. In the 2018 Payment Notice published in the December 22, 2016 Federal Register (81 FR 94058), we finalized a provision that allows an expanded de minimis range for certain bronze plans.

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on policies related to the operation of Exchanges. We have held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input, with a particular focus on risks to the individual and small group markets, and how we can alleviate burdens facing patients and issuers. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

III. Provisions of the Proposed Regulations, and Analysis of and Responses to Public Comments

We published the "Patient Protection and Affordable Care Act; Market Stabilization" proposed rule in the February 17, 2017 Federal Register (82 FR 10980) (the proposed rule). We received 4,005 timely comments. The comments ranged from general support for or opposition to the proposed provisions to specific questions or comments regarding proposed changes. We received a number of comments and suggestions that were outside the scope of the proposed rule that will not be addressed in this final rule.

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In this final rule, we provide a summary of each proposed provision, a summary of those public comments received that directly related to the proposals, our responses to them, and a description of the provisions we are finalizing.

Comment: We received comments stating that the comment period was unreasonably short, making it difficult for stakeholders to provide in-depth analysis and input. Some commenters stated that the short comment period represented a violation of the Administrative Procedure Act, 5 U.S.C. Ch. 5, Subch. II, sec. 551 et seq. Commenters suggested that HHS extend the comment period and provide a comment period of 30 or 60 days from the date of publication in the Federal Register.

Response: We published the proposed rule in order to promote issuer participation in the individual and small group markets and to address concerns raised by consumers, States, and issuers. While our general practice is to allow 30 to 60 days for comment, doing so is not specifically required by the Administrative Procedure Act. Because the changes directly affect issuers' plan designs and rates for 2018, HHS determined that it was necessary to have a 20-day comment period to finalize the rule in time for issuers to be able to factor the changes into their plans for the 2018 plan year. In addition, we believe that the short comment period was necessary to implement these changes in time to provide flexibility to issuers to help ***18349** attract healthy consumers to enroll in health insurance coverage, improving the risk pool and bringing additional stability and certainty to the individual and small group markets for the 2018 plan year. Given the limited number of changes to existing rules contemplated by the proposed rule, we believe that the 20-day comment period provided adequate time for interested stakeholders to participate in the rulemaking process by submitting comments. The submission of more than 4,000 comments, many of which provided thoughtful, complex analyses of the proposals, suggests that the timeframe provided interested stakeholders with time to carefully consider and provide input on the proposals.

Comment: We received a number of comments in support of the proposed rule. Those commenters stated that the rule would stabilize and strengthen the risk pool by preventing gaming and encouraging full-year enrollment. In addition, those commenters stated that the proposals in the rule would benefit consumers by increasing coverage options, increasing consumer choice, and putting downward pressure on premiums, which would make coverage more affordable.

Response: We agree that the policies are expected to have a positive impact on stabilizing the markets, increasing consumer choice, and making coverage more affordable.

Comment: We received a number of comments discouraging HHS from finalizing the proposed rule. Some commenters stated that the rule was designed to benefit health insurance companies and would have an adverse impact on consumers' access to affordable health coverage. Commenters noted that they believed the rule would increase premiums and out-of-pocket costs, limit provider networks, and reduce covered benefits. Commenters also believed that the proposed rule would increase the number of uninsured and under-insured individuals. Furthermore, some commenters stated that the proposed rule would weaken the consumer protections offered under the PPACA, limit consumer choices, and limit patients' access to care. Those commenters also noted that the proposals would place undue administrative burdens on consumers and Exchanges. Many of these commenters suggested that additional changes to the Exchanges would cause further uncertainty and confusion for consumers and providers and encouraged HHS to wait to make any regulatory changes until Congress has passed new healthcare reform legislation.

Response: We appreciate the importance of ensuring that coverage purchased through the Exchanges is affordable to consumers, and believe affordability is critical to the success of the Exchanges. We understand commenters' concerns about loosening consumer protections, limiting patients' access to choices of coverage, and increasing administrative burdens. We note that this rule does not change the majority of standards for certification for QHPs, and agree that it is important to promote patients' access to quality coverage. Furthermore, we believe that this rule will improve the risk pools and help stabilize the individual and small group health insurance markets, which will help protect patients and consumers by encouraging issuers to maintain a presence in those markets and lower premiums, thereby increasing consumers' choices of affordable coverage options. We believe prompt regulatory action is necessary to stabilize the markets for the upcoming plan year, and recognize the importance of clearly communicating these changes in light of confusion and uncertainty for consumers and providers.

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

1. Guaranteed Availability of Coverage (§ 147.104)

The guaranteed availability provisions at section 2702 of the PHS Act and § 147.104 require health insurance issuers offering non-grandfathered coverage in the individual or group market to offer coverage to and accept every individual and employer in the State that applies for such coverage, unless an exception applies.[FN3] Individuals and employers typically are required to pay the first month's premium (sometimes referred to as a binder payment) before coverage is effectuated.

We have previously interpreted the guaranteed availability requirement to mean that an issuer is prohibited from applying a binder payment made for a new enrollment to past-due premiums [FN4] owed from any previous coverage and then refusing to effectuate the enrollment based on failure to pay premiums.[FN5] However, should the individual seek to renew existing coverage, the issuer could attribute the enrollee's forthcoming premium payments to any past-due premiums.

In prior rulemaking related to the 2014 Market Rules, HHS received public comments expressing concerns about the potential for individuals with a history of non-payment to take unfair advantage of the guaranteed availability rules by declining to make premium payments, for example, at the end of a benefit year, yet being able to immediately sign up for new coverage for the next benefit year during the individual market open enrollment period.[FN6] In the preamble to the 2014 Market Rules, HHS encouraged States to consider approaches to discourage gaming and adverse selection while upholding consumers' guaranteed availability rights, and indicated an intention to address this issue in future guidance.

To address the concern about potential misuse of grace periods, we proposed to modify our interpretation of the guaranteed availability rules with respect to non-payment of premiums. Under the proposed rule, an issuer would not be considered to violate the guaranteed availability requirements if the issuer attributes a premium payment for coverage under the same or a different product to premiums due to the same issuer within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums. To the extent permitted by applicable State law, this would permit an issuer to require an individual or employer to pay all past-due premiums owed to that issuer for coverage in the prior 12-month period in order to effectuate new coverage from that issuer. Under the proposed rule, an issuer choosing to adopt a policy of attributing payments in this way would be required to apply its premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market regardless of health status, and consistent with applicable non-discrimination requirements.[FN7] The ***18350** proposal would not permit an issuer to condition the effectuation of new coverage on payment of premiums owed to a different issuer, or permit an issuer to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium, as we do not believe it is reasonable to hold persons responsible for payments they were not contractually responsible for making. We stated that if the proposal were to be finalized, we would encourage States to adopt a similar approach, with respect to any State laws that might otherwise prohibit this practice.

Because of rules regarding grace periods and termination of coverage, individuals with past-due premiums would generally owe no more than 3 months of premiums.[FN8] Furthermore, for individuals on whose behalf the issuer received APTC, their past-due premiums would be net of any APTC that was paid on the individual's behalf to the issuer, with respect to any months for which the individual is paying past-due premiums.

We noted that due to operational constraints, the Federally-facilitated Small Business Health Options Program (FF-SHOP) would be unable to offer issuers this flexibility at this time. We solicited comments on the proposal, including on whether issuers that choose to adopt this type of premium payment policy should be permitted to implement it with a premium payment threshold policy, under which the issuer can consider an individual to have paid all amounts due, if the individual pays an amount, as determined by the issuer, that is less than the total past-due premiums. We also solicited comments on whether issuers should be required to provide notice to individuals regarding whether they have adopted a premium payment policy permitted under this proposal.

We are finalizing this proposal as follows. To the extent permitted by applicable State law, an issuer may attribute to any past-due premium amounts owed to that issuer the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage. If the issuer is a member of a controlled group, the issuer may attribute any past-due premium amounts owed to any other issuer that is a member of such controlled group, for coverage in the 12-month period preceding the effective date of the new coverage when determining whether an individual or employer has made an initial premium payment to effectuate new coverage. Consistent with the scope of the guaranteed availability provision and subject to applicable State law, this policy applies both inside and outside of the Exchanges in the individual, small group, and large group markets,[FN9] and during applicable open enrollment or special enrollment periods. This policy does not permit a different issuer (other than one in the same controlled group as the issuer to which past-due premiums are owed) to condition the effectuation of new coverage on payment of past-due premiums or permit any issuer to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premiums.[FN10] As further described later in this preamble, for this purpose, the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Code. We also specify that issuers adopting this premium payment policy, as well as any issuers that do not adopt the policy but are within an adopting issuer's controlled group, must clearly describe in any enrollment application materials, and in any notice that is provided regarding non-payment of premiums, in paper or electronic form, the consequences of non-payment on future enrollment. We encourage States to adopt a similar approach; however, States may narrow the circumstances and conditions under which an issuer may apply a premium payment policy to past-due premiums before effectuating coverage or may prohibit the practice altogether.

The following is a summary of the public comments we received on this proposal, and our responses.

Comment: Many commenters supported the proposal, suggesting that this approach is common in other industries such as housing, utilities, or telecommunications, where past-due payment for prior services must be made prior to restarting the same service. However, many other commenters objected to the proposal, stating that there is no statutory authority for the policy, that there is insufficient evidence of misuse of the grace period, and that individuals fail to make payments for a variety of other reasons, including poor or changing financial situations, poor health, or issuer or Exchange error. One commenter stated that the individual shared responsibility payment that is imposed for months in which non-exempt individuals do not have minimum essential coverage, as well as the fact that individuals have to pay for all of their healthcare expenses during any uninsured period, address any concerns about deliberate misuse of the grace period.

Other commenters who objected to the proposal stated that issuers have other ways, including collection actions, for recovering past-due premiums. Some of these commenters suggested that the individuals most likely to miss their premium payments are younger, healthier individuals, who could help balance the individual market risk pool. A few commenters stated that forcing individuals to pay retroactively for premiums covering months in which they did not seek healthcare will be a disincentive to signing up for coverage.

Response: We believe this interpretation of the guaranteed availability requirement will have a positive impact on the risk pool by removing economic incentives individuals may have had to pay premiums only when they were in need of healthcare services. We also believe this policy is an important means of encouraging individuals to maintain continuous coverage throughout the year and preventing abuses. While the guaranteed availability provision in section 2702 of the PHS Act does not explicitly refer to premium payment, it is clear from reading this provision together with the guaranteed renewability provision in section 2703 of the PHS Act that an issuer's sale and continuation in force of an insurance policy is contingent upon payment of premiums. We do not believe that the guaranteed availability provision is ***18351** intended to require issuers to provide coverage to applicants who have not paid for such coverage. To the extent an individual or employer makes payment in the amount required to effectuate new coverage, but the issuer lawfully credits all or part of that amount toward past-due premiums, the consumer has not made sufficient initial payment for the new coverage.

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With respect to individuals experiencing poor financial circumstances, we note that the PPACA provides for APTC and cost-sharing reductions (CSRs) for low-income individuals, and that increased APTC and CSRs are available as income decreases. We also note that consumers who experience a change in household income during a policy year are instructed to submit updated financial information to an Exchange and may potentially gain new, or additional, APTC or CSRs.

We disagree that the individual shared responsibility payment and paying for healthcare in the absence of coverage are sufficient to prevent abuses of the grace period, given that individuals may qualify for the short coverage gap exemption from the individual shared responsibility payment, and that individuals who misuse the grace period are likely to be individuals in good health who do not wish to make premium payments for periods of time during which they anticipate that they will not incur significant health expenses.

We acknowledge that issuers have ways of collecting debt other than by applying premium payments to past-due premiums. However, the policy in this regulation is intended to achieve a broader purpose than simply assisting issuers in collecting past-due premiums; rather this policy is intended to encourage individuals to maintain continuous coverage (and thereby avoid incurring past-due premiums) in order to help stabilize the risk pool for all participants, and prevent abuse of grace periods.

We believe the notice requirements discussed below, which will inform individuals of the consequences of missing their premium payments, will encourage younger, healthier individuals to maintain continuous coverage. Further, we disagree that requiring individuals to pay premiums owed for the months of prior coverage in which they did not seek healthcare will be a disincentive to signing up for coverage. We believe that with sufficient notice of having to pay past-due premiums before enrolling in new coverage, many individuals will instead opt to keep their coverage by making regular monthly premium payments.

Comment: Several commenters supported expanding the proposal. Some commenters stated that an issuer other than the specific licensed entity to which past-due premiums are owed, such as successors, assignees, commonly owned entities, other issuers within an Exchange, or any other issuer, should be permitted to refuse to effectuate new coverage as a result of unpaid past-due premiums. One commenter stated that limiting the proposal only to the specific licensed entity to which past-due premiums are owed will merely cause consumers to seek coverage from another issuer, thus limiting the policy's intended effect. Although several commenters agreed that the policy should not affect the ability of any individual other than the person contractually responsible for the payment of premiums to purchase coverage (such as the dependent of a policyholder, or an employee, when their employer has past-due premiums), several others commented that the policy should apply to the policyholder and to all covered dependents. For example, if a covered dependent of a former policyholder applies for new coverage, the issuer could refuse to effectuate new coverage for any individual in the enrollment group, unless past-due premiums are paid. Several commenters stated that the policy should permit issuers to collect all past-due premiums before effectuating coverage, even those for coverage beyond the past 12 months. Other commenters, however, suggested that a 12-month look-back is excessively punitive.

Response: In response to comments received, we believe that it will further the goals of this interpretation of guaranteed availability to allow the issuer to which past-due premiums are owed, and any other issuer that is a member of the same controlled group, to refuse to effectuate coverage unless the past-due premiums are paid. For this purpose, the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Code, which is the same definition used for other purposes related to the guaranteed renewability provision.[FN11] We believe this approach strikes a balance between comments suggesting a broad approach when premiums are owed to any issuer and comments favoring a narrow approach specific to premiums owed to the licensed entity. For now, we leave open the question of whether a successor or assignee issuer may take advantage of this flexibility to State interpretation, including in States where HHS is directly enforcing the guaranteed availability requirements. We believe that permitting an issuer to apply the policy to the dependent of a previous policyholder, when that dependent was covered under that previous policyholder's policy, or to an employee, when his or her employer was the previous policyholder, would be unreasonable, as it would require an individual or entity to pay a debt it has no legal obligation to pay. We also believe that a look-back period of 12 months (as opposed to a

longer or shorter period) appropriately balances the objectives of the policy, without being unduly burdensome for consumers or carrying forward a debt owed for months beyond the previous year of coverage. We note that, although the look-back period is for 12 months, individuals with past-due premiums would generally owe no more than 1 to 3 months of premiums; they would not owe premiums for months in which they were not covered.

Comment: One commenter stated that Exchange assisters should inform consumers that if they wish to terminate their coverage, they should do so proactively, rather than simply fail to pay premiums.

Response: We encourage all entities and persons providing enrollment assistance, such as issuers, agents and brokers, Navigators, and other assisters, to educate consumers about how to terminate coverage so that it will not affect their ability to sign up for new coverage.

Comment: Many commenters stated that there should be a hardship exemption from the policy for individuals who are delinquent in their premiums for reasons other than gaming (such as domestic violence, falling victim to a crime, or issuer or Exchange error), and an appeals process for consumers to demonstrate hardship. A few commenters stated that any appeals process should include external review, or HHS review.

Response: States and issuers have the flexibility to create exemptions for extenuating circumstances, and appeals processes by which individuals and employers may demonstrate that they qualify for any such exemptions, as long as the policy is applied uniformly to individuals in similar circumstances in the applicable market within the State and not based on health status and consistent with applicable non- ***18352** discrimination requirements. To the extent a State mandates an appeal or review process, it may also determine the logistics of that process.

Comment: Several commenters requested clarification that if an issuer collects past-due premiums, the issuer should be required to pay claims submitted for that individual during the grace period. They also stated that issuers should be required to immediately notify providers when an enrollee enters the grace period, so the providers could determine whether the providers would be penalized for furnishing non-urgent care, if past-due premiums are not paid. Another commenter stated that when past-due premiums are paid in full during a grace period, issuers should be required to pay all pended claims without the need for the provider to resubmit the claim or claims within 30 days of the enrollee's account becoming current. One commenter stated that if an issuer authorizes care and a provider provides care in reliance on that authorization, the issuer should be responsible for the claim, even if the claim would not otherwise be paid pursuant to the policy in this regulation.

Response: We clarify that issuers are required to pay all appropriate claims for services rendered to the enrollee during any months of coverage for which past-due premiums are collected. In the case of enrollees in the 3 consecutive month grace period, a QHP issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period, regardless of whether past-due premiums are paid, and must notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period, as specified in § 156.270(d). We are not modifying the rules regarding grace periods in this final rule. However, we will consider whether to make changes regarding provider notification requirements in the future.

Comment: We received several comments specific to loss of APTC. Several commenters stated that when individuals lose APTC for a period and then regain it, they have the right to choose whether they would like the APTC to be applied prospectively or retroactively. These commenters stated that Exchanges should be required to confirm with consumers if they would like the APTC to be applied retroactively, to reduce the amount of past-due premiums.

Response: Individuals generally must have their APTCs applied prospectively, and do not have a right to choose to have the APTC applied retroactively. Only in limited circumstances, such as when an eligibility appeal determines that an Exchange erred in its determination of eligibility for APTC, are individuals permitted to have APTC applied retroactively. Where an individual's coverage through the Exchange has been terminated for non-payment of premiums, APTC is not available during any resulting

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coverage gap. While individuals may reapply for APTC to be applied prospectively, APTC cannot be applied retroactively to periods during which the individual's coverage through the Exchange was terminated for non-payment of premiums. We note that individuals whose coverage is terminated at the conclusion of a grace period would owe premiums for the first month of the grace period, net of any APTC paid on their behalf to the issuer, but would not owe for the second and third months of the grace period, because the last day of enrollment in a QHP through the Exchange is the last day of the first month of the 3-month grace period, as outlined in § 155.430(d)(4). Additionally, the individuals would not owe premiums for the months following termination.

Comment: Many commenters stated that issuers should be required to allow individuals to pay past-due premiums in installments, while the issuer sells them new coverage. One commenter stated that, during the installment period, consumers should be permitted to report any income changes, changes in household, or hardships, in order to make adjustments to the repayment plan.

Response: The policy in this final rule permits but does not require issuers to collect past-due premiums before effectuating new coverage. However, we are not requiring issuers that adopt the policy to accept installment payments in this final rule, although State law permitting or requiring issuers to accept such installment payments, as well as any requirements relating to notice of an adjustment to installment periods, would apply, provided the amount of installment payments an issuer will accept, and its decision whether or not to accept installment payments is applied uniformly to individuals or employers in similar circumstances in the applicable market within the State and not based on health status, and consistent with applicable non-discrimination requirements.

Comment: All commenters who commented on whether issuers should be permitted to accept a threshold amount of past-due premiums as payment in full supported this approach. One commenter stated that issuers that have a premium threshold for the binder and monthly premiums should not be required to do so for past-due premiums, and vice-versa. Another commenter stated that HHS should set a threshold that issuers should be required to accept. With respect to the disclosure of whether an issuer will accept a threshold, and the threshold amount, many commenters stated that issuers applying a payment threshold should be required to disclose the amount of the threshold either before purchase of the insurance policy, or at the time of enrollment. One commenter, however, stated that issuers should not be required to provide notice of a threshold, as such notice would incentivize partial payments.

Response: We decline to set a premium payment threshold or mandate that issuers set and apply one, or for those that do, require that they provide any such notice. Rather, issuers may set and apply a threshold to the extent permitted by applicable State law, provided that the issuer does so uniformly for individuals or employers in similar circumstances in the applicable market within the State and without regard to health status, and consistent with applicable non-discrimination requirements. Also, in accordance with the premium payment threshold regulation at § 155.400(g) and guidance, issuers on an FFE, and on the State-based Exchanges on the Federal platform (SBE-FPs), that choose to apply a payment threshold policy must apply the policy in a uniform manner to all enrollees, and are expected to do so for the entire plan year.[FN12] Additionally under that regulation and guidance, if the issuer adopts such a policy, it is expected to apply the policy uniformly to the initial premium payment and any subsequent premium payments, and to any amount outstanding at the end of a grace period for non-payment of premium.

Comment: With respect to the comment solicitation regarding whether notice should be provided by issuers that adopt the premium payment policy, many commenters stated that such notice should be required. However, several commenters stated that no separate notice document is necessary. Rather, commenters stated that notice of the policy could be included on billing statements, any general payment policy notices, on the application, prior to purchase, or on issuers' Web sites. Commenters in favor of requiring notice stated that it should include the consequences of delinquent payment on ***18353** the ability to purchase new coverage from the issuer, and other relevant information. Some commenters recommended this information appear in Plan Compare and in the Exchange eligibility determination notice.

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Response: We agree that notice is important, but do not believe that a separate document is necessary, as issuers already have effective ways of communicating with consumers about premium payment. Therefore, we specify that issuers adopting a premium payment policy permitted under this section, as well as any other issuers that do not adopt the policy but are within an adopting issuer's controlled group, are required to clearly describe, in any enrollment application materials, and in any notice that is provided regarding non-payment of premiums, in paper or electronic form, the consequences of non-payment on future enrollment. We believe this notice is sufficient to inform consumers of their obligations to pay past-due premiums, and are not specifying additional notice in Plan Compare or in the Exchange eligibility determination at this time.

Comment: We received a few comments related to operationalizing the policy. One commenter stated that it would require information technology enhancements for an Exchange to process and store the industry standard code received from issuers that is sent when a consumer does not pay premiums. This would allow the issuer's system and enrollee's account to reflect the enrollment status with the issuer that elected to use their premium payment to satisfy past-due premiums. Due to the new interface requirements, the changes would be a large project and would consume a large amount of resources at considerable expense. Another commenter stated that the policy would require coordination between the Exchanges and issuers, and might require development in Exchanges' billing systems that would require time and resources for deployment. One commenter stated that the policy should be made optional because it is burdensome for issuers to reconcile 60 days of claims in order to reenroll individuals. One commenter asked for confirmation that the FFEs would operationalize the new policy by requiring issuers to send the Exchange a cancellation transaction for an enrollment of an individual who did not pay the outstanding balance by the applicable due date.

Response: As regards technical and operational challenges described by commenters related to permitting issuers to collect past-due premiums before effectuating new coverage, we note that nothing in this rule requires an issuer or Exchange to implement this type of premium payment policy before effectuating new coverage. We also note that these challenges are only applicable to Exchanges that perform premium collection on behalf of issuers, such as the FF-SHOP, which due to operational limitations, is not able to implement the policy at this time. As regards comments about processing enrollment-related transactions, we note that QHP issuers are currently required to communicate to the FFE and to SBE-FPs whether an enrollment is effectuated or cancelled, such as when the individual fails to make sufficient payment to effectuate new coverage.[FN13]

Comment: One commenter stated that the policy should apply only to individuals who enter the grace period, and to past-due premiums accrued, after the effective date of the final rule.

Response: For issuers that choose to adopt the premium payment policy, and for other issuers in such an issuer's controlled group, the requirement to provide notice of the policy will become effective beginning with notices provided 60 days after publication of the final rule. Beginning on or after that date, issuers will not be considered to violate Federal guaranteed availability requirements if they attribute payments toward past-due premiums consistent with this section and then deny enrollment for failure to pay the initial payment for a new enrollment to individuals to whom such notice was provided prior to their failure to pay premiums that become past-due premiums.

In addition to the policy on past-due premiums, we proposed to amend § 147.104(b)(2)(i) to conform to proposed changes to special enrollment periods discussed in greater detail in section III.B.2. of the proposed rule (82 FR 10984). Because the proposed changes to § 155.420(a)(4) and (5) applied to special enrollment periods in the individual market, both inside and outside of an Exchange, we proposed to amend § 147.104(b)(2)(i) to specify that these paragraphs apply to special enrollment periods throughout the individual market. We solicited comments on how these changes would be operationalized outside of the Exchanges.

A summary of those comments are found in section III.B.3. of this final rule. Instead of the proposed changes at § 147.104(b)(2)(i), we are finalizing a new paragraph (b)(2)(iii) of § 147.104 to reflect our decision that the changes in § 155.420(a)(4) in this final rule apply only within the individual market Exchanges.

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B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Patient Protection and Affordable Care Act

1. Enrollment of Qualified Individuals Into QHPs (§ 155.400)
We are finalizing an amendment to § 155.400 to address binder payment requirements that apply when a consumer whose enrollment was delayed due to an eligibility verification opts to delay the coverage start date under § 155.420(b)(5). A more detailed discussion of the pre-enrollment verification procedures for special enrollment periods and the related changes that we are finalizing in § 155.400 are provided in section III.B.3 of this final rule.

2. Initial and Annual Open Enrollment Periods (§ 155.410)
We proposed to amend paragraph (e) of § 155.410, which provides the dates for the annual Exchange open enrollment period in which qualified individuals and enrollees may apply for or change coverage in a QHP. The Exchange open enrollment period is extended by cross-reference to non-grandfathered plans in the individual market, both inside and outside of an Exchange, under guaranteed availability regulations at § 147.104(b)(1)(ii). In prior rulemaking, we established that the open enrollment period for the benefit year beginning on January 1, 2018, would begin on November 1, 2017 and extend through January 31, 2018; and that the open enrollment period for the benefit years beginning on January 1, 2019 and beyond would begin on November 1 and extend through December 15 of the calendar year preceding the benefit year.[FN14] We noted at the time that we believe that, as the Exchanges continue, a month-and-a-half open enrollment period provides sufficient time for consumers to enroll in or change QHPs for the upcoming benefit year. Furthermore, this timeframe would achieve our goals of shifting to an earlier open enrollment end date, so that all consumers who enroll during this time will receive a full year of coverage, which will increase access for patients and simplify operational processes for issuers and the Exchanges. In addition, we noted that we also believe that this shorter open enrollment period may have a positive ***18354** impact on the risk pool because it will reduce opportunities for adverse selection by those who learn that they will need healthcare services in late December or January. Although we originally thought a longer transition period was needed before moving to this shorter open enrollment period, in the proposed rule, we stated that we believe that the market and issuers are now ready for this adjustment sooner. Therefore, we proposed to amend § 155.410(e) to change the open enrollment period for benefit year 2018 so that it begins on November 1, 2017 and runs through December 15, 2017. All consumers who select plans on or before December 15, 2017 would receive an enrollment effective date of January 1, 2018, as already required by § 155.410(f)(2)(i). We noted that we believe that this open enrollment period would align better with many open enrollment periods for employer-based coverage, as well as the open enrollment period for Medicare Advantage.

We solicited comments on this proposal, in particular on the capacity of State Exchanges (SBEs) to shift to the shorter open enrollment period for the 2018 benefit year, on the effect of the shorter enrollment period on issuers' ability to enroll healthy consumers, and any difficulties agents, brokers, Navigators, and other assisters may have in serving consumers seeking to enroll during this shorter time period.

We are finalizing this provision as proposed.

Comment: Many commenters supported our proposal to shift the open enrollment period end date to December 15, 2017 for the 2018 benefit year. These commenters noted that this change will improve the risk pool by encouraging people to maintain coverage and preventing adverse selection from partial-year enrollments, as well as eliminate operational complexity for issuers. Several of these commenters stated that a uniform January 1 coverage start date is an important element in promoting continuous, full-year coverage, and will help prevent gaming by healthy individuals who wait until the end of open enrollment to enroll in coverage with a later effective date, which would help issuers manage risk and develop appropriate rates with consumers enrolled for the full year.

A large number of commenters expressed concerns with our proposal. Among these commenters, many worried that a shorter open enrollment period would reduce enrollment overall. These commenters disagreed that a shorter open enrollment period

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would reduce premiums or improve the health of the risk pool. Instead, they were concerned that it would discourage enrollment by young and healthy consumers, who typically wait until the end of open enrollment to enroll. Others disagreed with the proposal that it was important that the open enrollment timeframe mirror employer-sponsored insurance, pointing out that the enrollees in employer-sponsored insurance have different characteristics from Exchange enrollees and the process for enrolling in health coverage is markedly different.

Response: After consideration of the comments received, we are finalizing an open enrollment period for the 2018 benefit year that begins on November 1, 2017 and runs through December 15, 2017. We had already planned to implement a consistent month-and-a-half open enrollment period beginning with open enrollment for the 2019 benefit year; therefore, we believe that implementing the same open enrollment timeframe 1 year earlier will not increase the burden on consumers or make it harder to enroll. As we have previously stated, shifting to an earlier open enrollment period closing date ensures that consumers who enroll during this time will receive a full year of coverage, which will reduce adverse selection risk for issuers.[FN15] We agree with commenters who noted that ending the open enrollment period on December 15, 2017, for the 2018 benefit year will decrease operational complexity and cost for issuers, since the coverage start date for all enrollments (other than those pursuant to a special enrollment period) will be on the same day (January 1, 2018), and the Exchange open enrollment period will align better with that for employer-based and Medicare Advantage plans. We intend to conduct outreach to consumers to ensure that they are aware that the deadline for enrolling in coverage during the open enrollment period has changed and recognize the importance of targeting young and healthy individuals who, as commenters noted, often wait until close to the deadline to enroll.

Comment: Commenters both in favor of and opposed to the proposed timeframe expressed concern about the burden a shortened open enrollment period could create on the Exchanges and on other resources. These commenters warned that because a greater number of people will be trying to enroll at the same time, Exchanges must increase technology infrastructure and capacity to accommodate this shorter open enrollment period. Commenters stated that implementing this shorter timeframe a year earlier than previously planned does not allow Exchanges sufficient time to work out glitches and fix errors. Some commenters were concerned that agents, brokers, Navigators, and other assisters would be overwhelmed with such a short period of time to assist consumers. Among these commenters, some recommended enhanced funding for Navigators and other assisters, so that they could produce the same quality of assistance in a shorter timeframe. Some commenters worried that the overlap of the Exchange open enrollment period with the Medicare Advantage open enrollment period may confuse consumers, or strain the capacity of agents and brokers. Other commenters expressed concern that a compressed open enrollment period would increase the administrative and marketing burden on issuers, resulting in an increase in administrative costs. Several commenters were concerned that State budgets could not accommodate additional outreach or technology expenditures for the next open enrollment period.

Many commenters worried that the proposed timeframe would cause confusion and hardship for consumers, particularly during the winter holidays and towards the end of school semesters. Some commenters worried that consumers would not have sufficient time to respond to outreach and advertising, review and compare plans and make informed decisions about their coverage, or have their documentation ready and their information verified by an Exchange. Many commenters stated that younger populations, consumers with limited English proficiency, low-income communities, rural communities, and first-time enrollees need more time to process and understand coverage options. Many commenters sought greater specificity on HHS's outreach plans, and encouraged additional education and marketing efforts to ensure that consumers are aware of the shortened open enrollment period.

Response: We believe that shifting the open enrollment period end date to December 15, 2017, for the 2018 benefit year provides sufficient time for all entities involved in the annual open enrollment process to conduct outreach, provide assistance, or enroll in coverage. We intend to conduct outreach to consumers to ensure that they are aware of the newly shortened open enrollment period in advance of the November 1, 2017, start date and are prepared to enroll or re-enroll in 2018 coverage.

***18355** We agree with commenters that, because of the compressed timeframe, consumers may require additional assistance with submitting requested documents and choosing the plan that works best for them. We note that many Navigators already

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focus on the populations who may require this additional help, such as consumers with limited English proficiency and low-income and rural communities.

Comment: Many commenters recommended providing State flexibility to determine open enrollment period timeframes. Other commenters recommended alternative open enrollment period timeframes. Among these commenters, some recommended maintaining the current open enrollment period from November 1 through January 31. Other commenters proposed alternative open enrollment periods lasting from November 1 through December 31, from October 1 through December 15, from January 1 through February 15, or from November 1 to April 15 to align with the tax season. Some commenters recommended structuring open enrollment periods around consumers' birth month, similar to traditional Medicare enrollment, or by consumers' last name. Lastly, other commenters recommended that we allow enrollment year-round.

Response: We believe that a consistent, nationwide, individual market open enrollment period will help prevent consumer confusion and reduce administrative complexity for issuers, agents, brokers, Navigators and other assisters who serve States with FFEs and States with SBEs. Shifting the start date of open enrollment prior to November 1 for the 2018 benefit year would not allow Exchanges, issuers, or assisters adequate time to prepare for open enrollment. Instead, we believe implementing the same open enrollment timeframe for the 2018 benefit year as we will implement for the 2019 benefit year and beyond will help promote stability in the Exchanges and consistency across benefit years. However, we recognize that some SBEs may have operational difficulties this year in transitioning to this shorter open enrollment period. Under their existing regulatory authority, those Exchanges may elect to supplement the open enrollment period with a special enrollment period, as a transitional measure, to account for those operational difficulties.

We intend to closely monitor the implementation of this open enrollment period and will consider whether we should shift to an earlier open enrollment period start date of either October 1 or October 15 for future open enrollment periods.

3. Special Enrollment Periods (§ 155.420)

Section 1311(c)(6) of the PPACA establishes enrollment periods, including special enrollment periods, for qualified individuals for enrollment in QHPs through an Exchange. Section 1311(c)(6)(C) of the PPACA states that the Secretary is to provide for special enrollment periods specified in section 9801 of the Code and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(3) of the PHS Act also directs the Secretary to provide for market-wide special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974.

Special enrollment periods are a longstanding feature of employer-sponsored coverage. They exist to ensure that people who lose health coverage during the year (for example, through non-voluntary loss of minimum essential coverage provided through an employer), or who experience other qualifying events, such as marriage or the birth or adoption of a child, have the opportunity to enroll in new coverage or make changes to their existing coverage. In the individual market, while the annual open enrollment period allows previously uninsured individuals to enroll in new coverage, special enrollment periods are intended, in part, to promote continuous enrollment in health coverage during the benefit year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage.

Our past practice, in many cases, was to permit individuals seeking coverage through the Exchanges to self-attest to their eligibility for most special enrollment periods and to enroll in coverage without further verification of their eligibility or without submitting proof of prior coverage. This practice had the virtue of minimizing barriers to obtaining coverage for consumers, which can, in particular, deter enrollment by healthy individuals. However, as the Government Accountability Office noted in a November 2016 report, relying on self-attestation without verifying documents submitted to show a special enrollment period triggering event could allow applicants to obtain subsidized coverage for which they would otherwise not qualify.[FN16] In addition, allowing previously uninsured individuals who elected not to enroll in coverage during the annual open enrollment period to instead enroll in coverage through a special enrollment period for which they would not otherwise qualify during the benefit year, undermines the incentive for enrolling in a full year of coverage through the annual open enrollment period and

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increases the risk of adverse selection from individuals who wait to enroll until they are sick. Such behaviors can create a sicker risk pool, leading to higher rates and reduced availability of coverage.

a. Pre-Enrollment Verification of Special Enrollment Period Eligibility

In an effort to curb abuses of special enrollment periods, in 2016 we added warnings on HealthCare.gov regarding inappropriate use of special enrollment periods. We also eliminated several special enrollment periods and tightened certain eligibility rules. [FN17] Also in 2016, we announced retrospective audits of a random sampling of enrollments through loss of minimum essential coverage and permanent move special enrollment periods, 2 commonly used special enrollment periods. Additionally, we created a special enrollment confirmation process under which consumers enrolling through common special enrollment periods were directed to provide documentation to confirm their eligibility.[FN18] Finally, we proposed to implement (beginning in June 2017) a pilot program for conducting pre-enrollment verification of eligibility for certain special enrollment periods.[FN19]

As discussed in the 2018 Payment Notice, the impact of special enrollment period verification on risk pools may be complex. Some commenters suggested that additional steps to determine special enrollment period eligibility worsen the problem by creating new barriers to enrollment, with healthier, less motivated individuals, the most likely to be deterred. The pilot was initially planned to sample 50 percent of consumers who were attempting to newly enroll in Exchange coverage ***18356** through certain special enrollment periods in order to provide a statistically sound method to compare the claims experience in the second half of 2017 between individuals subject to pre-enrollment verification with those who were not.

However, based on strong issuer feedback and the potential to help stabilize the market for 2018 coverage, we proposed to increase the scope of pre-enrollment verification of special enrollment periods to all applicable special enrollment periods in order to ensure complete verification of eligibility. We proposed to begin to implement this expanded pre-enrollment verification starting in June 2017. We have consistently heard from issuers and other stakeholders that pre-enrollment verification of special enrollment periods is critical to promote continuous coverage, protect the risk pool, and stabilize rates. We agree that policies and practices that allow individuals to remain uninsured and wait to enroll in coverage through a special enrollment period only after becoming sick can contribute to market destabilization and reduced issuer participation, which can reduce the availability of coverage for individuals.

Therefore, we proposed that HHS conduct pre-enrollment verification of eligibility for Exchange coverage for applicable categories of special enrollment periods for all new consumers in all States served by the HealthCare.gov platform, which includes FFEs and SBE-FPs.

Under pre-enrollment verification, HHS would verify eligibility for new consumers who seek to enroll in Exchange coverage through applicable special enrollment periods. Consumers would be able to submit their applications and select a QHP; then, as is the current practice for most special enrollment periods, the start date of that coverage would be determined by the date of QHP selection. However, the consumers' enrollment would be “pended” until the Exchange completes verification of their special enrollment period eligibility. In this context, “pending” means the Exchange will hold the information regarding QHP selection and coverage start date until special enrollment period eligibility is confirmed, and only then release the enrollment information to the relevant issuer. Consumers would have 30 days from the date of QHP selection to provide documentation, and could either upload documents into their account on HealthCare.gov or send their documents in the mail.

When possible, we intend to make every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means instead of through consumer-submitted documentation. For example, we would verify a birth by confirming the baby's existence through existing electronic verifications or electronically verify that a consumer was denied Medicaid or CHIP coverage, where such information is available. Otherwise, we intend to seek documentation from the individual applying for coverage through the special enrollment period. We noted that, even though we do not currently perform verification for all consumers new to the Exchange, we already require all consumers to provide documentation if they are applying for coverage through a special enrollment period based on certain qualifying events. As proposed, we anticipate approximately the same amount of documentation under the rule that is currently required, and therefore, would not anticipate

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an increased burden on consumers. We solicited comments on the impact on consumers. We also solicited comments on our proposed method for pre-enrollment verification and whether we should retain a small percentage of enrollees outside of the pre-enrollment verification process to conduct the study discussed above. We noted that if we do not, HHS would continue to monitor other indicators of risk where available, in lieu of the statistical comparison. Recognizing that pre-enrollment verification could have the unintended consequence of deterring healthier individuals from purchasing Exchange coverage, we also solicited comments on what strategies HHS should take to increase the chances that these individuals complete the verification process.

In addition, we recommended that SBEs that do not currently conduct pre-enrollment verification of special enrollment period eligibility consider following this approach as well, and requested comment on whether SBEs should also be required to conduct pre-enrollment verification, with an appropriate amount of time to implement such a process, and how long that transition period should be.

We are moving forward with a pre-enrollment verification of eligibility for applicable special enrollment periods as proposed. This initiative will include all States served by the HealthCare.gov platform, which includes FFEs and SBE-FPs. We note that implementation of pre-enrollment verification of special enrollment periods in these States will be phased in, focusing first on the categories with the highest volume and of most concern—such as loss of minimum essential coverage, permanent move, Medicaid/CHIP denial, marriage, and adoption. We intend to closely monitor the effectiveness of pre-enrollment verification methods for those categories of special enrollment periods and will continue to adjust and improve our verification processes in order to ensure accurate determinations of eligibility for all special enrollment periods.

SBEs maintain flexibility to determine whether and how to implement a pre-enrollment verification of eligibility for special enrollment periods. For example, an SBE could consider allowing issuers to conduct the verification, if the SBE itself is unable to implement pre-enrollment verification.

Comment: Commenters expressed concern about the proposal to conduct pre-enrollment verification of eligibility for special enrollment periods, which they fear will increase barriers to enrollment and deter consumers, especially young and healthy consumers, from enrolling in coverage, which will worsen the risk pool. Commenters stated that consumers with ongoing medical needs will spend the time and effort needed to submit documentation, but those without a current or ongoing need for healthcare services or who do not have documents readily available or easily accessible, will be more likely to forgo verifying their eligibility for a special enrollment period. Citing a study that estimated that only 5 percent of eligible consumers enroll through special enrollment periods during the year,[FN20] commenters expressed concern that special enrollment periods are already underutilized and expressed fear that instituting a pre-enrollment verification of eligibility will further reduce the percentage of eligible consumers enrolling through special enrollment periods. Commenters cited early results from a 2016 HHS study of post-enrollment verification of special enrollment periods, which reported a 20 percent decrease in special enrollment period enrollments compared to the same time period in 2015, and found that applications with younger household contacts were less likely to verify their special enrollment periods.[FN21] These commenters warned ***18357** that pre-enrollment verification of special enrollment period eligibility could have a greater impact across both of these measures.

In addition to consumers opting not to submit documents, commenters noted that other groups of consumers, such as those in rural areas, low-income workers, immigrants, and those with limited English proficiency, will likely be disproportionately impacted by a pre-enrollment verification and may experience difficulty submitting their documents, even if qualifying for a special enrollment period and being motivated to enroll in and start new health coverage. These commenters noted that external variables, such as the distance to the nearest assister, agent, or broker; difficulty taking time off work; difficulty obtaining needed documents; or confusion about which documents to submit and how, all affect consumers' ability to submit documents. For example, commenters maintained that farm workers often have difficulty documenting that they moved and consumers living in rural areas may be unable to easily copy or upload documents. For the special enrollment periods for loss of minimum essential coverage and permanent move, commenters raised concerns that even though consumers may be enrolled or recently enrolled in coverage, they may still have difficulty submitting documents due to the fact that issuers and health plans are no longer required to send enrollees certificates of credible coverage (commenters requested that this prior HIPAA requirement be reinstated) and

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due to printing and re-printing delays at State Medicaid agencies. Other commenters mentioned that the event that qualifies the consumer for a special enrollment period, such as a permanent move, may itself impair the consumer's ability to submit required documentation on time. Therefore, several commenters requested that the document submission deadline be extended from 30 to 60 or 90 days, and that consumers be able to request a deadline extension if they are having difficulty gathering documents.

In addition to concerns about consumers' ability to gather and submit needed documents, commenters expressed concerns about possible delays in enrollment due to system issues, processing backlogs, and long wait times, confusion, or lack of information at the Exchange call center. Commenters were concerned that these delays could have serious negative health consequences for consumers, especially children. Several commenters requested that the FFE exclude from pre-enrollment verification any special enrollment periods that are often used to enroll children, such as the special enrollment periods for birth, adoption, foster care placement, court order, and Medicaid or CHIP denial.

Commenters noted that there are still many unknowns about the consumers who enroll in coverage through special enrollment periods, including a lack of evidence demonstrating misuse and abuse. In addition, commenters observed, that to the extent that misuse and abuse exist, it is unclear whether requiring pre-enrollment verification will serve as an effective deterrent. Some commenters requested that we share this data before proceeding with pre-enrollment verification or that we continue to collect data about consumer behavior by continuing with post-enrollment verification of eligibility for special enrollment periods. Other commenters stated that, if the FFE is to proceed with pre-enrollment verification of eligibility for special enrollment periods, it should proceed with caution by rolling it out slowly, in order to permit sufficient education of stakeholders and other entities involved, to address any unanticipated technical or other issues that may arise, and to collect robust data about impacted consumers. Many of these commenters recommended that the FFE start with a randomly selected pilot that would subject 50 percent of applicants attempting to enroll through a special enrollment period to pre-enrollment verification, as originally planned, while other commenters recommended proceeding with a 90 percent pilot, assuming the remaining 10 percent constitute a statistically significant control group.

In contrast, other commenters support conducting a pre-enrollment verification of eligibility for all applicants attempting to enroll through a special enrollment period. These commenters noted that pre-enrollment verification is the existing standard in the small group market, so it makes sense to apply the same standard to the individual market. Commenters requested that HHS establish consistent standards for verifying eligibility both across special enrollment periods and across markets, so that consumers are treated the same. Several issuers requested that the FFE agree to share collected documents with issuers at their request in order to assist with verifying enrollments outside of the Exchange. These commenters stated that performing pre-enrollment verification of eligibility for all special enrollment periods is a necessary next step to deter bad actors and prevent misuse and abuse of special enrollment periods. Doing so, commenters stated, will drive down premium costs in the future, which will benefit consumers across the individual market.

Commenters who supported robust pre-enrollment verification of eligibility for special enrollment periods stated that it was not necessary to exclude any consumers from being subject to pre-enrollment verification and urged us to proceed with verifying 100 percent of consumers attempting to enroll in coverage through a special enrollment period. Some commenters stated that we could use enrollment data from the past 2 years as a control group for the purpose of measuring any potential consumer impact of a pre-enrollment verification of eligibility.

Response: We appreciate commenters' concerns about the potential impact that pre-enrollment verification may have on young and healthy consumers, and their decision about whether to complete the steps needed to verify their eligibility. We are acutely aware of the importance of attracting healthy consumers to the individual market, and Exchanges in particular, in order to stabilize and improve the risk pool. As we implement pre-enrollment verification, we will seek to monitor enrollments by different groups of individuals affected by this process to determine its impact. In addition, we appreciate the concerns that certain consumers, especially vulnerable populations, may face barriers to gathering and timely submitting documents, and that delays in enrollment can have a negative impact on consumers', especially children's, health. We plan to conduct trainings for both internal and external stakeholders, so that they understand what the new pre-enrollment verification requirements are,

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what information will be available, and how to successfully prove one's eligibility for each special enrollment period where documentation will be required. We are also committed to expediting review of these documents to minimize any delay, and will be equipping our call center with frequent status updates in order to assist in answering questions that may arise.

We understand that consumers may not currently possess or may require time to gather the necessary documents to verify their eligibility, and intend to exercise reasonable flexibility with respect to the documentation required under this policy. We believe that documentation is likely to be most difficult for consumers who qualify for ***18358** the loss of minimum essential coverage, permanent move, or Medicaid or CHIP denial special enrollment periods. Therefore, we will permit consumers to send us the details about their qualifying event with an explanation of why they are unable to submit requested documentation, and we will take their letters into consideration when deciding whether to exercise reasonable flexibility. In addition, in response to the comments regarding certificates of credible coverage, we note that under sections 1502 and 1514 of the PPACA and section 6055 of the Code, enrollees have proof of previous year health coverage via their tax statements, which may be helpful in some circumstances. We also note that the Exchanges will accept many other types of documentation from consumers seeking to verify their prior coverage, including letters from insurers, employers, and government health programs.

Despite the concerns raised, we believe that in order to help stabilize the individual market, we must implement a robust pre-enrollment verification of eligibility for special enrollment periods where new consumers will have their eligibility verified. This will help ensure that consumers are not misusing special enrollment periods, which we anticipate will both improve the risk pool and reduce premiums for all Exchange enrollees. Therefore, we are proceeding as proposed to implement pre-enrollment verification of eligibility for special enrollment periods beginning in June 2017. Stakeholders will receive additional updates from us in the coming months.

Comment: Commenters supported using electronic verification, to the extent possible, to verify eligibility for special enrollment periods. Commenters stated that using electronic data sources will minimize any potential burden on consumers seeking to enroll and any delays in starting their coverage. A few commenters requested that the FFE wait to begin a pre-enrollment verification of eligibility until methods for electronically verifying eligibility for all special enrollment periods were in place. Other commenters requested that we continue to explore the use of additional electronic data sources, and several issuers offered to work with us on this effort. Absent a streamlined method for electronic verification of all special enrollment periods, commenters expressed concerns about the lack of Federal staff and resources available to adjudicate documents in a timely manner, especially when the work is layered on top of ongoing post-enrollment documentation verification for inconsistencies. Commenters noted the increased costs to the Federal government due to increased staffing needs and secure storage of submitted documents, and the additional time both consumers and assisters will need to spend to adhere to these new requirements. A few commenters indicated that a pre-enrollment verification of special enrollment period eligibility may also affect other entities, such as issuers and medical providers who would incur costs in re-submitting or refiling claims, processing retroactive claims, and effectuating retroactive enrollments. One commenter suggested that HHS's cost analysis include these costs, as well as the consumer cost of spending time requesting that claims be re-billed.

Response: We appreciate commenters' support for using electronic data sources, to the extent possible, to verify eligibility for special enrollment periods, and agree that the use of electronic data sources will minimize the burden on consumers and facilitate faster verifications. For these reasons, we intend to make every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means when possible. Furthermore, we are exploring ways to enhance and expand our use of electronic verification to other special enrollment periods in the near future. We hope to minimize any burden on other stakeholders by swiftly reviewing any verification documents received and releasing pended enrollments as quickly as possible.

We appreciate the concerns about the increased burden and cost that a documentation requirement for pre-enrollment verification of eligibility for special enrollment periods will have on all entities involved. We are dedicated to reviewing all special enrollment period documents received as quickly as possible in order to minimize delays. Although we recognize that gathering and submitting these documents can be difficult and time consuming, we do not believe that this places a new burden on

consumers and those providing enrollment assistance since consumers are already required to submit documentation to prove their eligibility after enrollment for 5 common special enrollment periods. Because of our plans for timely document review, we do not believe that new costs will be incurred by issuers, medical providers, or consumers needing to re-submit, refile, or re-bill for claims for services received due to this new requirement.

Comment: Many commenters requested that States be provided flexibility on whether and how to implement a pre-enrollment verification of eligibility for special enrollment periods. Several States commented that they already have procedures and policies in place to verify eligibility for special enrollment periods, and would prefer to continue using methods that make sense for their State. Commenters also expressed concern about the technical build that would be required for SBEs to mirror the proposed process for FFEs and SBE-FPs, and several States commented that they do not think they could be ready for a June 2017 implementation date. Commenters who supported requiring SBEs to conduct a pre-enrollment verification of eligibility for enrollment through special enrollment periods expressed an interest in standardizing requirements and processes across Exchanges, so that all consumers are held to the same standards and treated the same.

Response: While we appreciate the benefits of consistency across Exchanges and markets to ensure fair and equal treatment of consumers, we believe it is important to provide States with flexibility to adopt policies that fit the needs of their State, and will not require a State to conduct pre-enrollment verification. However, we encourage SBEs to implement pre-enrollment verification as soon as possible, and hope that they will utilize creative and innovative methods to do so, including allowing issuers to perform the verification on behalf of the SBE. In addition, we recognize that several SBEs have already made progress in developing methods for verifying eligibility for special enrollment periods.

b. Special Enrollment Period Limitations for Existing Enrollees

As noted above, the pre-enrollment verification of special enrollment period eligibility is intended to address concerns about potential adverse selection among qualified individuals who are new to the Exchanges. However, we have heard concerns that existing Exchange enrollees are utilizing special enrollment periods to change plan metal levels based on health needs that emerge during the benefit year, and that this is having a negative impact on the risk pool. As discussed in the proposed rule, we have concerns about pending a new enrollment until pre-enrollment verification is conducted for current Exchange enrollees, who would still have an active policy. We believe the potential overlap of current, active policies and pended new enrollments would cause significant confusion for consumers and create burdens on issuers with respect to managing the potential operational issues. For ***18359** example, if a current enrollee seeks to add a new spouse under the marriage special enrollment period, the current coverage would generally remain in force until the consumer submits documentation to verify the marriage. At that time, the pended new enrollment for both individuals would be released, potentially with a retroactive coverage effective date based on the date of the plan selection, and the current coverage with the single enrollee would be retroactively terminated to when the new policy begins. If the new plan selection is with a new issuer, any claims incurred during the time period the new enrollment is pended would need to be reconciled across the issuers.

As an alternative to performing pre-enrollment verification of special enrollment period eligibility for existing Exchange enrollees, we proposed to limit the ability of existing Exchange enrollees to change plan metal levels during the benefit year. This proposed change was reflected in regulatory text by proposed revisions to the introductory text of § 155.420(d), and the proposed additions of paragraphs (a)(3) and (4) to § 155.420. We proposed that paragraph (a)(4) would also apply in the individual market outside the Exchanges, but would not apply in the group market. We proposed changes to §§ 147.104(b)(2)(i) and 155.725(j)(2)(i) to specify this. We solicited comments on all aspects of the proposal, including whether it would be preferable to address adverse selection concerns for existing enrollees by applying the approach of pending plan selections until pre-enrollment verification is completed based on document reviews instead of the proposed restrictions based on current plan and metal level. We also solicited comments on any alternative strategies for addressing potential adverse selection issues for existing enrollees who are eligible for a special enrollment period.

We understand that SBEs may not be able to implement these changes starting in 2017, and sought comments on an appropriate transitional period for SBEs, or whether these changes should be optional for SBEs.

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Under new paragraph (a)(4)(i) of § 155.420, we proposed to require that, if an enrollee qualifies for a special enrollment period due to gaining a dependent as described in paragraph (d)(2)(i), the Exchange may allow him or her to add the new dependent to his or her current QHP (subject to the ability to enroll in silver level coverage in certain circumstances as discussed in the next paragraph). Alternatively, if the QHP's business rules do not allow the new dependent to enroll (for example, because the QHP is only available as self-only coverage), the Exchange may allow the enrollee and his or her new dependent to enroll in another QHP within the same level of coverage (or an “adjacent” level of coverage, if no such plans are available), as defined in § 156.140(b). Alternatively, new dependents may enroll by themselves in a separate QHP at any metal level. This proposal sought to ensure that enrollees who qualify for the special enrollment period due to gaining a dependent are using this special enrollment period for its primary purpose of enrolling the new dependent in coverage. We stated in the proposed rule that, if finalized, we intended to implement this policy for the FFEs and SBE-FPs as soon as practicable.

Section 155.420(a)(4)(ii) proposed to require that if an enrollee or his or her dependent is not enrolled in a silver level QHP and becomes newly eligible for cost-sharing reductions and qualifies for the special enrollment periods in paragraphs (d)(6)(i) and (ii) of § 155.420, the Exchange may allow the enrollee and dependent to enroll in a QHP at the silver level, as specified in § 156.140(b)(2), if they choose to change their QHP enrollment. We solicited comments on this proposal, including with respect to whether individuals newly eligible for APTC who qualify for the special enrollment periods at § 155.420(d)(6)(i) and (ii) should also be able to enroll in a silver level QHP, or QHPs at other metal levels.

Paragraph (a)(4)(iii) of § 155.420 proposed that, for an enrollee who qualifies for the remaining special enrollment periods specified in paragraph (d), the Exchange generally need only allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage, as defined in § 156.140(b), if other QHPs at that metal level are available. This restriction would extend to enrollees who are on an application where a new applicant is enrolling in coverage through a special enrollment period. As proposed, this rule would ensure that enrollees who qualify for a special enrollment period or are on an application where an applicant qualifies for a special enrollment period to newly enroll in coverage are not using this special enrollment period to simply switch levels of coverage during the benefit year. This policy would apply to most Exchange enrollees who qualify for a special enrollment period during the benefit year, further protecting issuers from adverse selection. Affected special enrollment periods include special enrollment periods for enrollees who lost minimum essential coverage through the Exchange during the benefit year in accordance with paragraph (d)(1); demonstrated to the Exchange that the QHP into which they have enrolled has violated a material provision of its contract in accordance with paragraph (d)(5); gained access to a new QHP due to a permanent move in accordance with paragraph (d)(7); or were affected by material plan or benefit display errors in accordance with paragraph (d)(12). Enrollees who qualify for the special enrollment periods in paragraphs (d)(4), (d)(9), and (d)(10) would be excluded from this new requirement because the qualifying events that enable them to qualify for these special enrollment periods may also result in an inability to enroll in their desired plan during the annual open enrollment period. In addition, we proposed to exclude the special enrollment period in paragraph (d)(8) for Indians and their dependents from this requirement. We solicited comments on the proposal, and whether other special enrollment periods should be excluded. We also solicited comments on the appropriate transitional period to enable SBEs to build these capacities, or whether the proposals in paragraph (a)(4) should be at the option of the Exchanges. Lastly, we solicited comments on how this proposal would be operationalized in the individual market outside of the Exchanges.

For Exchanges, we are finalizing these provisions largely as proposed, with slight changes to make it clearer that the new paragraph (a)(3) of § 155.420 is applicable, in all circumstances, except for the circumstances specified in paragraph (a)(4) (relating to restrictions limiting the plans into which current enrollees may enroll through certain special enrollment periods). Paragraph (a)(3) applies to qualified individuals who are not current enrollees, as well as current enrollees other than current enrollees covered by paragraph (a)(4), such as Exchange enrollees who are eligible for a special enrollment period under paragraph (d)(4), as this special enrollment period is excepted from new paragraph (a)(4)(iii). We are also modifying proposed paragraph (a)(4)(iii) of § 155.420 to clarify that this new requirement applies to current enrollees, whether the current enrollee qualifies for a special enrollment period or whether a new qualified individual being added to the current enrollee's QHP qualifies

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for a special enrollment period, as discussed earlier in this final ***18360** rule, and to allow these individuals to enroll in an “adjacent” level of coverage, if no other plans are available at their current metal level.

We are also modifying the proposed policy in light of comments received, such that new paragraph (a)(4) will not apply to the individual market outside of the Exchanges because we recognize that requiring issuers outside of the Exchanges to implement this provision would significantly increase issuer burden by requiring the creation of new enrollment systems that would use information that the issuer may not currently possess about the metal level of a consumer's prior coverage. We also recognize that outside of the Exchanges, issuers can perform pre-enrollment verification of special enrollment period eligibility, which mitigates concerns about misuse of special enrollment periods by current enrollees outside of the Exchanges. Accordingly, we are finalizing a new paragraph (b)(2)(iii) in § 147.104, rather than the proposed amendments to § 147.104(b)(2)(i). Lastly, we are making a technical correction by finalizing new text at § 155.725(j)(7), rather than the proposed amendment to § 155.725(j)(2)(i), to clearly reflect that § 155.420(a)(4) will not apply in the group markets outside of the Exchanges or in the SHOP.

Comment: Many commenters expressed concerns about our proposal to limit current Exchange enrollees' ability to change plans or metal levels in new proposed § 155.420(a)(4). Commenters primarily noted that limiting consumer choice with regard to QHP enrollment is prohibited by section 1311(c)(6)(C) of the PPACA and violates the guaranteed issue provision at 42 U.S.C. 300gg-1, in addition to being inconsistent with current industry practice for employer-sponsored coverage, HIPAA, and Medicare Part D. Commenters noted that that the events that qualify these Exchange enrollees for special enrollment periods midyear may also impact the type of coverage they qualify for, the amount of coverage they can afford, and the level of coverage they need. Commenters also observed that special enrollment periods are natural times for households to re-evaluate their healthcare spending. In addition, commenters expressed concerns that this policy would disadvantage consumers who enroll in coverage through the Exchanges during the annual open enrollment period and subsequently experience a qualifying event and want to change their QHP enrollment, as opposed to those who are enrolled in off-Exchange coverage at the beginning of the benefit year and then, upon experiencing a qualifying event, decide to enroll in QHP coverage through the Exchanges. The latter group would be able to view and select among all QHPs for which they are qualified, while the former group would not. For young and healthy consumers, commenters warned that this lack of choice may incentivize them to drop coverage midyear, rather than maintain coverage in a QHP or at a metal level they no longer want. Some commenters requested clarification on the issue that HHS is trying to solve with this proposed policy and requested data to justify implementing these restrictions. One commenter expressed doubt that this policy, if finalized, would be an effective method to protect issuers from gaming and other misuse of special enrollment periods.

In contrast, several commenters supported restricting enrollees' ability to change metal levels during the year, which they believe will increase the integrity of the Exchange markets and improve the risk pool by reducing adverse selection and preventing households from re-evaluating healthcare needs midyear, as opposed to during open enrollment like the rest of the individual market. Several commenters expressed general support for this policy, but requested that HHS permit consumers who qualify for any of these special enrollment periods to be able to change their QHP enrollment to a different QHP at the same metal level or a lower metal level. In addition, one commenter supports this proposal as a short-term strategy to reduce misuse and abuse of special enrollment periods, but would prefer that we move toward verification of eligibility for special enrollment periods for existing Exchange enrollees in the future, and another commenter preferred that the agency require verification of eligibility for special enrollment periods right away.

Response: We understand commenters' concerns about limiting enrollees' choice when they qualify for a special enrollment period during the benefit year and appreciate the fact that households' health coverage needs may change throughout the year. However, we believe putting these restrictions in place is necessary in order to stabilize the Exchanges, which will benefit all Exchange enrollees moving forward. We continue to encourage enrollees to explore all available QHPs during open enrollment and to change plans if another QHP better meets their or their family's needs.

We considered the concerns regarding conflicts with the statute, but believe that limiting enrollees' ability to change QHPs or metal levels is consistent with the requirements in section 1311(c)(6)(C) of the PPACA directing the Secretary to require

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Exchanges to establish special enrollment periods as specified in section 9801 of the Code and under circumstances similar to such periods under Part D of title XVIII of the Act, as well as the Secretary's authority under section 2702(b)(3) of the PHS Act to promulgate regulations for the individual market with respect to special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. Given that the PPACA itself called for one annual open enrollment period and additional enrollment opportunities only in the case of special circumstances, we believe it is reasonable to interpret the special enrollment period and guaranteed issue provisions of the PPACA in this manner.

Comment: Commenters expressed concerns about our proposal at § 155.420(a)(4)(i) to limit the ability of existing enrollees to change QHPs when enrolling a new dependent. Commenters stated that this restriction may negatively affect the healthcare access and health of babies and children, especially if their parents' current coverage is not well suited to their needs, for example, if it does not cover their needed pediatric doctors or medication or other services for a specific health condition. Several commenters supported restricting the ability of new parents or any applicable existing enrollees to change their QHP enrollment, but many disagreed with placing the same restrictions on new minor dependents, especially babies, for whom the family is unable to anticipate their healthcare needs in advance. Several commenters requested that we establish an exceptions process for babies who have increased healthcare needs that would not be covered under their parents' existing plan. Commenters also noted that changes in household size, which are likely the case for all consumers qualifying for one of the gain a dependent special enrollment periods at § 155.420(d)(2)(i), may impact a household's ability to qualify for new, more cost-effective QHPs or to newly qualify for, or qualify for more, financial assistance.

Some commenters requested that in addition to implementing this new restriction on enrollees' ability to change their QHP, HHS clarify that the special enrollment periods at § 155.420(d)(2)(i) are only intended for the new dependent and that other members of the household may not enroll in or change coverage through this special enrollment period.

***18361** Response: We appreciate the concerns raised by commenters about potential impacts of this policy on new dependents, especially babies and children, and would like to clarify that, under this policy, new dependents could enroll in a new QHP at any metal level, if they enroll in a separate QHP from other existing enrollees. The restrictions on changing QHPs only applies when the new dependent is enrolling in the same QHP with those who are already QHP enrollees. We also remind commenters that the special enrollment period at § 155.420(d)(2)(i) as currently written is intended for both those who have gained a dependent or become a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support or other court order. Therefore, both the dependent and the individual who gained a dependent are entitled to newly enroll in a QHP, or, if current enrollees, change to a new QHP at the same metal level if the new dependent cannot be added to the existing QHP because of applicable business rules. Alternatively, the dependent can enroll in a new policy at any metal level.

Comment: Commenters raised concerns about § 155.420(a)(4)(ii) negatively affecting consumers who, despite newly qualifying for cost-sharing reductions, would prefer to enroll in a QHP at a different metal level and forgo those cost-sharing reductions. Commenters were divided on the anticipated impact of this proposal, with some commenters stating that most enrollees in this situation are likely to already be enrolled in a silver plan or that this is likely the level of coverage they will want given their change in circumstance, so there would be minimal impact of this restriction.

Response: We understand commenters' concerns about limiting the ability of these consumers to change to the QHP metal level that they believe will be most beneficial. However, the rationale behind this particular special enrollment period is to allow individuals newly eligible for cost-sharing reductions to enroll in a plan through which they could receive cost-sharing reductions.

Comment: Commenters supported excluding members of Federally recognized tribes or Alaska Native Claims Settlement Act Corporation Shareholders from the new requirements at § 155.420(a)(4)(iii). Several commenters expressed concern about the metal level restrictions in paragraph (a)(4)(iii) if an existing enrollee qualifies for a special enrollment period and there are no other QHPs at their current metal level into which he or she could enroll. Commenters stated that this provision would prevent this consumer from utilizing that special enrollment period.

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Response: We agree that members of Federally recognized tribes or Alaska Native Claims Settlement Act Corporation Shareholders should not be subject to these new requirements and are finalizing their exclusion as proposed. We also agree that, in the event that an enrollee qualifies for a special enrollment period or is adding an individual to his or her existing QHP during the year through a special enrollment period and there are no other QHPs at the enrollee's current metal level into which he or she can enroll, he or she should be permitted to enroll in an adjacent level of coverage. We have amended paragraph (a)(4)(iii) to reflect this flexibility.

Comment: Commenters expressed concern that the complexity of these proposals will lead to consumer confusion, as well as confusion by assisters and others providing enrollment assistance. The level of complexity of these requirements also raised concerns for commenters about SBEs' ability to both build for and comply with these requirements, and the commenters requested that States be given flexibility with respect to implementation. One commenter also questioned how these requirements could be implemented outside of the Exchange, where issuers do not currently receive information about consumers' prior coverage. To that end, commenters noted that these provisions would be burdensome to implement, requiring significant technical builds by Exchanges and stakeholder trainings.

Response: We acknowledge the complexity of these provisions and are taking time to properly plan for their implementation, including developing needed resources for consumers, agents, brokers, Navigators, and other assisters so that they will understand available options. While we encourage SBEs to implement these provisions as quickly as possible, we also appreciate that it will require time for them to make sure that the provisions are implemented correctly. We agree that it would be difficult to implement these requirements outside of the Exchanges, where issuers do not currently receive information about consumers' prior coverage, and therefore are not finalizing our proposal to apply the requirements in new § 155.420(a)(4) outside of the individual market Exchanges, and are finalizing revised language in § 147.104 to reflect this.

c. Special Enrollment Period Coverage Effective Dates

In the 2018 Payment Notice, HHS finalized paragraph (b)(5) to allow a consumer to request a later coverage effective date than originally assigned if his or her enrollment was delayed due to an eligibility verification and the consumer would be required to pay 2 or more months of retroactive premium in order to effectuate coverage or avoid cancellation. When finalizing this amendment, we did not limit how much later the coverage effective date could be. After further consideration of concerns raised by stakeholders regarding potential adverse selection impacts, we proposed modifying that option and instead allowing consumers to start their coverage no more than 1 month later than their effective date would ordinarily have been, if the special enrollment period verification process delays their enrollment such that they would be required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation. We interpret 2 or more months of retroactive premium to mean that, at the time that the enrollment transaction is sent by the FFE to the issuer, no less than 2 months has elapsed from the date that the consumer's coverage was originally scheduled to begin. As proposed, a consumer who was originally scheduled to begin coverage on March 1, may elect to have coverage start on (and premiums payable for) April 1, if at the end of the document verification process, the enrollment transaction was sent to the issuer at such a time that would require retroactive payment of premiums for March and April. We noted that we do not anticipate that many consumers would be eligible to request a later effective date under this paragraph, as we do not expect the pre-enrollment verification processes to result in such delays. However, we recognized that there may be unforeseen challenges as we implement the verification process and believe it is important to offer this flexibility in the event of such delays. We also noted that we believe the option to have a later effective date could help keep healthier individuals in the market, who otherwise might be deterred by the prospect of paying for 2 or more months of retroactive coverage that they did not use. We solicited comments on this proposal, and the appropriate coverage effective date for these consumers.

We are finalizing this policy as proposed, but are making a technical correction to clarify that these consumers would be required to pay ***18362** retroactive premiums in order to avoid cancellation in accordance with § 155.430(e)(2), as opposed to termination. Additionally, in response to comments and to ensure that there is no conflict or confusion with existing binder payment rules we are revising our existing binder payment regulation in new § 155.400(e)(1)(iv) to specify that, in the case

of a pended enrollment due to special enrollment period eligibility verification, the consumer's binder payment must consist of the premiums due for all months of retroactive coverage through the first prospective month of coverage consistent with the consumer's coverage start date, as described in § 155.420(b)(1), (2) and (3) or, if elected, (b)(5), and that the deadline set by the issuer for making this binder payment must be no earlier than 30 calendar days from the date that the issuer receives the enrollment transaction.

Comment: Commenters were divided in their response to the proposal to modify § 155.420(b)(5) to allow consumers whose enrollment was delayed due to verification of their eligibility for special enrollment periods and owe 2 or more months of retroactive premium to push their coverage start date forward 1 month, at the option of the consumer. Some commenters supported this proposal and stated that it balanced the needs of different stakeholders. Other commenters supported this proposal for providing consumer flexibility. They maintained that consumers should not have to pay premiums for several months of retroactive coverage caused by processing delays beyond the consumer's control. Other commenters opposed the proposal because it would limit existing consumer flexibility. They contended that, if verification of special enrollment periods was delayed by more than 2 months, then consumers should have the flexibility to select an appropriate coverage effective date in accordance with the current § 155.420(b)(5), and not be limited to a coverage effective date only 1 month later than the date originally assigned. Additional commenters raised concerns about the fact that consumers might be in this situation due to delays at an Exchange and recommended that our policy instead be that if consumers' verification is delayed by 5 or more days (other commenters suggested by 15 or more days) due to delays at an Exchange, then the Exchange should release their pended enrollment, so that they may start using their coverage.

Other commenters opposed the proposal because they stated it could promote adverse selection. They contended that healthy consumers would be incentivized to delay their coverage effective date by 1 month, while sicker consumers would not. They recommended that, if the rule is finalized, consumers should be required to select their coverage effective date at the time of QHP selection. The appropriate coverage effective date should then be sent to the issuer through the consumer's enrollment transaction. In addition, a few commenters recommended that this paragraph be amended to limit this flexibility to delays caused by the Exchanges, as opposed to including consumer delays in submitting documentation.

Several commenters expressed the need for State flexibility in adopting and implementing this proposal. Finally, a few commenters questioned how the proposal would coordinate with a continuous coverage requirement and urged HHS to consider that when crafting future policy around continuous coverage. Specifically, commenters were concerned that delays in verification could result in coverage lapses for which consumers could be penalized if policies requiring continuous coverage or the imposition of a waiting period or premium surcharge were adopted.

Response: We appreciate the variety of perspectives received on this proposal and agree with commenters that this provision strikes a balance of providing consumer flexibility while protecting from adverse selection. We clarify that consumers who qualify for a special enrollment period due to adoption, placement for adoption, placement in foster care, or through a child support or other court order at § 155.420(d)(2)(i), are still entitled to the alternative coverage effective date options as described in paragraphs § 155.420(b)(2)(i) and (v), at the option of the Exchange. In addition, any SBE conducting a pre-enrollment verification of eligibility for special enrollment periods must also provide this flexibility for consumers. For the FFEs and SBE-FPs, we plan to implement this provision initially through a manual process, and will explore ways to automate such a date shift in the future. SBEs are encouraged to do the same.

d. Tightening Other Special Enrollment Periods

As part of our enhanced verification efforts for special enrollment periods, we proposed to take additional steps to strengthen and streamline the parameters of several existing special enrollment periods and ensure consumers are adhering to existing and new eligibility parameters to further promote continuity of coverage and market stability.

First, in order to ensure that a special enrollment period for loss of minimum essential coverage in paragraph (d)(1) is not granted in cases where an individual was terminated for non-payment of premium, as described in paragraph (e)(1), we proposed

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that FFE (and SBE-FPs) will permit the issuer to reject an enrollment for which the issuer has a record of termination due to non-payment of premiums by the individual, unless the individual fulfills obligations for premiums due for previous coverage, consistent with the guaranteed availability approach discussed in the preamble of this final rule for § 147.104. We noted that we believe that verifying that consumers are not attempting to enroll in coverage through the special enrollment period for loss of minimum essential coverage when the reason for their loss of coverage is due to non-payment of premiums is an important measure to prevent instances of gaming related to individuals only paying premiums and maintaining coverage for months in which they seek services.

Further, HHS intends to explore options for verifying that a consumer's coverage was not terminated due to non-payment of premiums for coverage within the FFEs as a precursor for being eligible for the loss of minimum essential coverage special enrollment period. We proposed to allow Exchanges to collect and store information from issuers about whether consumers have been terminated from Exchange coverage due to nonpayment of premiums, so that the Exchange may automatically prevent these consumers from qualifying for the special enrollment period due to a loss of minimum essential coverage, if the consumer attempts to renew his or her Exchange coverage within 60 days of being terminated. We noted that we are focused on the 60 days following termination because if the consumer attempts to renew his or her Exchange coverage more than 60 days after being terminated due to nonpayment of premiums, the Exchange would continue to find the consumer ineligible for a special enrollment period because the loss of minimum essential coverage would be more than 60 days prior, and therefore the individual would not be eligible for the loss of minimum essential coverage special enrollment period.

We are finalizing these provisions as proposed, and we additionally clarify that the FFE (and SBE-FPs) will permit the issuers in the same controlled group ***18363** as the issuer that has a record of termination due to non-payment of premiums to refuse to effectuate new coverage, unless the individual pays sufficient premiums to fulfill his or her obligations for past-due premiums and to make the required binder payment, consistent with the guaranteed availability approach discussed in the preamble for § 147.104, and the binder payment requirements in § 155.400(e).

Comment: Commenters had mixed reactions to our proposals to allow issuers to reject enrollments from consumers previously terminated from coverage due to nonpayment of premiums, and our proposal to allow the FFE to store this information from issuers in order to prevent these consumers from qualifying for a special enrollment due to loss of minimum essential coverage due to termination for nonpayment of premiums.

Commenters in support of these proposals stated that they are necessary to prevent misuse of the special enrollment period for loss of minimum essential coverage. Some stated that the proposals help support continuous coverage by ensuring that consumers do not stop paying their premiums in order to be terminated from coverage for a portion of the year only to re-enroll in coverage when health needs arise. Encouraging both proper use of special enrollment periods and continuous coverage, commenters stated, will improve the risk pool moving forward.

Commenters opposing these proposals cautioned that there are legitimate reasons why consumers might stop paying their premiums midyear that are unrelated to a desire to game the system, such as a reduction in household income, other pressing needs that affect household finances, or technical issues in making premium payments. In addition, some commenters observed that some consumers who want to terminate their coverage experience difficulty or confusion over how to end it, resulting in termination due to nonpayment of premiums. Commenters expressed concern that giving issuers the authority to reject enrollments received through the Exchange is a slippery slope towards allowing issuers to make eligibility determinations for coverage, and asked that HHS ensure that Exchanges continue to make eligibility determinations. Finally, commenters expressed concern that HHS may be making it too difficult for consumers to enroll in coverage with these proposals, leading to consumers getting caught in a cycle of being uninsurable.

Response: We appreciate commenters' concerns about our proposals to prevent consumers who were terminated from coverage due to nonpayment of premium from enrolling in coverage midyear through a special enrollment period due to loss of minimum essential coverage, but believe that these provisions are an important step to ensuring that consumers are not obtaining Exchange

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coverage through special enrollment periods only when healthcare needs arise. We believe that it is important for consumers to maintain continuous coverage both as protection against unforeseen health needs and to create stability in the individual market, and therefore are finalizing these provisions as proposed, with a modification to reflect the revised interpretation of guaranteed availability discussed in the preamble for § 147.104.

Second, in response to concerns that consumers are opting not to enroll in QHP coverage during the annual open enrollment period and are instead newly enrolling in coverage during the benefit year through the special enrollment period for marriage, we proposed to add new paragraph (d)(2)(i)(A) to require that, if consumers are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must demonstrate having had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage. However, we noted that we recognize that individuals who were previously living in a foreign country or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage in accordance with 26 CFR 1.5000A-1(b) prior to moving to the U.S. Therefore, we proposed new paragraph (a)(5), to allow that, when consumers are newly enrolling in coverage during the benefit year through the special enrollment period for marriage, at least one spouse must either demonstrate that they had minimum essential coverage or that they lived in a foreign country or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. We proposed this change for the individual market only.

We are finalizing this provision for the individual market as proposed, with minor modifications to § 155.420(a)(5) to: (1) Clarify that by those living outside of the U.S, we mean those living in a foreign country; and (2) exempt Indians, as defined by section 4 of the Indian Health Care Improvement Act, from this requirement due to the fact that the Indian Health Service has not been designated as minimum essential coverage.

Comment: Some commenters supported the proposal to add a new prior coverage requirement for at least one spouse applying for coverage through the special enrollment period for marriage at § 155.420(d)(2)(i)(A) because they believed this new requirement will deter abuse and adverse risk selection and is similar to current special enrollment period eligibility processes for small group plans. Commenters stated that this requirement supports continuous coverage and should also be extended to all applicable special enrollment periods. One commenter requested that it be extended to both spouses. Commenters requested that any prior coverage standards and verification methods be standardized across markets.

However, many commenters opposed this proposal and expressed concern that requiring a prior coverage requirement for the special enrollment period for marriage is prohibited by section 1311(c)(6)(C) of the PPACA and violates guaranteed issue provisions at 42 U.S.C. 300gg-1, in addition to being inconsistent with current industry practice for employer sponsored coverage, HIPAA, and Medicare Part D. Commenters stated that the existing individual shared responsibility provision is a sufficient deterrent to prevent these consumers from avoiding coverage prior to marriage, if otherwise eligible. Of particular concern to these commenters was that one or both spouses may have been ineligible for affordable coverage prior to marriage due to the gap in insurance affordability program eligibility for individuals under the poverty line in States that did not expand their Medicaid program.

Some commenters also expressed concern that this requirement and any onerous verification process will discourage participation of newly married individuals, who are more likely to be part of the young and healthy population needed to balance the risk pool. Commenters also expressed concern that consumers who qualify for this special enrollment period may have had prior coverage but may not have documentation to submit due to the elimination of the prior HIPAA requirement for issuers and health plans to send enrollees certificates of credible coverage, and requested that, in the event that this provision is finalized, that this requirement be reinstated.

In addition, commenters requested that SBEs be given flexibility on the effective date of this provision, ***18364** recognizing the resources needed to comply, and to allow for adequate time for implementation.

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Response: We agree with comments noting the potential for this provision to reduce adverse selection and promote continuous coverage. The proposed rule aims to stabilize the individual market, such that coverage will be more accessible and affordable for all potential enrollees.

We considered the concerns regarding conflicts with the statute, but believe that the additional requirement for marriage special enrollment period eligibility is consistent with the requirement in section 1311(c)(6)(C) of the PPACA directing the Secretary to require Exchanges to establish special enrollment periods as specified in section 9801 of the Code and under circumstances similar to such periods under Part D of title XVIII of the Act and the Secretary's authority under section 2702(b)(3) of the PHS Act to promulgate regulations for the individual market with respect to special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. The PPACA itself called for one annual open enrollment period and additional opportunities for enrollment only in the case of special circumstances. Section 155.420(d) provides each of the special enrollment periods required by section 1311(c)(6)(C) of the PPACA and section 2702(b)(3) of the PHS Act. Section 1321(a) of the PPACA grants the Secretary broad discretion to issue regulations setting standards with respect to the operation of the Exchange program and other requirements the Secretary determines are appropriate to support its viability. Given that there is nothing in section 1311(c)(6)(C) of the PPACA that otherwise limits the Secretary's broad discretion under section 1321(a) of the PPACA, we believe we may place reasonable limits on access to special enrollment periods that promote the overall goal of the PPACA to ensure continuous health coverage and the viability of Exchanges.

We are also sensitive to commenter concerns regarding the coverage gap that might prevent some consumers from having access to affordable coverage prior to marriage. However, if the married couple's combined income makes them newly eligible for APTC then that couple would be able to qualify for the special enrollment period for consumers in this situation at § 155.420(d)(6)(iv), and would not need to enroll through the marriage special enrollment period.

We appreciate commenters' concerns that adding a prior coverage requirement to the marriage special enrollment period would discourage enrollment by this population, but we believe that this requirement is important to ensure that previously uninsured individuals do not negatively impact the risk pool. In response to the comments regarding certificates of credible coverage, we note that per sections 1502 and 1514 of the PPACA and section 6055 of the Code, enrollees have proof of previous year health coverage via their tax statements that may help in certain circumstances. We also note that the FFEs and SBE-FPs will accept other types of documentation from consumers to verify their prior coverage, including letters from insurers, employers, and government health programs. We will also exercise reasonable flexibility with respect to the documentation required under this policy.

While we are not adjusting the effective date of the regulation, we understand that the prior coverage requirement may require system changes that take additional time for some SBEs and expect that Exchanges will implement the requirement as soon as technically feasible.

Comment: Commenters requested that members of Federally recognized tribes and Alaska Claims Settlement Act Corporation Shareholders be excluded from this requirement because the Indian Health Service, a major provider of healthcare services for members of Federally recognized tribes, is not designated as minimum essential coverage, thus individuals moving off of tribal land after a marriage and seeking to enroll in Exchange coverage will not be able to prove prior coverage.

Response: We agree with commenters that members of Federally recognized tribes and Alaska Claims Settlement Act Corporation Shareholders should be excluded from this prior coverage requirement, in addition to the prior coverage requirement for permanent move at § 155.420(d)(7), and finalize a modification to our proposed regulation at § 155.420(a)(5) accordingly.

To streamline our regulations regarding special enrollment periods that require consumers to demonstrate prior coverage, we proposed to add new paragraph (a)(5) to clarify that qualified individuals who are required to demonstrate prior coverage can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event or that they lived in a foreign country or in a U.S. territory for 1 or

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more days during the 60 days preceding the date of the qualifying event. Paragraph (a)(5) would apply to paragraph (d)(2)(i)(A) for marriage (discussed above) and paragraph (d)(7)(i) for permanent move and paragraph (a)(5) would replace current paragraph (d)(7)(ii).

We did not receive comment on this proposal and are finalizing it as proposed, with minor modifications: (1) To clarify that by those living outside of the U.S. we mean those living in a foreign country; and (2) to exempt Indians, as defined by section 4 of the Indian Health Care Improvement Act, from this requirement due to the fact that the Indian Health Service is not designated as minimum essential coverage. Additionally, the finalized amendments to § 155.725(j) include a change to the proposed text to reflect that the new prior coverage requirement for the marriage special enrollment period under § 155.420(d)(2) does not apply outside of the individual market. The proposed rule had incorrectly cross-referenced § 155.420(a)(5), which describes how the prior coverage requirement may be satisfied. We had not intended in the proposed rule to prevent individuals applying for special enrollment periods under § 155.420(d)(7) in the SHOP from satisfying the prior coverage requirement as specified under § 155.420(a)(5). We note that § 155.420(a)(5) is already incorporated through the cross-references to revised § 155.420(d) in § 155.725(j)(2)(i). Similarly, we note that we are finalizing that § 155.420(a)(5), specifying how an individual can demonstrate prior coverage, applies in the individual market outside of the Exchange, but determined that the proposed change to § 147.104(b)(2)(i), which would have specified this, is not necessary because § 155.420(a)(5) is already incorporated through the cross-reference to revised § 155.420(d) in § 147.104(b)(2).

We acknowledge that the proposed rule included changes for special enrollment periods in the individual market that differ from the rules regarding special enrollment periods in the group market. For example, the proposed rule included changes that would require consumers to demonstrate prior coverage to qualify for the special enrollment period for marriage in proposed paragraph (d)(2)(i)(A) and would generally limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period during the benefit year in proposed paragraph (a)(4). However, we noted that we believe that the differences in the markets—and the impacts of those differences on the risk pool—warrant an ***18365** approach in the individual market that diverges from long-standing rules and norms in the group market. Employer-sponsored coverage is generally a more stable risk pool and less susceptible to gaming because the coverage is tied to employment and often substantially subsidized by the employer. Thus, we noted that we believe taking an approach in the individual market that imposes tighter restrictions on special enrollment periods and the ability to change plans for current enrollees better addresses the unique challenges faced in the individual market. We also noted that this approach is consistent with the requirement in section 1311(c)(6)(C) of the PPACA directing the Secretary to require Exchanges to establish special enrollment periods as specified in section 9801 of the Code and under circumstances similar to such periods under Part D of title XVIII of the Act and the Secretary's authority under section 2702(b)(3) of the PHS Act to promulgate regulations for the individual market with respect to special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. We interpret section 1311 of the PPACA and section 2702 of the PHS Act to require the Secretary to implement special enrollment periods with the same triggering events as in the group market, but to provide the Secretary with flexibility in the specific parameters as to how those special enrollment periods are implemented in the individual market, due to the unique dynamics of the individual market.

Third, we proposed to expand the verification requirements related to the special enrollment period for a permanent move in paragraph (d)(7). This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move and had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from a foreign country or a U.S. territory. (Following finalization of the changes discussed above to paragraph (a)(5), individuals will also be exempt from demonstrating prior coverage if they demonstrate they are Indians.) Currently, we require documentation to show a move occurred, and accept an attestation regarding having had prior coverage or moving from a foreign country or a U.S. territory. To ensure that consumers meet all the requirements for this special enrollment period, we proposed to require that new applicants applying for coverage through this special enrollment period submit acceptable documentation to the FFEs and SBE-FPs to prove both their move and evidence of prior coverage, if applicable, through the pre-enrollment verification process.

We are finalizing this provision as proposed and intend to release guidance on what documentation would be acceptable.

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Comment: Comments were mixed regarding our proposal to expand the verification requirements for individuals seeking a permanent move special enrollment period. Commenters who supported this proposal stated that requiring and verifying prior coverage is necessary to prevent misuse and abuse of this special enrollment period, which will protect the risk pool.

Commenters who opposed this proposal expressed concerns that some individuals may have been ineligible for affordable coverage where they were previously living or may experience barriers to providing proof of prior coverage. Commenters expressed concerns about consumer capacity to procure needed documents, especially if the consumer was formerly enrolled in Medicaid. Others expressed specific concerns about the ability of vulnerable low-income workers who often move for work to produce documentation, since their employers often do not provide documentation and insurance companies are no longer required to do so via certificates of credible coverage.

In addition, several commenters supported using electronic methods to verify both prior coverage and the permanent move, when able, to decrease the burden on consumers.

Response: We appreciate commenters' input on the merits and drawbacks of requiring consumers to submit evidence of prior coverage or evidence that they are exempt from the requirement to show prior coverage. Although we agree that some consumers may have legitimate reasons for not obtaining coverage prior to their move, we established in prior rulemaking that prior coverage is generally a requirement to qualify for the permanent move special enrollment period, and we did not propose to change this requirement in the proposed rule. We agree with those commenters who believed that the proposed additional verification steps were necessary to prevent abuse and misuse of this special enrollment period, and therefore, we will finalize our proposal to verify prior coverage for this special enrollment period, when applicable. As mentioned earlier in this section, we will also exercise reasonable flexibility with respect to the documentation required under this policy.

We agree with comments regarding use of electronic verification where available and are investigating our ability to expand our use of electronic verification and encourage SBEs to do the same. We also clarify that these changes only apply in the individual market.

Fourth, for the remainder of 2017 and for future plan years, we proposed to significantly limit the use of the exceptional circumstances special enrollment period described in paragraph (d)(9). In previous years, this special enrollment period has been used to address eligibility or enrollment issues that affected large cohorts of individuals where they had made reasonable efforts to enroll but were hindered by outside events. For example, in past years, the FFEs have offered exceptional circumstances special enrollment periods to groups of consumers who were enrolled in coverage that they believed was minimum essential coverage at the time of enrollment, but was not. We proposed to apply a more rigorous test for future uses of the exceptional circumstances special enrollment period, including requiring supporting documentation where practicable, under which we would only grant this special enrollment period if provided with sufficient evidence to conclude that the consumer's situation was highly exceptional and in instances where it is verifiable that consumers were directly impacted by the circumstance, as practicable. We would provide guidance on examples of situations that we believe meet this more rigorous text and what corresponding documentation consumers would be required to provide, if requested by the FFE.

We are finalizing this provision as proposed.

Comment: We received comments both supporting and opposing our proposal to limit the use of the special enrollment period for exceptional circumstances. One commenter supported this proposal because of a belief that this special enrollment should only be used for truly exceptional circumstances and should not be used to provide a pathway to coverage for large categories of consumers.

Commenters opposing the proposal generally expressed concern that Exchanges have already imposed sufficient constraints with regard to granting eligibility for this special enrollment period and expressed concern that this proposal would prevent

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eligible consumers experiencing situations outside of their control from enrolling in coverage. Commenters also ***18366** questioned whether HHS would be able to adequately establish guidelines for this special enrollment period because it is used for situations that are unanticipated and unpredictable. Several commenters requested that HHS publish more guidance either in the final rule or guidance as to what qualifies as an exceptional circumstance for the purposes of this special enrollment period.

A few commenters noted the importance of allowing SBEs flexibility to determine what constitutes an exceptional circumstance.

Response: The exceptional circumstances special enrollment period provides an important avenue to coverage for consumers who experience or are affected by unanticipated events, often outside of their control. We agree that this special enrollment period should be granted as consistently as possible based on established criteria, while still allowing enough flexibility to account for the inherent unpredictability of exceptional circumstances. Currently, the vast majority of exceptional circumstances special enrollment periods granted through the FFEs are reviewed in detail by HHS staff and evaluated based on standardized protocols. We believe this process balances the need for standardization and flexibility while ensuring that claims of exceptional circumstances can be verified. HHS expects to continue using this process as it applies a more rigorous test for future uses of the exceptional circumstances special enrollment period. We believe SBEs should retain the flexibility to determine what constitutes an exceptional circumstance, but we urge them to establish a similar process to grant such special enrollment periods consistently and, to help in this effort, as we mentioned in the proposed rule, we expect to provide additional guidance on what constitutes an exceptional circumstance for the purposes of qualifying for this special enrollment period and clarify that this change only applies to the individual market.

Previously, the Exchanges have, at times, offered special enrollment periods for a variety of circumstances related to errors that occurred more frequently in the early years of operations. As the Exchanges continue to mature, HHS has previously evaluated, and will continue to evaluate, these existing special enrollment periods to determine their continued utility and necessity. For the purposes of clarity and in response to confusion by stakeholders about whether certain of these special enrollment periods previously made available through guidance are still available to consumers, we proposed to formalize previous guidance [FN22] from HHS that the following special enrollment periods are no longer available:

• Consumers who enrolled with APTC that is too large because of a redundant or duplicate policy;

• Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents;

• Lawfully present non-citizens that were affected by a temporary error in the determination of their eligibility for APTC;

• Lawfully present non-citizens with incomes below 100 percent of Federal Poverty Level (FPL) who experienced certain processing delays; and

• Consumers who were eligible for or enrolled in COBRA and not sufficiently informed about their coverage options.

We are finalizing this provision as proposed.

Comment: A few commenters expressed concern about our proposal to codify the elimination of several special enrollment periods that were eliminated through prior guidance due to fear that we are cutting off the availability of special enrollment periods to vulnerable populations that need a pathway to coverage.

Response: The special enrollment periods listed for elimination in this rule have not been available to consumers since 2016; they were originally eliminated in subregulatory guidance because all consumers in the situations described had already been provided with a pathway to coverage. Codifying the elimination of these special enrollment periods will not affect vulnerable consumers' ability to access coverage in the future.

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4. Continuous Coverage

Because of the challenges in the individual market related to adverse selection, HHS believes it is especially important in this market to adopt policies that promote continuous enrollment in health coverage and to encourage individuals to enroll and remain in coverage for the full year.

While the provisions in this rule relating to guaranteed availability, the annual open enrollment period, and special enrollment periods encourage individuals to maintain coverage throughout the year, we noted in the proposed rule that we are also actively exploring additional policies in the individual market that would promote continuous coverage and sought input on which policies would effectively do so, consistent with existing legal authorities. For example, with respect to special enrollment periods that require evidence of prior coverage, we are considering policies for the individual market that would require that individuals show evidence of prior coverage for a longer "look back" period. Individuals could be required to provide proof of prior coverage for 6 to 12 months, except that an individual with a small gap in coverage (such as up to 60 days), could be considered to have had prior coverage. Alternatively, for individuals who are not able to provide evidence of prior coverage during such a look back period, an exception could allow them to enroll in coverage if they otherwise qualify for a special enrollment period, but impose a waiting period of at least 90 days before effectuating enrollment, or assess a late enrollment penalty. These policies could encourage individuals to maintain coverage throughout the year, thus promoting continuous coverage.

HHS is also interested in whether policies are needed for the individual market similar to those that existed under HIPAA, which in the group market required maintenance of continuous, creditable coverage without a 63-day break if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain circumstances. Although the HIPAA rules did not require that individuals maintain coverage, the rules were designed to provide an important incentive for individuals to enroll in coverage for the full year, not just when in need of healthcare services; reduce adverse selection; and help prevent premiums from climbing to levels that would keep most healthy individuals from purchasing coverage.

We are interested in policies that not only encourage uninsured individuals to enroll in coverage during the open enrollment period, but also encourage those with coverage to maintain continuous coverage throughout the year.

We solicited comments on additional policies that would promote continuous coverage, but did not propose any of the policies described in this section III.B.3. of this final rule. The following is a summary of the public comments received on the discussed continuous coverage policies and our responses:

***18367** Comment: A minority of commenters, primarily issuers, supported the policies discussed in the proposed rule, or the general concept of policies to promote continuous coverage. Many of these commenters emphasized the need for policies like continuous coverage requirements, waiting periods or late enrollment penalties, if the individual shared responsibility provision is eliminated. These commenters recommended imposing longer look-back periods of varying lengths for special enrollment periods; a few recommended late enrollment surcharges of specific amounts (for example, 150 percent, lasting for at least 18 months); and one commenter expressed a preference for premium penalties over making prior coverage an eligibility requirement for special enrollment periods. Several of these commenters cautioned HHS against re-introducing waiting periods, noting the operational burden, consumer harm, or perceived limited effectiveness as compared to other penalties for having a coverage lapse. Several commenters noted the importance of clearly communicating continuous coverage requirements to consumers.

Some commenters believed continuous coverage policies should apply during open enrollment. One commenter recommended that if a continuous coverage policy were adopted that applied only to special enrollment periods, an exemption from the look-back period should be provided to anyone who enrolled during the most recent open enrollment period. That commenter also believed that the longer the look-back period is, the stronger the incentive to remain insured and the less opportunity to game the system; and commented that the discussed policies could result in reduced usage of special enrollment periods and higher out-of-pocket costs for consumers. Some commenters opposed applying continuous coverage requirements to special enrollment

periods. A few commenters specifically urged HHS to exempt the monthly special enrollment period for Indians and their dependents from any continuous coverage requirements. Some commenters observed that some of the changes being finalized in this rule, particularly those related to verification of eligibility for special enrollment periods, could result in more people experiencing coverage lapses.

The majority of commenters opposed the adoption of the continuous coverage policies discussed in this section. Many commenters believed the discussed policies would deter individuals from purchasing coverage in the individual market, would have a negative impact on the risk pool, or increase premiums. Many commenters urged HHS not to adopt policies that would penalize people who have coverage lapses for legitimate reasons. Commenters questioned the premise that coverage lapses were primarily due to gaming behavior. Commenters observed that people often experience coverage gaps for reasons unrelated to gaming behavior, such as financial difficulties paying their premiums, challenges associated with mental or chronic illnesses, job loss, changes in family circumstances (for example, death, divorce or moves), mix-ups with insurance companies or the Exchanges, lack of awareness about the individual shared responsibility provision, and losing APTC. Many of these commenters suggested that the continuous coverage policies discussed in the proposed rule are unlikely to encourage these individuals to maintain coverage, particularly those who are healthy and leaving for economic reasons. Some commenters recommended exceptions be included in any adopted continuous coverage policies to account for individuals who have legitimate reasons not to maintain coverage, or who have received an exemption from the individual shared responsibility provision. Some commenters observed that the people most likely to have gaps in coverage are also the least likely to be able to pay higher premiums, and could thus be locked out of the market after a coverage lapse. Some commenters predicted such policies would increase the uninsured rate. Commenters urged HHS not to adopt policies that would make insurance less affordable.

Many commenters expressed concern that the continuous coverage policies discussed in the proposed rule would hurt consumers, particularly vulnerable populations, including low- and middle-income individuals; seasonal or migratory workers; and individuals with chronic diseases, disabilities, or other pre-existing conditions. Many commenters believed policies that include longer look-back periods, waiting periods, late enrollment penalties, or HIPAA-style rules could disrupt patients' care or cause people to delay or go without care, resulting in increased costs in the future and worse health outcomes. One commenter raised concerns that issuers could game continuous coverage requirements to avoid covering sicker individuals. One commenter also expressed concern that such policies could result in other unintended consequences like increased crime or homelessness. Many commenters were concerned that HHS's interest in policies promoting continuous coverage presaged an end to the prohibitions against pre-existing condition exclusions, medical underwriting, or rescissions (except in limited circumstances). Some commenters expressed a belief that such policies are immoral. Many commenters stated it was unfair to penalize people once they obtain coverage, or believed it was unfair to apply both the individual shared responsibility provision and penalties associated with continuous coverage requirements.

One commenter noted that it believes HHS has significant authority to impose continuous coverage requirements on all special enrollment periods, although that commenter also recommended exempting several special enrollment periods from continuous coverage requirements. Another commenter noted that they believed current law precludes imposing continuous coverage requirements during open enrollment periods, but not for special enrollment periods. However, many commenters stated that the discussed policies, and pre-existing condition exclusions, were counter to the PPACA's guaranteed availability protections, and that assessing a late enrollment penalty or surcharge was also counter to the requirements regarding rating variations.

Commenters raised concerns related to applying continuous coverage requirements in the individual market, including a concern about applying rules similar to the HIPAA rules outside of the employment context, and a concern about adopting continuous coverage requirements in the individual market that differ from rules for other markets. One commenter strongly opposed requiring SBEs to adopt continuous coverage policies.

Many commenters believed that the individual shared responsibility provision promotes continuous coverage better than the policies discussed in the proposed rule. Some recommended increasing the amount of the individual shared responsibility payment. A few commenters encouraged the Administration to communicate that it intended to enforce the individual shared

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responsibility provision as a way to stabilize the individual market. Some commenters recommended helping people understand their responsibility under the individual shared responsibility provision as a means to promote continuous coverage.

Some commenters provided suggestions for alternative approaches to promote continuous coverage, including minimizing barriers to enrollment, ***18368** providing more support to people as they enroll, ensuring plans provide adequate value to consumers, making plans more affordable, increasing subsidies, and creating incentives for multi-year enrollments. One commenter recommended enrollees be contractually bound to pay premiums for a full year, with insurers having a mechanism to recover unpaid premiums. Multiple commenters recommended a form of universal healthcare as a way to achieve continuous coverage.

Response: We thank commenters for their input. We continue to explore policies that would promote continuous coverage and that are within HHS's legal authority, and will not take action in this final rule.

5. Enrollment Periods Under SHOP

Because the proposed changes to restrict enrollment options though special enrollment periods for current enrollees and to require a demonstration of prior coverage in order to qualify for the marriage special enrollment period were proposed for special enrollment periods in the individual market only, we proposed to amend § 155.725(j)(2)(i) to specify that § 155.420(a)(3) through (5) do not apply to special enrollment periods under the Small Business Health Options Program (SHOP). We are finalizing the proposal that the change to restrict enrollment options though special enrollment periods for current enrollees in § 155.420(a)(4) and the change to require a demonstration of prior coverage in order to qualify for the marriage special enrollment period these paragraphs do not apply to special enrollment periods under SHOP. However, instead of finalizing the proposed amendment to § 155.725(j)(2)(i), we are finalizing a new § 155.725(j)(7). This change more clearly reflects that § 155.420(a)(4) and the requirement to demonstrate prior coverage to qualify for the marriage special enrollment period do not apply to the SHOP. We note that under the finalized language, § 155.420(a)(5) would be applicable to the SHOP. Although the requirement to show prior coverage is not applicable in the SHOP for the marriage special enrollment period, it is applicable for the permanent move special enrollment period under § 155.420(d)(7). We had not intended the proposed rule to prevent individuals applying for special enrollment periods under § 155.420(d)(7) in the SHOP from satisfying the prior coverage requirement as specified under § 155.420(a)(5). A more detailed discussion of the proposed and finalized changes in § 155.420(a) is provided in section III.B.3. of this final rule.

The following is a summary of the public comments received on the enrollment periods under the SHOP proposed provisions and our responses:

Comment: Commenters expressed concern about applying different rules for special enrollment periods in the small group and individual markets, noting the potential for confusion among consumers or assisters, and operational challenges; or questioning the need for different rules. One commenter opposed creating a different set of special enrollment period rules between the individual and small group markets because the commenter's State has a merged market such that its qualified health plans are offered in both the individual and small group markets. Some commenters supported not applying the proposed changes to special enrollment periods to the SHOP, and one requested clarification that the changes also not apply to the small group in the off-Exchange market.

Response: We appreciate the comments. We note that there are other rules relating to special enrollment periods where the rules differ for the individual Exchanges and the SHOPs. The finalized rules regarding special enrollment periods in § 155.420(a)(4) and (d)(2)(i)(A) do not apply to the small group market.

6. Exchange Functions: Certification of Qualified Health Plans (Part 155, Subpart K)

In light of the need for issuers to make modifications to their products and applications to accommodate the changes finalized in this rule, we are concurrently issuing separate guidance to update the QHP certification calendar and the rate review submission

deadlines to give additional time for issuers to develop, and States to review, form and rate filings for the 2018 plan year that reflect these changes.[FN23]

C. Part 156—Health Insurance Issuer Standards Under the Patient Protection and Affordable Care Act, Including Standards Related to Exchanges

1. Levels of Coverage (Actuarial Value) (§ 156.140)

Section 2707(a) of the PHS Act and section 1302 of the PPACA direct issuers of non-grandfathered individual and small group health insurance plans, including QHPs, to ensure that these plans adhere to the levels of coverage specified in section 1302(d)(1) of the PPACA. A plan's coverage level, or AV, is determined based on its coverage of the EHB for a standard population. Section 1302(d)(1) of the PPACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the PPACA directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the PPACA authorizes the Secretary to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

As stated in the proposed rule, we believe that further flexibility is needed for the AV de minimis range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we noted that we believe that changing the de minimis range will allow more plans to keep their cost sharing the same from year to year. More specifically, we noted that as established at § 156.135(a), to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS for the given benefit year, and that we made several key updates to the AV Calculator for 2018. Due to the scope and number of these updates in the 2018 AV Calculator, the impact on current plans' AVs will vary. Therefore, we proposed to amend the definition of de minimis included in § 156.140(c), to a variation of -4/+2 percentage points, rather than +/- 2 percentage points for all non-grandfathered individual and small group market plans (other than bronze plans meeting certain conditions) that are required to comply with AV. As proposed, for example, a silver plan could have an AV between 66 and 72 percent. We believe a broader de minimis range will provide additional flexibility for issuers to make adjustments to their plans within the same metal level.

While we proposed to modify the de minimis range for the metal level plans (bronze, silver, gold, and platinum), we did not propose to modify the de minimis range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420. The de minimis variation for a silver plan variation of a single percentage point would still apply. In the Actuarial Value and Cost-Sharing ***18369** Reductions Bulletin (2012 Bulletin) we issued on February 24, 2012,[FN24] we explained why we did not intend to require issuers to offer a cost-sharing reduction (CSR) silver plan variation with an AV of 70 percent. However, we proposed to consider whether the ability for an issuer to offer a standard silver plan at an AV of 66 percent would require a silver plan variation to be offered at an AV of 70 percent or would require some other mechanism to provide for CSR silver plan variations for eligible individuals with household incomes that are more than 250 percent but not more than 400 percent of the FPL.

We proposed to maintain the bronze plan de minimis range policy finalized in the 2018 Payment Notice at § 156.140(c) with one modification. We proposed to change the de minimis range for the expanded bronze plans from -2/+5 percentage points to -4/+5 percentage points to align with the proposed policy. Therefore, for those bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), we proposed the allowable variation in AV would be -4 percentage points and +5 percentage points.[FN25]

We solicited comments on the proposal, including on the appropriate de minimis values for metal level plans and silver plan variations, and on whether those values should differ when increasing or decreasing AV. We proposed the policy for 2018, but we also considered proposing that the change be effective for the 2019 plan year. We noted that, if finalized for 2018, we would update the 2018 AV Calculator in accordance with this policy.

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We are finalizing the policy as proposed and are adding regulation text to reflect that the policy applies to plan years beginning on or after January 1, 2018. The following is a summary of the public comments received on the levels of coverage (actuarial value) (§ 156.140) proposed provisions and our responses:

Comment: Some commenters supported the proposed policy as generally increasing issuer flexibility by allowing issuers to offer more innovative plans, to assist with premium impact and to stabilize the market. Others supported the policy for similar reasoning, but recommended a different range or combination, such as +/-4 percent, as AVs typically go up each year (and not down). Other commenters did not support the proposed range, wanting to keep the current range to ensure consumers can meaningfully compare plan designs. Some commenters stated that the proposed de minimis range was unlawful under section 1302(d)(3) of the PPACA as the de minimis range is to account for differences in actuarial estimates only and not for the reasoning provided in the proposed rule. Some commenters were concerned that the distinction, transparency, and variation between and within metal levels would create consumer confusion and could lead to enrollment issues, with some commenters particularly concerned about the proposed 1 percent difference between bronze and silver levels of coverage and the distinction between those metal levels. A commenter also noted that the policy would allow plan designs that are simultaneously compliant with bronze and silver metal tiers in the Final 2018 AV Calculator (due to the induced demand between metal levels). Other commenters wanted to ensure State AV-related flexibility. Some commenters wanted HHS to engage with stakeholders to consider the impact of the proposal before finalizing the policy. Commenters generally supported retaining the current de minimis range for the CSR silver plan variations.

Response: As discussed in the proposed rule, the health and competitiveness of the Exchanges, as well as the individual and small group markets in general, have recently been threatened by issuer exit and increasing rates in many geographic areas. Therefore, while we recognize the importance of consumers being able to compare plan designs, we are committed to providing issuers increased AV flexibility to improve the health and competitiveness of the markets. For these reasons, we believe that a de minimis range of -4/+2 percentage points provides the flexibility necessary for issuers to design new plans while ensuring comparability of plans within each metal level. Through our authority under section 1302(d)(3) of the PPACA, which directs the Secretary to develop guidelines to provide for a de minimis variance in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates, and section 1321(a)(1)(A) and (D) of the PPACA, which requires the Secretary to issue regulations setting standards for meeting the requirements for the establishment and operation of Exchanges, as well as such other requirements as the Secretary determines appropriate, we are finalizing the definition of the AV de minimis range included in § 156.140(c) to be a variation of -4/+2 percentage points for all non-grandfathered individual and small group market insurance plans (other than bronze plans meeting certain conditions) that are required to comply with AV, starting with plan years beginning in 2018. Because of the urgent need to stabilize the market and attract and retain issuers to ensure that consumers have options for coverage in the 2018 Exchanges, we do not believe that consulting stakeholders in advance of finalizing the rule is necessary at this time, but we hope to engage stakeholders on what, if any, modifications are needed to publicly available data as a result of this change.

Furthermore, we are also finalizing the de minimis range change for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2) from -2/+5 percentage points to -4/+5 percentage points to align with the policy in this rule, starting in plan year 2018. We recognize that the difference between the bronze and silver plans under this de minimis range is only 1 percent and that AVs typically increase each year; therefore, we may consider further changes to the de minimis ranges in the future as we intend to monitor the effects in 2018. We also recognize that States are the enforcers of AV policy and nothing under this policy precludes States from applying stricter standards, consistent with Federal law. For example, a State may apply a +/-2 percent for the AV de minimis range for metal level plans, which would be tied to the metal level definitions under section 1302(d)(1) of the PPACA, would be within the Federal de minimis range, and would be considered a stricter standard than the Federal requirements. However, a State cannot require issuers to design plans that apply an AV range that is not consistent with our implementation of section 1302(d)(1) and (d)(3) of the PPACA (which defines the metal level definitions). Also, it is the

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responsibility of the State to enforce implementation of a de minimis range using the Federal AV Calculator or an ***18370** AV Calculator that utilizes State-specific data under § 156.135(e).[FN26]

Comment: Many commenters were opposed to the proposed policy or were concerned about the potential impact on increasing cost sharing for consumers, especially in the form of higher deductibles, an area where commenters noted consumers, are already struggling. These commenters were also concerned about potential decreases in the amount of APTCs [FN27] that most Exchange consumers use to purchase coverage, particularly for those consumers between 250 and 400 percent of FPL who are not eligible for the current CSR silver plan variations. Many commenters generally believed that the proposed policy would reduce the value of coverage by making it less affordable; for example, a decrease in APTC could affect current enrollees' ability to stay in their current plan without having to pay more in premiums, or could affect consumers' use of services due to higher cost sharing and the associated financial implications. Some commenters commented on the lack of value of coverage for enrollees who do not receive APTCs given the high cost of coverage. Some commenters stated that a silver plan is defined in the statute as a plan with a 70 percent AV plan and supported requiring that the second lowest cost silver plan (the benchmark plan), which is used to calculate APTCs, have an AV of at least 70 percent. Some commenters recommended finalizing a de minimis range that ensures that a change in de minimis range does not impact AV for silver plans that are used to calculate the benchmark plan for PTCs, or recommended increasing the de minimis range on only bronze plans. Other commenters noted that the proposed policy would not affect bronze plans due to the annual limitation on cost sharing, limiting the ability of a bronze plan to have a lower AV. Some commenters supported a silver plan variation eligible for CSRs at the 70 percent AV level, with some commenters believing that a 66 percent AV does not meet the statutory requirements at section 1402 of the PPACA, with some recommending that HHS establish a 70 percent plan or ensure that plans with a 70 percent AV are available, and some commenters wanted further details on the proposal to establish a 70 percent AV silver plan variation. Other commenters did not support requiring an additional silver plan variation eligible for CSRs at the 70 percent AV level due to administrative and cost burden to issuers and the absence of regulations that support an additional silver variation, and also because the reasoning in the 2012 Bulletin still applies, given that the reduction in the out-of-pocket limit would cause increases in other cost sharing. Some commented on the policy's impact on enrollees in CSR plans and on enrollees in zero cost share plans that typically use APTCs to enroll in bronze plans.

Response: In response to comments, we considered limiting this policy to the bronze level of coverage or excluding the silver level of coverage to ensure that this policy does not affect APTCs. However, we believe that limiting the policy in either way would significantly blunt the impact of the policy. As discussed in the preamble of the proposed 2018 Payment Notice, all plans subject to the annual limitation on cost sharing under section 1302(c) of the PPACA have a minimum level of generosity that limits the lowest AV that a plan can achieve, which means that issuers would not receive much additional flexibility if the expanded de minimis range were only applied to bronze plans. Because of the annual limitation on cost sharing, issuers have limited ability to design a bronze plan with an AV lower than 58.54 percent.[FN28] Therefore, we believe that if this policy was limited to bronze plans, the policy would likely not affect the market. Also, if the policy did not apply to silver plans, the policy would have limited impact because it would only provide issuers with significant flexibility for plans with gold and platinum levels of coverage. Based on the Exchange plan and enrollment numbers from 2016 and 2017, there are significantly more plans and more enrollees in the silver and bronze tiers than in the gold and platinum tiers. Additionally, we do not believe that gold and platinum plans are the levels of coverage most likely to attract healthy enrollees to enter the risk pool.

In finalizing the -4/+2 percent for the de minimis range for all metal levels (other than bronze plans meeting certain conditions), we recognize that, in the short run, this change would generate a transfer of costs from consumers to issuers, but believe the additional flexibility for issuers will have positive effects for consumers over the longer term. Similar to the -2 percent de minimis range flexibility that we have previously provided for AV, the change to allow for -4 percent de minimis range could reduce the value of coverage for consumers compared to a narrower de minimis range, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs. However, providing issuers with additional flexibility could help stabilize premiums over time, increase issuer participation, and ultimately provide consumers with more coverage options at the silver level and above, thereby attracting more young and healthy enrollees into plans at these levels.

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In the short term, the benchmark plans used to calculate the amount of APTCs available to consumers below 400 percent of FPL could be based on a plan at the lower end of the new de minimis range that has lower premiums, meaning that a lower APTC amount could be available to all consumers eligible for APTC to retain current coverage. The impact of the policy is dependent on which plans consumers choose to enroll in and the plans that are available in the market. Consumers whose APTC decreases could instead choose a plan with lower premiums to mitigate an increase in the amount of premium they owe, but that plan may have higher cost sharing to offset the decrease in premium. Specifically, enrollees who choose to use their APTC amounts to purchase coverage for lower priced plans, such as bronze or lowest cost silver, could also be negatively impacted. Assuming issuers offer silver metal tier plans at the lower end of the new de minimis range, when individuals who are eligible for CSRs choose the silver plan variations, there could be an increase of CSRs for the lower AV plan to reach the plan variation's AV. Individuals with a household income up to 250 percent of FPL, who enroll in a CSR silver plan variation, will receive additional CSRs to make up the difference between the lower AV of the standard silver plan and the CSR silver plan variation. Individuals with a household income in the range of 250 to 400 percent of FPL do not currently receive CSRs and cannot choose to enroll in a silver plan variation will experience greater out of ***18371** pocket expenses. Previously, providing a reduced maximum annual limitation on cost sharing for a 70 percent AV plan would have resulted in an AV of the standard silver plan being outside of the de minimis range unless substantive increases to other cost-sharing parameters are made. These individuals in the range of 250 to 400 percent of FPL may be affected by the policy finalized in this rule because they will not have the choice to enroll in CSR silver plan variations to cover the difference from the increased cost sharing from the standard silver plan.

As discussed in the proposed rule, we considered creating a new 70 percent silver plan variation for enrollees between 250 and 400 percent of FPL. In response to comments, we analyzed the effect of reducing the maximum annual limitation on cost sharing based on how we calculated the 2018 reduced maximum annual limitation on cost sharing. We found that it is possible to design plans at 66 percent AV and still be below 70 percent AV when the maximum annual limitation on cost sharing is reduced. However, we are not certain what the AV spread of plan designs will be under the finalized policy, whether issuers will in fact reduce the AVs of their base silver plans to the lower end of the de minimis range, and whether issuers will retain plan designs above the 70 percent AV range. Therefore, we intend to monitor 2018 standard silver plan designs to consider whether to require a 70 percent silver plan variation or explore other potential means of mitigating the effect on affordability for enrollees. For this reason, we are not changing the CSR silver plan variation policy for enrollees with incomes between 250 to 400 percent of FPL or coordinating with IRS to change the way the benchmark plans are determined for 2018, but we may explore whether we can do so in the future.

Comment: Some commenters supported the policy for 2018, and some commenters did not support applying the policy in 2018. Some commenters noted concerns about 2018 State filing deadlines. Some commenters requested a revised AV Calculator as soon as possible, and some commenters noted that the policy could help plans affected by the AV Calculator changes.

Response: As discussed in the proposed rule, we believe that changing the AV de minimis range will help retain and attract issuers to the non-grandfathered individual and small group markets, which will increase competition and choice for consumers, and therefore believe it is important to finalize the change for 2018. We agree with commenters that increased flexibility in the de minimis range could be helpful for plans affected by AV Calculator changes. Furthermore, while we recognize that AVs typically increase each year, flexibility in the de minimis range will give these plans greater flexibility to grow in future years. We appreciate the importance of releasing a revised AV Calculator, and are releasing the revised AV Calculator concurrently with this rule.[FN29] Because the AV range is widening and not narrowing, we believe that the policy will not create difficulties in meeting the State filing deadlines.

Comment: Some commenters commented on the potential impact of the proposed policy on plan competition, on whether the proposed policy would increase or decrease enrollment or premiums including among consumers that may receive a decreased APTC amount, or on whether the issuer or the consumer would ultimately benefit under the proposed policy with some commenters raising concerns about the purpose and impact of the policy discussed in the proposed rule. Some commenters questioned the impact of the proposed policy on risk adjustment and on current plans being considered the same plan. Other

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commenters commented on applying a de minimis range similar to the proposed policy to dental plans, and others submitted comments beyond the scope of the proposed rule.

Response: The risk adjustment model uses metal level specific simulated plan liability to predict estimated plan expenditures. The model plan designs used to derive plan liability are based on representative plans offered by issuers in each metal tier. Given that the risk adjustment model estimates relative differences in plan liability to calculate risk adjustment transfers and payments based on plan risk that may not have been incorporated in rate setting, we believe the risk adjustment methodology will continue to function as intended to compensate issuers based on relative differences in health risk of enrollees. However, in instances where the AV gap between two metal tiers is smaller than previously allowed, it is possible that the simulated plan liability expenditure differences between metal tiers may not be representative of plans offered. Additionally, although issuers may offer plans at the lower end of the updated de minimis range to obtain competitive advantage, because the risk adjustment transfer formula is based on relative plan level differences, and incorporates metal level AV, it will continue to preserve the calculation of transfers based on relative differences in health risk of enrollees across plans. Similarly, the induced utilization factors in the current risk adjustment transfer formula represent relative differences between the plans and we do not believe the relative differences will be affected by the changes in the de minimis range. Therefore, we are not making any changes to the risk adjustment methodology to accommodate the changes to the de minimis range at this time. We intend to monitor the impact of asymmetric changes to the de minimis range on plan benefit designs offered, and any impacts on risk adjustment methodology and transfer formula calculations. Additionally, as we have noted in the 2018 Payment Notice, we anticipate reexamining the induced utilization factors in the future as the enrollee-level data from the risk adjustment program becomes available.

Under the exceptions to guaranteed renewability for uniform modification of coverage under § 147.106(e), an issuer may, only at the time of coverage renewal, modify the health insurance coverage for a product offered in the individual market or small group market if the modification is consistent with State law and is effective uniformly for all individuals or group health plans with that product. To be considered a uniform modification of coverage, among other things, each plan within the product that has been modified must have the same cost-sharing structure as before the modification, except any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the PPACA. States have flexibility to broaden what cost-sharing changes are considered within the scope of a uniform modification of coverage and may, for example, consider uniform cost-sharing changes that result in plans having the same metal level based on the expanded de minimis range to be uniform modifications.

We intend to monitor the impact of this policy on plan design and by extension, Exchange enrollment to consider whether further changes are needed. We may also consider similar changes for dental plans in the future.

2. Network Adequacy (§ 156.230)

In recognition of the traditional role States have in developing and enforcing network adequacy standards, we proposed to rely on State reviews for ***18372** network adequacy in States in which an FFE is operating, provided the State has a sufficient network adequacy review process. For the 2018 plan year, we proposed to defer to the States' reviews in States with the authority that is at least equal to the “reasonable access standard” identified in § 156.230 and means to assess issuer network adequacy.

We also proposed a change to our approach to reviewing network adequacy in States that do not have the authority and means to conduct sufficient network adequacy reviews. In those States, we would, for the 2018 plan year, apply a standard similar to the one used in the 2014 plan year.[FN30] As HHS did in 2014, in States without the authority or means to conduct sufficient network adequacy reviews, we proposed for 2018 to rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. HHS has previously recognized three accrediting entities for the accreditation of QHPs: The National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care.[FN31] We proposed to utilize these same three accrediting entities for network adequacy reviews for the 2018 plan year. Unaccredited issuers would be required to submit an access plan as part of the QHP Application. To show that the QHP's network meets the requirement in § 156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in

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place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act.[FN32]

We proposed that we would further coordinate with States to monitor network adequacy, for example, through complaint tracking. We also noted that we intended to release an updated timeline for the QHP certification process for plan year 2018 that would provide issuers with additional time to implement changes that are finalized prior to the 2018 coverage year. This new timeline was released on February 17, 2017,[FN33] with a version that includes finalized dates for rate review being released concurrently with this rule.

We are finalizing the changes as proposed. The following is a summary of the public comments received on the network adequacy proposed provisions and our responses:

Comment: Many commenters supported the proposal to rely on States with a sufficient network adequacy review process, to rely on an issuer's accreditation in States without a sufficient network adequacy review process, and the submission of access plans in States without sufficient review for issuers that are unaccredited. Many commenters also supported HHS no longer employing the time and distance standard. Some commenters recommended that all compliance and complaint tracking should be handled solely by States to avoid duplicative oversight and stated that States are better positioned to monitor networks.

Response: We appreciate commenters' support of our proposed policy and are finalizing the proposals as proposed. We believe this approach affirms the traditional role of States in overseeing network adequacy standards.

Comment: One commenter recommended that HHS rely on State review of network adequacy for SADPs in all States, rather than applying an accreditation standard to SADPs in States that do not have network adequacy review authority, because dental issuers do not get accredited.

Response: In States that are determined to not have sufficient network adequacy review, HHS will require SADPs to submit an access plan that demonstrates that the issuer has standards and procedures in place to maintain an adequate network consistent with NAIC's Health Benefit Plan Network Access and Adequacy Model Act (NAIC Model Act).

Comment: Many other commenters opposed the proposed change to rely primarily on State review of network adequacy and raised concerns that this could decrease healthcare access and create disparities in access to and quality of providers for consumers depending on their State or could lead to narrow networks.

Response: We appreciate the concerns, and recognize the importance of patients having access to adequate networks. However, we believe that States are best positioned to determine what constitutes an adequate network in their geographic area. We do not believe relying on State reviews in States that have the authority and means to conduct sufficient network adequacy reviews will translate to decreased access to providers. We look forward to working closely with States in this area as we implement the new network adequacy review approach. We also plan to continue to monitor the States' implementation of the NAIC Model Act, and we intend to use that information to shape future network adequacy policy. We also plan to provide information to issuers about which States have been determined not to have sufficient network adequacy processes in the near future.

Comment: Some commenters stated that accreditation is not a substitute for a robust provider network and that accreditation organizations can only revoke accreditation and do not provide ongoing oversight of QHP issuers and advocated for the continuation of time and distance criteria. One State commented that it relies on HHS for the evaluation of network adequacy and questioned if relying upon the issuer's accreditation will be sufficient.

Response: We appreciate the comments regarding these concerns. Accredited issuers are required to develop reasonable standards for access and availability of services and measure themselves against those standards. Further, we believe that the requirement for unaccredited issuers to submit an access plan to demonstrate that an issuer has standards and procedures in

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place to maintain an adequate network consistent with the NAIC Model Act will ensure an issuer has a sufficient provider network. We are finalizing this proposal as proposed.

3. Essential Community Providers (§ 156.235)

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Act. Section 156.235 establishes requirements for inclusion of ECPs in QHP provider networks and provides an alternate standard for issuers that provide a majority of covered services through employed physicians or a single contracted medical group.

For conducting upcoming reviews of the ECP standard for QHP and SADP certification for the 2018 plan year, we ***18373** proposed to follow the approach previously finalized in the 2018 Payment Notice and outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces, with two changes as outlined below. States performing plan management functions in the FFEs would be permitted to use a similar approach.

Section 156.235(a)(2)(i) stipulates that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS. For the 2014 plan year, we set this minimum percentage at 20 percent, but, starting with the 2015 Letter to Issuers in the Federally-facilitated Marketplaces, we increased the minimum percentage to 30 percent.[FN34] For certification for the 2018 plan year, we proposed to return to the percentage used in the 2014 plan year, and to again consider the issuer to have satisfied the regulatory standard if the issuer contracts with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network. The calculation methodology outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces and 2018 Payment Notice would remain unchanged.

We stated that we believe this standard will substantially reduce the regulatory burden on issuers while preserving adequate access to care provided by ECPs. In particular, as noted in the proposed rule, the standard would result in fewer issuers needing to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard in § 156.235. For the 2017 plan year, 6 percent of issuers were required to submit such a justification. Although none of their networks met the 30 percent ECP threshold, all of these justifications were deemed sufficient, and each network would have met the 20 percent threshold. We anticipate that issuers will readily be able to contract with at least 20 percent of ECPs in a service area, and that enrollees will have reasonable and timely access to ECPs.

For certification for the 2018 plan year, we also proposed to modify our previous guidance regarding which providers issuers may identify as ECPs within their provider networks. Under our current guidance, issuers would only be able to identify providers in their network who are included on a list of available ECPs maintained by HHS ("the HHS ECP list"). This list is based on data maintained by HHS, including provider data that HHS receives directly from providers through the ECP petition process for the 2018 plan year.[FN35] In previous years, we also permitted issuers to identify ECPs through a write-in process. Because the ECP petition process is intended to ensure qualified ECPs are included in the HHS ECP list, we indicated in guidance that we would not allow issuers to submit ECP write-ins for plan year 2018. However, we are aware that not all qualified ECPs have submitted an ECP petition, and therefore have determined the write-in process is still needed to allow issuers to identify all ECPs in their network. Therefore, as for plan year 2017, for plan year 2018, we proposed that an issuer's ECP write-ins would count toward the satisfaction of the ECP standard only for the issuer that wrote in the ECP on its ECP template, provided that the issuer arranges that the written-in provider has submitted an ECP petition to HHS by no later than the deadline for issuer submission of changes to the QHP application. For example, issuers may write in any providers that are currently eligible to participate in the 340B Drug Program described in section 340B of the PHS Act [FN36] that are not included on the HHS list, or not-for-profit or State-owned providers that would be entities described in section 340B of the PHS Act but do not receive Federal funding under the relevant section of law referred to in section 340B of the PHS Act, as long as the provider has submitted a timely ECP petition. Such providers include not-for-profit or governmental family planning service sites that

do not receive a grant under Title X of the PHS Act. We believe the proposal would help build the HHS ECP list so that it is more inclusive of qualified ECPs and better recognize issuers for the ECPs with whom they contract.

As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years. At a minimum, such narrative justification would include the number of contracts offered to ECPs for the 2018 plan year; the number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations; the names of the specific ECPs to which the issuer has offered contracts that are still pending; and contingency plans for how the issuer's provider network, as currently designed, would provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

For the 2018 plan year, we are finalizing our proposals to decrease the minimum ECP threshold from 30 to 20 percent of the available ECPs in a plan's service area, and to continue to allow an issuer's ECP write-ins to count toward the satisfaction of the ECP standard for only the issuer that wrote in the ECP on its ECP template, provided that the issuer arranges that the written-in provider has submitted an ECP petition to HHS by no later than the deadline for issuer submission of changes to the QHP application.

Comment: Several commenters supported our proposal to decrease the minimum ECP threshold from 30 to 20 percent, stating that the lower threshold requirement would reduce the administrative burden on issuers, especially for those issuers in rural areas or States with few ECPs. Other commenters recommended that HHS further lower the ECP threshold to 15 percent for dental issuers, due to fewer ECPs that offer dental services.

Response: We appreciate these comments and agree that the lower 20 percent threshold requirement would reduce the administrative burden on issuers without affecting the ability of low-income and medically-underserved individuals to receive reasonable and timely access to care. At this time, we do not believe lowering the ECP threshold to 15 percent for dental issuers would adequately promote patient access to dental ECPs, given that there are fewer available dental ECPs compared to medical ECPs for low-income and medically-underserved consumers to access dental care.

Comment: Many commenters opposed our proposal to decrease the minimum ECP threshold that an issuer must achieve from 30 to 20 percent of the number of available ECPs located in a plan's service area. These commenters ***18374** expressed concerns that the lower threshold requirement would result in access barriers to care for low-income consumers; restricted access to specialty care; dangerous and costly treatment interruptions; continuity of care challenges; increased travel time; poor access to culturally appropriate healthcare providers; and diminished access to community health centers, safety net and children's hospitals, HIV/AIDS clinics, and family planning health centers. Many of these commenters stated that lowering the ECP threshold to achieve a reduced administrative burden on issuers is unnecessary given that 94 percent of issuers satisfied the 30 percent threshold for plan year 2017 and the remaining 6 percent were able to submit a satisfactory justification to meet the ECP regulatory requirement. Several commenters opposed the reduction in the threshold requirement, stating that the 30 percent threshold for plan year 2017 was not high enough to provide sufficient access to ECPs. One commenter supported the decrease of the ECP threshold for States with issuers that experienced difficulty satisfying the 30 percent threshold, but suggested that States with issuers that did not experience any difficulty be given the flexibility to require a higher ECP percent threshold.

Response: We are finalizing our proposal to decrease the ECP threshold requirement from 30 to 20 percent for plan year 2018 in an effort to reduce the regulatory burden on issuers and stabilize the Exchanges. The final rule provides that this threshold will be applicable for the 2018 plan year. Given the recent refinements to the HHS ECP list through the ECP petition process (for example, the addition of newly qualified ECPs and the removal of former ECPs that no longer provide care to low-income, medically-underserved populations), a 20 percent ECP threshold requirement is expected to adequately protect consumer access to ECPs for plan year 2018, while reducing the issuer burden that was associated with heavier reliance on

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the ECP write-in process to achieve the 94 percent issuer compliance with the 30 percent threshold for plan year 2017. We appreciate the suggestion to provide States with issuers that did not experience any difficulty achieving the 30 percent threshold the flexibility to require a higher ECP percent threshold. However, because the lower threshold reduces issuer burden while adequately protecting consumer access to ECPs, we believe it is important that this change apply in all States with FFEs.

Comment: All commenters supported the proposal to continue the ECP write-in process for the 2018 plan year using the ECP petition process. Some commenters stated that it would reduce administrative burden by continuing to allow issuers to count providers they have contracted with for the 2018 plan year but who missed the ECP petition window for the final 2018 plan year ECP list. Other commenters appreciated the additional time for providers to petition to be added to the HHS ECP list. Several commenters urged that we sunset the ECP write-in process for the 2019 plan year and beyond, allowing the 2018 plan year to further refine the ECP petition process.

Response: We are finalizing our proposal to continue the ECP write-in process for the 2018 plan year using the ECP petition process. We agree with commenters that continuation of the ECP write-in process for the 2018 plan year using the ECP petition process will ensure that issuers are better recognized for the ECPs with whom they contract by offering those providers additional time to petition for inclusion on the HHS ECP list. We appreciate commenters' recommendations regarding the appropriate time to sunset the ECP write-in process, and will take these into consideration in the future.

Comment: Numerous commenters urged that HHS extend the continuity of care protections under § 156.230(d) to ECP discontinuations from the issuer's provider network across plan years. These commenters stated that extending continuity of care provisions to ECPs would have negligible impact on issuers because issuers must already follow these requirements for provider discontinuations within a plan year. Commenters further explained that this protection would discourage discriminatory benefit design and support enrollee continuance within the same plan, promoting market stability. Without these protections, commenters expressed concern that issuers will attempt to shed high-cost enrollees by eliminating their ECPs from the provider network.

Response: In the 2017 Payment Notice (81 FR 12204), we finalized two policies related to continuity of care at § 156.230(d), which began applying in 2017 and apply to ECP terminations. First, we require the issuer, under § 156.230(d)(1), to make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change, or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a nonrenewal. Second, in cases where a provider is terminated without cause, we require the issuer, under § 156.230(d)(2), to allow enrollees in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. These policies apply to provider transitions that occur because a QHP issuer in an FFE discontinues its contract with an ECP. More explicitly, with respect to § 156.230(d)(1), this policy applies to ECP contract discontinuations, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal; and with respect to § 156.230(d)(2), this policy applies to ECP contract discontinuations where a provider is terminated without cause.

IV. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. However, this final rule makes clarifications to the scope of the guaranteed availability policy regarding unpaid premiums; makes modifications to the provisions relating to special enrollment periods; finalizes amendments to § 155.400 to conform to changes made in this rule; and makes clarifications regarding States' roles.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for

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review and approval. This final rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs, with an estimate of the annual burden. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comments on the following issues:

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

***18375** • Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of the proposed rule that contain ICRs.

A. ICRs Regarding Verification of Eligibility for Special Enrollment Periods (§ 155.420)

Starting in June 2017, HHS will begin to implement pre-enrollment verification of eligibility for all categories of special enrollment periods for all States served by the HealthCare.gov platform. Currently, individuals self-attest to their eligibility for many special enrollment periods and submit supporting documentation, but enroll in coverage through the Exchanges without any pre-enrollment verification. As mentioned in the preamble to this rule, beginning in June 2017, we previously planned to implement a pilot program to conduct pre-enrollment verification for a sample of 50 percent of consumers attempting to enroll in coverage through special enrollment periods. We will now expand pre-enrollment verification to all new consumers for applicable special enrollment periods, so that enrollment will be delayed or "pended" until verification of eligibility is completed. Individuals will have to provide supporting documentation within 30 days. Where possible, the FFE will make every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means instead of through a consumer's submission of documentation. Since consumers currently provide required supporting documentation even though there is no pre-enrollment verification process, the provisions will not impose any additional paperwork burden on consumers.

Based on enrollment data, we estimate that HHS eligibility support staff members will conduct pre-enrollment verification for an additional 650,000 individuals. Once individuals have submitted the required verification documents, we estimate that it will take approximately 12 minutes (at an hourly cost of $40.82) to review and verify submitted verification documents. The verification process will result in an additional annual burden for the Federal government of 130,000 hours at a cost of $5,306,600.

We have revised the information collection currently approved under OMB control number 0938-1207 (Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment) to account for this additional burden. The 30-day notice soliciting public comment will be published in the Federal Register at a future date.

SBEs that currently do not conduct pre-enrollment verification for special enrollment periods are encouraged to follow the same approach. States that choose to do so will change their current approach. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as we anticipate it would affect fewer than 10 entities in a 12-month period.

Comment: Commenters expressed concerns about the lack of Federal staff and resources available to adjudicate documents in a timely manner, especially when the work is layered on top of ongoing post-enrollment documentation verification for inconsistencies. Commenters noted the increased costs to the Federal government due to increased staffing needs and secure storage of submitted documents, and the additional time both consumers and assisters will need to spend to adhere to these new

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requirements. A few commenters indicated that a pre-enrollment verification of special enrollment period eligibility may also affect other entities, such as issuers and medical providers who would incur costs in re-submitting or refiling claims, processing retroactive claims, and effectuating retroactive enrollments. One commenter suggested that HHS's cost analysis include these costs, as well as the consumer cost of spending time requesting that claims be re-billed.

Response: We appreciate the concerns about the increased burden and cost that a documentation requirement for pre-enrollment verification of eligibility for special enrollment periods will have on all entities involved. We are dedicated to reviewing all special enrollment period documents received as quickly as possible in order to minimize delays. Although we recognize that gathering and submitting these documents can be difficult and time consuming, we do not believe that this places a new burden on consumers or those providing enrollment assistance since consumers are already required to submit documentation to prove their eligibility after enrollment for 5 common special enrollment periods. Because of our plans for timely document review, we do not believe that new costs will be incurred by issuers, medical providers, or consumers needing to re-submit, refile, or re-bill for claims for services received due to this new requirement.

B. ICRs Regarding Network Adequacy Reviews and Essential Community Providers (§ 156.230, § 156.235)

After further review and consideration, HHS has determined that the ICRs associated with QHP certification have already been assessed and encompassed by CMS-10592/OMB Control No. 0938-1187 (Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers). As such, the proposed ICRs related to QHP certification in the proposed rule have been removed in this final rule.

VI. Regulatory Impact Analysis

A. Statement of Need

As noted previously in the preamble, the Exchanges have experienced a decrease in the number of participating issuers and many States have recently seen increases in premiums. This final rule, which is being published as issuers develop their proposed plan benefit structures and premiums for 2018, aims to improve market stability and issuer participation in the Exchanges for the 2018 benefit year and beyond. This rule also aims to reduce the fiscal and regulatory burden on individuals, families, health insurers, patients, recipients of healthcare services, and purchasers of health insurance. This rule seeks to lower insurance rates and ensure dynamic and competitive markets in part by preventing and curbing potential misuse and abuse associated with special enrollment periods and gaming by individuals taking advantage of the current regulations on grace periods and termination of coverage due to the non-payment of premiums.

This rule addresses these issues by changing a number of requirements that HHS believes will provide needed flexibility to issuers and help stabilize the individual insurance markets, allowing consumers in many State or local markets to retain or obtain health insurance while incentivizing issuers to enter, or remain, in these markets while returning greater autonomy to the States for a number of issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, ***18376** Pub. L. 96-354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental,

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public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

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

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

The provisions in this final rule aim to improve the health and stability of the Exchanges. They provide additional flexibility to issuers for plan designs, reduce regulatory burden, reduce administrative costs, seek to improve issuer risk pools and lower premiums by reducing potential gaming and adverse selection and incentivize consumers to maintain continuous coverage. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to affordable health coverage. Although there is some uncertainty regarding the net effect on enrollment, premiums, and total premium tax credit payments by the government, we anticipate that the provisions of this final rule will help further HHS's goal of ensuring that all consumers have quality, affordable healthcare; that markets are stable; and that Exchanges operate smoothly.

In accordance with Executive Order 12866, HHS has determined that the benefits of this regulatory action justify the costs.

C. Impact Estimates and Accounting Table

In accordance with OMB Circular A-4, Table 1 depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

The provisions in this rule will have a number of effects, including reducing regulatory burden for issuers, reducing the impact of adverse selection, stabilizing premiums in the individual insurance markets, and providing consumers with more affordable health insurance coverage. The effects in Table 1 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this final rule.

Table 1—Accounting Table

Part II
Benefits:
Qualitative:
• Improved health and protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical

conditions (if health insurance enrollment increases). [a]

• Cost savings due to reduction in providing medical services (if health insurance enrollment decreases). [a] [b]

• Cost savings to issuers from not having to process claims while enrollment is "pended" during pre-enrollment verification of eligibility for special enrollment periods. [c]

• Cost savings to the government and plans associated with the reduced open enrollment period.

• Costs savings to consumers and issuers due reduced administrative costs to issuers.

Costs:

Qualitative:

• Harms to health and reduced protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment decreases). [a]

• Cost due to increases in providing medical services (if health insurance enrollment increases). [a] [b]

• Possible decrease in quality of medical services (for example, reductions in continuity of care due to lower ECP threshold).

• Administrative costs incurred by the Federal government and by States that start conducting verification of special enrollment period eligibility.

• Costs to issuers of redesigning plans.

• Costs to the Federal government and issuers of outreach activities

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associated with shortened open enrollment period.

• Administrative costs to stakeholders to read, comprehend and comply with provisions of the final rule.

Transfers	Low estimate (million)	High estimate (million)	Year dollar —D	Discount rate (percent)	Period covered
Annualized Monetized ($millions/ year)	$200	$400	2016	7	2018-2022
	200	400	2016	3	2018-2022
Transfer from Federal Government to issuers and providers via possible increases in CSRs, as well as a transfer of similar magnitude via possible reductions in APTC subsidies from some combination of enrollees and issuers to the Federal Government.					
Qualitative:					
• Transfers, via premium reductions and claim reductions, from special enrollment period applicants who do not provide sufficient documentation and their medical providers to all other enrollees and issuers.					
• Transfers related to changes in AV from enrollees to issuers.					
• Transfer from enrollees to issuers in the form of payments made for past due premiums. Notes:					

***18377 1. Guaranteed Availability of Coverage**

This final rule provides that, to the extent permitted by applicable State law, issuers may apply a premium payment to past-due premiums owed for coverage from the same issuer, or another issuer in the same controlled group within the prior 12 month period preceding the effective date of coverage before effectuating new coverage. Individuals with past due premiums will generally owe no more than 1 to 3 months of past-due premiums. The issuer will have to apply its premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market and State and regardless of health status and consistent with applicable non-discrimination requirements. Furthermore, issuers adopting a premium payment policy, as well as any issuers that do not adopt the policy but are within an adopting issuer's controlled group, must clearly describe in any enrollment application materials and in any notice that is provided regarding non-payment of premiums, whether in paper or electronic form, the consequences of non-payment on future enrollment. Plan documents and related materials are usually reviewed and updated annually before a new plan year begins. Issuers may include this information in their plan

documents and related materials at negligible cost at that time. This will reduce misuse of grace periods and the risk of adverse selection by consumers while likely also discouraging some individuals from obtaining coverage.

A recent study [FN37] surveying consumers with individual market plans concluded that approximately 21 percent of consumers stopped premium payments in 2015. Approximately 87 percent of those individuals repurchased plans in 2016, and 49 percent of these consumers purchased the same plan on which they had previously stopped payment.

Based on internal analysis, we estimate that approximately one in ten enrollees in the FFE had their coverage terminated due to non-payment of premiums in 2016. We estimate that approximately 86,000 (or 16 percent) of those individuals whose coverage was terminated due to non-payment of premium in 2016 and who lived in an area where their 2016 issuer was available in 2017 had an active 2017 plan selection with the same issuer at the end of the open enrollment period. Additionally, for those individuals living in an area where their 2016 issuer was the only issuer available in 2017, 23 percent of those individuals whose coverage was terminated due to non-payment in 2016 had an active 2017 plan selection with that issuer at the end of the open enrollment period—equating to approximately 21,000 individuals. In the absence of data, we are unable to determine the amount of past-due premiums that consumers will have to pay in order to effectuate new coverage with the same issuer or an issuer in the same controlled group, though individuals will generally owe no more than 1 to 3 months of premiums.

2. Open Enrollment Periods

This final rule amends § 155.410(e) and changes the individual market annual open enrollment period for coverage year 2018 to begin on November 1, 2017, and run through December 15, 2017. This is expected to have a positive impact on the individual market risk pools by reducing the risk of adverse selection. However, the shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period. The change in the open enrollment period could lead to additional reductions in enrollment if Exchanges and enrollment assisters do not have adequate support, which can lead to potential enrollees facing longer wait times. In addition, this change is expected to simplify operational processes for issuers and the Exchanges. However, the Federal government, SBEs, and issuers may incur costs if additional consumer outreach is needed.

3. Special Enrollment Periods

Special enrollment periods ensure that people who lose health insurance during the year (for example, through non-voluntary loss of minimum essential coverage provided through an employer), or who experience other qualifying events such as marriage or birth or adoption of a child, have the opportunity to enroll in new coverage or make changes to their existing coverage. In the individual market, while the annual open enrollment period allows previously uninsured individuals to enroll in new insurance coverage, special enrollment periods are intended to promote continuous enrollment in health insurance coverage during the benefit year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage.

However, allowing previously uninsured individuals to enroll in coverage via a special enrollment period that they would not otherwise qualify for can increase the risk of adverse selection, negatively impact the risk pool, contribute to gaps in coverage, and contribute to market instability and reduced issuer participation.

Currently, in many cases, individuals self-attest to their eligibility for most special enrollment periods and submit supporting documentation, but enroll in coverage through the Exchanges without further pre-enrollment verification. As mentioned earlier in the preamble, in 2016 we took several steps to further ***18378** verify eligibility for special enrollment periods and planned to implement a pilot program to conduct pre-enrollment verification for a sample of 50 percent of consumers attempting to enroll in coverage through special enrollment periods. The provisions finalized in this rule will increase the scope of pre-enrollment verification, strengthen and streamline the parameters of several existing special enrollment periods, and limit several other special enrollment periods. Starting in June 2017, new consumers in all States served by the HealthCare.gov platform attempting to enroll through applicable special enrollment periods will have to undergo pre-enrollment verification of eligibility,

so that their enrollment would be delayed or "pended" until verification of eligibility is completed by the Exchange. Where possible, the FFE will make every effort to verify an individual's eligibility for a special enrollment period through automated electronic means instead of through documentation. Based on past experience, we estimate that the expansion in pre-enrollment verification to all individuals seeking to enroll in coverage through all applicable special enrollment periods will result in an additional 650,000 individuals having their enrollment delayed or "pended" annually until eligibility verification is completed. As discussed previously in the Collection of Information Requirements section, there will be an increase in costs to the Federal government for conducting the additional pre-enrollment verifications. SBEs that begin to conduct pre-enrollment verification will incur administrative costs to conduct those reviews. We anticipate that there will be a reduction in costs to issuers since they will not have to process any claims while the enrollments are "pended", though these savings may be negated as issuers process any claims that occur while an enrollment is "pended" once an enrollee's special enrollment period eligibility has been verified.

The changes will promote continuous coverage and allow individuals who qualify for a special enrollment period to obtain coverage, while ensuring that uninsured individuals who do not qualify for a special enrollment period obtain coverage during open enrollment instead of waiting until they get sick, which is expected to protect the Exchange risk pools, enhance market stability, and in doing so, limit rate increases. On the other hand, it is possible that the additional steps required to verify eligibility may discourage some eligible individuals from obtaining coverage, and reduce access to healthcare for those individuals, increasing their exposure to financial risk. If it deters younger and healthier individuals from obtaining coverage, it can also worsen the risk pool.

If pre-enrollment verification causes premiums to fall and all individuals who inappropriately enrolled via special enrollment periods continue to be covered, there will be a transfer from such individuals to other consumers. Conversely, if some individuals are no longer able to enroll via special enrollment periods, they will experience reduced access to healthcare. If there is a significant decrease in enrollment,[FN38] especially for younger and healthier individuals, it is possible that premiums will not fall, and potentially might increase.

Office of the Actuary analysis of the net effect of pre-enrollment verification and other special enrollment period changes estimated that premiums will be approximately 1.5 percent lower. The premium difference was calculated by taking into account the greater claims cost per member per month for enrollees through special enrollment periods and fewer enrollees through special enrollment periods.

4. Levels of Coverage (Actuarial Value)

We are amending the de minimis range included in § 156.140(c), to a variation of -4/+2 percentage points, rather than +/- 2 percentage points for all non-grandfathered individual and small group market plans (other than bronze plans meeting certain conditions) that are required to comply with AV for plans beginning in 2018. We are also amending the expanded de minimis range for certain bronze plans from -2/+5 percentage points to -4/+5 percentage points to align with the policy in this rule for the same timeline. While we are modifying the de minimis range for the metal level plans (bronze, silver, gold, and platinum), we are not modifying the de minimis range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420. In the short run, the impact of this change will be to generate a transfer of costs from consumers to issuers. The change in AV may reduce the value of coverage for consumers, which can lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs. However, providing issuers with additional flexibility can help stabilize premiums over time, increase issuer participation and ultimately provide more coverage options at the silver level and above, thereby attracting more young and healthy enrollees into plans at these levels.

Taking into account limits on design flexibilities for bronze plans and related to State limits on flexibility, the Office of the Actuary analysis estimated that the change in AV will lead to a 0.75 percent reduction in total premiums. This analysis estimated that the change to the de minimis range would reduce premiums for the non-subsidized population at the silver, gold, and platinum metal levels.

The lower AV will decrease plan liability for non-cost-sharing variation plans in silver, gold, and platinum and therefore premiums for non-subsidized enrollees will have a proportional reduction in premiums comparable to the reduction in AV.

A reduction in premiums will likely also reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from APTC (or premium tax credit) recipients to the government. One commenter estimated that if the AV for all benchmark silver level plans were to decrease from 68 to 66 percent AV, this would result in a decrease of the benchmark premium by $131 per year, which would reduce APTCs the Federal government provides to consumers by $381 million dollars per year (holding enrollment constant). We agree with the commenter's assessment that lower financial assistance in the form of APTCs is likely. The premium reduction measures total premium reductions not the effects of lower APTC on net premiums for subsidized enrollees. With a decrease in the benchmark premium and therefore the APTC, enrollees, particularly subsidized enrollees who purchase plans with premiums less than the second lowest cost silver plan, could have higher net premiums than in prior years.

The decrease in the de minimis range for the silver metal tier will also affect the value of cost-sharing reductions provided to individuals who qualify for CSRs, with the magnitude of the impact based on individual income levels. Currently, individuals with a household income in the range of 250 to 400 percent of FPL do not receive any CSRs because reductions to the maximum ***18379** annual limitation on cost sharing under the previous de minimis range of 68 percent-72 percent AV, without substantive increases to other cost sharing parameters would have resulted in an AV that exceeded the statutory maximum 70 percent AV. Because enrollees with incomes between 250 to 400 percent of FPL do not receive CSRs, the lower AV for the silver metal tier will result in higher cost sharing for these individuals. However, individuals with a household income up to 250 percent of FPL, who enroll in a CSR silver plan variation, will benefit from additional CSRs that the issuer will provide to make up the difference between the lower AV of silver metal tier standard plans and the CSR silver plan variation AV. As part of CSR reconciliation, HHS will continue to calculate CSR amounts provided based on the cost sharing that the individual would have otherwise paid in a standard plan. That is, if the standard plan the CSR-eligible enrollee chooses is now a 66 percent AV plan, with a de minimis variation of 4 percent below 70 percent AV (or 2 percentage points below the lowest available silver plan at 68 percent AV previously), the CSRs provided will equal the difference between the value of CSRs in the applicable CSR silver plan variation (either 73 percent, 87 percent, 94 percent AV), and the standard plan (66 percent), which will be greater than the CSRs provided if the standard silver plan has +/-2 percent allowable variation. Based on the most recent data on CSRs provided by CSR plan variations, steady-state enrollment in CSR plans, and an increase in CSRs provided based on a conservative range of 30 to 50 percent of CSR eligible individuals choosing a standard silver plan with lower AV than previously available, we estimate the lowered AV under the new de minimis range will increase the CSRs provided to enrollees in 2018 by approximately $200 million to $400 million or approximately an amount equal to the expected reduction in APTCs (or premium tax credits) described above in this section.

5. Network Adequacy

Section 156.230(a)(2) requires a QHP issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. For the 2018 plan year, HHS will defer to the State's reviews in States with authority and means to assess issuer network adequacy; while in States without authority and means to conduct sufficient network adequacy reviews, HHS will rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. Unaccredited issuers in States without network adequacy review will be required to submit an access plan as part of the QHP Application. This may reduce administrative costs for issuers, which can ultimately lead to reduced premiums for consumers.

Depending on the level of review by State regulators and accrediting entities, this can have an impact on plan design. Issuers can potentially use network designs to encourage enrollment into certain plans, exacerbating selection pressures. The net effect on consumers is uncertain.

6. Essential Community Providers

Section 156.235(a)(2)(i) stipulates that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS. For the 2014 plan year, this minimum percentage was 20 percent, but starting with the 2015 Letter to Issuers in the Federally-facilitated Marketplaces, we increased the minimum percentage to 30 percent. For certification and recertification for the 2018 plan year, we will instead consider the issuer to have satisfied the regulatory standard if the issuer contracts with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network. In addition, we are reversing our previous guidance that we were discontinuing the write-in process for ECPs, and will continue to allow this process for the 2018 plan year. If an issuer's application does not satisfy the ECP standard, the issuer will be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years. We expect that issuers will be able to meet this requirement, with the exception of issuers that do not have any ECPs in their service area.

Less expansive requirements for network size will lead to both costs and cost savings. Costs can take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks.

Cost savings for issuers will be associated with reductions in administrative costs of arranging contracts, meeting QHP certification requirements, and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of healthcare provision.

7. Uncertainty

The net effect of these provisions on enrollment, premiums and total premium tax credit payments are uncertain. That is, premiums will tend to fall if more young and healthy individuals obtain coverage, adverse selection is reduced and issuers are able to lower costs due to reduced regulatory burden, and offer greater flexibility in plan design. However, if changes such as a shortened open enrollment period, pre-enrollment verification for special enrollment periods, reduced AV of plans, or less expansive provider networks result in lower enrollment, especially for younger, healthier adults, it will tend to increase premiums. Lower premiums in turn will increase enrollment, while higher premiums will have the opposite effect. In addition, lower premiums will tend to decrease total premium tax credit payments, which can be offset by an increase in enrollment. Increased enrollment will lead to an overall increase in healthcare spending by issuers, while a decrease in enrollment will lower it, although the effect on total healthcare spending is uncertain, since uninsured individuals are more likely to obtain healthcare through high cost providers such as emergency rooms.

D. Regulatory Alternatives Considered

In developing the final rule, we considered maintaining the status quo with respect to our interpretation of guaranteed availability, network adequacy requirements, and essential community provider requirements. However, we determined that the changes are urgently needed to stabilize markets, to incentivize issuers to enter into or remain in the market and to ensure premium stability and consumer choice.

With respect to the provision regarding essential community providers, we considered proposing a minimum threshold other than 20 percent, but believed that reverting to the previously used 20 percent threshold that issuers were used to would better help stabilize the markets, while adequately protecting access to ECPs.

***18380** We also considered keeping the current individual market open enrollment period for 2018 coverage, but determined that an immediate change would have a positive impact on the individual market risk pools by reducing the risk of adverse selection and that the market is mature enough for an immediate transition.

In addition, we considered increasing the scope of pre-enrollment verification for certain special enrollment periods to 90 percent instead of 100 percent. This would have allowed us to maximize the verification of eligibility while providing some control population for claims comparison as envisioned by the scaled pilot. We solicited comment on the issue, but noted that we believe that in order to minimize the risk of adverse selection, complete pre-enrollment verification for special enrollment periods is necessary. We also considered maintaining the existing parameters around special enrollment periods so that the individual market special enrollment periods would continue to align with group market policies. However, HHS determined that aspects of the individual market and the unique threats of adverse selection in this market justified a departure from the group market policies.

With respect to the provision regarding AV, we considered proposing that the change would be effective for the 2019 plan year, but determined that an immediate change would have a positive impact on the markets for the 2018 plan year.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601, et seq.) requires agencies to prepare a regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

This rule will affect health insurance issuers. We believe that health insurance issuers would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $38.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $32.5 million or less.[FN39] We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2015 MLR reporting year, approximately 97 out of 528 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less. This estimate may overstate the actual number of small health insurance companies that would be affected, since almost 74 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that would result in their revenues exceeding $38.5 million for Direct Health and Medical Insurance Carriers or $32.5 million for HMO Medical Centers.

HHS is not preparing an analysis for the RFA because it has determined, and the Secretary certifies, that this rule will not have a significant economic impact on a substantial number of small entities.

F. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a rule that includes any Federal mandate that may result in expenditures in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. Currently, that threshold is approximately $146 million. Although we have not been able to quantify all costs, we expect the combined impact on State, local, or Tribal governments and the private sector to be below the threshold.

G. Federalism

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

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In HHS's view, while this final rule will not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute and this final rule, States have choices regarding the structure, governance, and operations of their Exchanges. This rule strives to increase flexibility for SBEs. For example, we recommend, but do not require, that SBEs engage in pre-enrollment verification with respect to special enrollment periods; and we will defer to State network adequacy reviews provided the States have the authority and the means to conduct network adequacy reviews. Additionally, the PPACA does not require States to establish these programs; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

While developing this rule, HHS attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

H. Congressional Review Act

This rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 ***18381** U.S.C. 801, et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review.

I. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, entitled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment or otherwise promulgates a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. It has been determined that this final rule does not impose costs that trigger the above requirements of Executive Order 13771.

List of Subjects

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant administration, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, American Indian/Alaska Natives, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 147, 155, and 156 as set forth below:

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

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

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

45 CFR § 147.104

2. Section 147.104 is amended by adding paragraph (b)(2)(iii) to read as follows:

45 CFR § 147.104

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(2) * * *

(iii) Notwithstanding anything to the contrary in § 155.420(d) of this subchapter, § 155.420(a)(4) of this subchapter does not apply to limited open enrollment periods under paragraph (b)(2) of this section.

* * * * *

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

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

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

45 CFR § 155.400

4. Section 155.400 is amended by adding paragraph (e)(1)(iv) to read as follows:

45 CFR § 155.400

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) * * *

(1) * * *

(iv) Notwithstanding the requirements in paragraphs (e)(1)(i) through (iii) of this section, for coverage to be effectuated after pended enrollment due to special enrollment period eligibility verification, the binder payment must consist of the premium due

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for all months of retroactive coverage through the first prospective month of coverage consistent with the coverage effective dates described in § 155.420(b)(1), (2) and (3) or, if elected, § 155.420(b)(5) and the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction.
* * * * *45 CFR § 155.410
5. Section 155.410 is amended by revising paragraphs (e)(2) and (3) to read as follows:

§ 155. 410 Initial and annual open enrollment periods.
* * * * *
(e) * * *

(2) For the benefit years beginning on January 1, 2016 and January 1, 2017, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) For the benefit years beginning on or after January 1, 2018, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.
* * * * *45 CFR § 155.420
6. Section 155.420 is amended by:

a. Adding paragraph headings for paragraphs (a)(1) and (2);

b. Adding paragraphs (a)(3) through (5);

c. Revising paragraphs (b)(1) introductory text, (b)(5), and (d) introductory text;

d. Adding paragraph (d)(2)(i)(A) and reserved paragraph (d)(2)(i)(B); and

e. Revising paragraph (d)(7).

The additions and revisions read as follows:
45 CFR § 155.420

§ 155.420 Special enrollment periods.
(a) * * *

(1) General parameters. * * *

(2) Definition of dependent. * * *

(3) Use of special enrollment periods. Except in the circumstances specified in paragraph (a)(4) of this section, the Exchange must allow a qualified individual or enrollee, and when specified in paragraph (d) of this section, his or her dependent to enroll in a QHP if one of the triggering events specified in paragraph (d) of this section occur.

(4) Use of special enrollment periods by enrollees. (i) If an enrollee has gained a dependent in accordance with paragraph (d)(2)(i) of this section, the Exchange must allow the enrollee to add the dependent to his or her current QHP, or, if the current QHP's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and his or her dependents to ***18382** change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or, at the option of the enrollee or dependent, enroll the dependent in any separate QHP.

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(ii) If an enrollee and his or her dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and his or her dependents to change to a silver-level QHP if they elect to change their QHP enrollment.

(iii) If an enrollee qualifies for a special enrollment period or is adding a dependent to his or her QHP through a triggering event specified in paragraph (d) of this section other than those described under paragraph (d)(2)(i), (d)(4), (d)(6)(i), (d)(6)(ii), (d)(8), (d)(9), or (d)(10), the Exchange must allow the enrollee and his or her dependents to make changes to his or her enrollment in the same QHP or to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or, at the option of the enrollee or dependent, enroll in any separate QHP.

(5) Prior coverage requirement. Qualified individuals who are required to demonstrate coverage in the 60 days prior to a qualifying event can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event; lived in a foreign country or in a United States territory for 1 or more days during the 60 days preceding the date of the qualifying event; or that they are an Indian as defined by section 4 of the Indian Health Care Improvement Act.

(b) * * *

(1) Regular effective dates. Except as specified in paragraphs (b)(2), (3), and (5) of this section, for a QHP selection received by the Exchange from a qualified individual—

* * *

(5) Option for later coverage effective dates due to prolonged eligibility verification. At the option of the consumer, the Exchange must provide for a coverage effective date that is no more than 1 month later than the effective date specified in this paragraph (b) if a consumer's enrollment is delayed until after the verification of the consumer's eligibility for a special enrollment period, and the assignment of a coverage effective date consistent with this paragraph (b) would result in the consumer being required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation.
* * * * *
(d) Triggering events. Subject to paragraphs (a)(3) through (5) of this section, as applicable, the Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the triggering events occur:
* * * * *
(2) * * *

(i) * * *

(A) In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.

(B) [Reserved]
* * * * *
(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and—

(i) Had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move.

(ii) [Reserved]

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* * * * *45 CFR § 155.725
7. Section 155.725 is amended by adding paragraph (j)(7) to read as follows:
45 CFR § 155.725

§ 155.725 Enrollment periods under SHOP.
* * * * *
(j) * * *

(7) Notwithstanding anything to the contrary in § 155.420(d), § 155.420(a)(4) and (d)(2)(i)(A) do not apply to special enrollment periods in the SHOP.
* * * * *

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES
8. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301-1304, 1311-1313, 1321-1322, 1324, 1334, 1342-1343, 1401-1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).
45 CFR § 156.140
9. Section 156.140 is amended by revising paragraph (c) to read as follows:
45 CFR § 156.140

§ 156.140 Levels of coverage.
* * * * *
(c) De minimis variation. For plan years beginning on or after January 1, 2018, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is -4 percentage points and +2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -4 percentage points and +5 percentage points.

CMS-9929-P
Dated: April 10, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 11, 2017.

Thomas E. Price,

Secretary, Department of Health and Human Services.

[FR Doc. 2017-07712 Filed 4-13-17; 4:15 pm]

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Footnotes

1 The HIPAA requirement for guaranteed renewability, codified in section 2712 of the PHS Act, was renumbered by the PPACA to section 2703 of the PHS Act. HIPAA's guaranteed renewability requirement continues to apply in certain contexts, such as to issuers in the U.S. territories and issuers of expatriate health plans.

2 Initial Guidance to States on Exchanges (November 10, 2018). Available at https://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html.

3 Similar provisions in § 146.150 apply to health insurance issuers offering grandfathered and non-grandfathered coverage in the small group market.

4 For purposes of this rulemaking, the term "past-due premiums" refers to premiums that have not been paid by the applicable due date as established by the issuer in accordance with applicable Federal and State law. It does not include premiums for months in which individuals were not enrolled in coverage.

5 Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual, Section 6.3 Terminations for Non-Payment of Premiums, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf.

6 See summary of comments at 78 FR 13416 (Feb. 27, 2013).

7 Issuers may also have obligations under other applicable Federal laws prohibiting discrimination, and issuers are responsible for ensuring compliance with all applicable laws and regulations. There may also be separate, independent non-discrimination obligations under State law.

8 Section 156.270(d) requires issuers to observe a 3-consecutive month grace period before terminating coverage for those enrollees who upon failing to timely pay their premiums are receiving APTC. Section 155.430(d)(4) requires that when coverage is terminated following this grace period, the last day of enrollment in a QHP through the Exchange is the last day of the first month of the grace period. Therefore, individuals whose coverage is terminated at the conclusion of a grace period would owe at most 1 month of premiums, net of any APTC paid on their behalf to the issuer. Individuals who attempt to enroll in new coverage while in a grace period (and whose coverage has not yet been terminated) could owe up to 3 months of premium, net of any APTC paid on their behalf to the issuer.

9 As discussed below, the FF-SHOP is unable to offer issuers this flexibility at this time.

10 For example, a subscriber of an individual policy or an employer that purchases a group policy is typically responsible for payment of the premiums. Thus, an issuer cannot refuse to effectuate new coverage purchased by a dependent because the subscriber owes past-due premiums or new coverage purchased by a current or former employee (or his or her dependent) because the employee's employer owes past-due premiums.

11 See 45 CFR 147.106(d)(4). States adopting the policy may use a narrower definition of "controlled group."

12 FFM and FFM-SHOP Enrollment Manual (Section 6.1).

13 For example, see Section 6.1 of the FFM and FF-SHOP Enrollment Manual (revised July 19, 2016).

14 81 FR 12203, 12273.

15 See 81 FR 12274.

16 November 2016, Results of Enrollment Testing for the 2016 Special Enrollment Period, GAO-17-78, US Government Accountability Office.

17 February 25, 2016, Fact Sheet: Special Enrollment Confirmation Process. Available online at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html.

18 Ibid.

19 December 14, 2016, Fact Sheet: Pre-Enrollment Verification for Special Enrollment Periods, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF.

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20 Stan Dorn, Enrollment Periods in 2015 and Beyond: Potential Effects on Enrollment and Program Administration (Washington, DC: Urban Institute, February 2015), available online at http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf.

21 Centers for Medicare and Medicaid Services (CMS), Pre-Enrollment Verification for Special Enrollment Periods (Dec. 14, 2016), available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF.

22 HHS, Clarifying, Eliminating and Enforcing Special Enrollment Periods (January 19, 2016), available at http://wayback.archive-it.org/2744/20170118130449/https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/.

23 Key Dates for Calendar Year 2017: Qualified Health Plan Certification in the Federally-facilitated Exchanges; Rate Review; Risk Adjustment and Reinsurance, (April 2017), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#.

24 Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf.

25 Although we proposed to expand the de minimis range for bronze plans to -4 percentage points, we also recognized that achieving an AV below 58 percent is difficult with the claims distribution underlying the current AV Calculator.

26 As of the 2018 plan year, no State has an AV Calculator that utilizes state-specific data under § 156.135(e); therefore, an AV Calculator that utilizes State-specific data is intended for plan years beyond 2018.

27 For the purposes of this section of the rule, references to decreases in APTCs also reflect the possibility of decreases in premium tax credits not paid in advance.

28 A plan with a deductible of $7,350 that is equal to the annual limitation on cost sharing of $7,350 for 2018 with no services covered until the deductible and annual limitation on cost sharing are met, other than preventive services required to be covered without cost sharing under section 2713 of the PHS Act and § 147.130, has an AV of 58.54 percent based on the 2018 AV Calculator. 81 FR 61455. September 6, 2016.

29 A Revised Final 2018 AV Calculator, User Guide and Methodology are posted on CCIIO's Web site under “Plan Management” at https://www.cms.gov/cciio/resources/regulations-and-guidance/#Plan Management.

30 Letter to Issuers on Federally-facilitated and State Partnership Exchanges (April 5, 2013). Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

31 Recognition of Entities for the Accreditation of Qualified Health Plans 77 FR 70163 (November 23, 2012) and Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans 78 FR 77470 (December 23, 2013).

32 The National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act is available at http://www.naic.org/store/free/MDL-74.pdf.

33 Key Dates for Calendar Year 2017: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurances, Revised February 2017, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Key-Dates-for-Calendar-Year-2017-2-17-17.pdf.

34 2015 Letter to Issuers in the Federally-facilitated Marketplaces. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

35 List available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/FINAL-CMS-ECP-LIST-PY-2018_12-16-16.xlsx.

36 For a list of types of providers eligible to participate in the 340B Drug Program, see https://www.hrsa.gov/opa/eligibilityandregistration/index.html.

a Enrollment may increase due to decreases in premiums resulting from pass-through of administrative cost savings (as listed) and savings associated with reductions in special enrollment period or the shortened open enrollment period. Enrollment may decrease due to lessened consumer appeal of insurance with reduced AV and less access to ECPs, increases in premiums resulting from pass-through of administrative costs (as listed), former special enrollment period users discontinuing participation, or due to shortened enrollment periods. The net effect on enrollment is ambiguous.

b These cost and cost savings generalizations are somewhat oversimplified because uninsured individuals are relatively likely to obtain healthcare through high-cost providers (for example, visiting an emergency room for preventive services).

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c These savings will potentially be negated as issuers process any claims that occur while being "pended" once an enrollee's SEP eligibility has been verified.

37 2016 OEP: Reflection on enrollment, Center for U.S. Health System Reform, McKinsey & Company, May 2016, available at http://healthcare.mckinsey.com/2016-oep-consumer-survey-findings.

38 As some commenters noted, preliminary data regarding HHS's special enrollment confirmation process did indicate a decrease in special enrollment period plan selection. See, Frequently Asked Questions Regarding Verification of Special Enrollment Periods (Sept. 6, 2016) available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf.

39 "Table of Small Business Size Standards Matched to North American Industry Classification System Codes", effective February 26, 2016, U.S. Small Business Administration, available at https://www.sba.gov/contracting/getting-started-contractor/make-sure-you-meet-sba-size-standards/table-small-business-size-standards.

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Federally-facilitated Exchanges (FFEs) and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual

This manual is effective as of July 10, 2019. All enrollments made on or after July 10, 2019 should be processed in accordance with the operational requirements set forth in this document.

CMS intends to update this Manual regularly, and publish clarifying bulletins between updates. All previous versions of bulletins that have been incorporated into this version of the manual should be considered superseded by this manual. If you have questions related to content posted within this manual, please email: CMS_FEPS@cms.hhs.gov.

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1.3 PURPOSE OF DOCUMENT

This manual provides operational policy and guidance on key topics related to eligibility and enrollment within the FFEs and FF-SHOPs, as well as within the SBEs-FP, which use the federal platform for eligibility and enrollment. For ease of reference, this document will use the terms "FFEs" and "FF-SHOP" to refer to all individual market Exchanges and SHOPs that rely on the federal eligibility and enrollment platforms.

Where necessary, CMS will indicate whether the guidance described pertains to the FFEs and FF-SHOP, only the FFEs, or only the FF-SHOP. Additionally, we have indicated, where applicable, the guidance pertains to both QHPs and Exchange-certified stand-alone dental plans, which this manual refers to as qualified dental plans (QDPs).

The information provided in this document applies to organizations and entities that may be involved in or assist with enrolling a QI into a QHP and/or QDP using the FFEs eligibility and enrollment functions. These entities include:

- SBE-FPs;
- QHP and QDP issuers;
- Agents and brokers (A/B) who are registered with the FFEs;
- Navigators, certified application counselors (CACs), and caseworkers;
- Third-party administrators (TPAs) of QHPs, QDPs, or employer-sponsored coverage; and
- Trading partners of QHP and QDP issuers, such as health care clearinghouses.

1.4 ACRONYMS AND DEFINITIONS

Exhibit 1 and the subsection that follows describe the commonly used acronyms and terms that appear throughout this document.

Exhibit 1 – Commonly Used Acronyms

Acronyms	Descriptions
AMRC	Additional Maintenance Reason Code
API	Application Programming Interface
APTCs	Advanced Premium Tax Credits
A/B	Agent and/or Broker
BAR	Batch Auto-reenrollment
BHP	Basic Health Program
BUU	Batch Utility Update
CAC	Certified Application Counselor
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services

FFEs and FF-SHOP Enrollment

CIC	Change in Circumstance
CSRs	Cost-sharing Reductions
DE	Direct Enrollment
DMI	Data Matching Issues
DSH	Data Services Hub
EDI	Electronic Data Interchange
EDE	Enhanced Direct Enrollment
EDS	External Data Source
EDN	Eligibility Determination Notice
EFT	Electronic Funds Transfer
EHB	Essential Health Benefits
EIN	Employer Identification Number
ER&R	Enrollment Resolution and Reconciliation
FFEs	Federally-facilitated Exchanges
FF-SHOP	Federally-facilitated Small Business Health Options Program
FPL	Federal Poverty Level
HHS	Department of Health & Human Services
HICS	Health Insurance Casework System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIOS	Health Insurance Oversight System
IRS	Internal Revenue Service
LC	Life Change
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MCR	Management Consumer Record
MLR	Medical Loss Ratio
MOEN	Marketplace Open Enrollment Notice
OEP	Open Enrollment Period
PBP	Plan Benefit Package
PCL	Plan Category Limitations
PMP/PP	Partial Month Premium/Premium Proration
PPACA	Patient Protection and Affordable Care Act
PTC	Premium Tax Credit
QDP	Qualified Dental Plan

QHP	Qualified Health Plan
QI	Qualified Individual
RA	Risk Adjustment
RCNI	Reconciliation Inbound
SBE	State-based Exchange
SBE-FP	State-based Exchange – Federal Platform
SB-SHOP	State-based Small Business Health Options Program
SEP	Special Enrollment Period
SOAP	Simple Object Access Protocol
TPA	Third-party Administrator
UEFF	Unauthorized Enrollment Finder File

1.4.1 Definitions

Form 1095 A: A tax form (like a W-2) that the Exchange furnishes to individuals who are enrolled in Qualified Health Plans (QHPs) through the Exchange. The Form 1095-A provides enrollees with information about their health coverage so they can: file their taxes; reconcile advance payments of the premium tax credit (APTC); and claim the premium tax credit (PTC).

Advanced Premium Tax Credits: Advanced premium tax credits, also known as advance payments of the premium tax credit or APTCs, can be used by eligible taxpayers who are enrolled in QHPs through an individual market Exchange to lower their monthly premium costs. Eligible taxpayers may choose how much APTC to apply to their premiums each month, up to a maximum amount, which is then paid directly to the insurer. The APTC must be reconciled with the premium tax credit (PTC) on an individual's federal income tax return. If the APTC amount received for the year is less than the PTC, the individual will receive the difference as a higher refund or lower tax due. If the APTC amount received for the year is more than the PTC, the excess advance payments may have to be repaid with the individual's tax return.

Agent or Broker*:* Agent or Broker (A/B) has the meaning set forth in 45 CFR §155.20.

Applicant: Applicant has the meaning set forth in 45 CFR §155.20.

Application Filer: Application filer has the meaning set forth in 45 CFR §155.20.

Auto-Reenrollment (Passive): Auto-reenrollment is an enrollment transaction that continues coverage in the individual market FFEs for the new plan year for an enrollee who does not actively select a plan for the new plan year during the Open Enrollment Period (OEP) automatically without a lapse in coverage, if timely premium payment is made.

Batch Auto Reenrollment (BAR): BAR is the process the individual market FFEs use to

implement auto-reenrollment.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is federal legislation that amended the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act to provide for continuation of group health coverage that otherwise might be terminated. COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of group health plan coverage at group rates. This coverage, however, is available only when coverage under the group health plan is lost due to specific events.

Cost-sharing Reductions (CSRs): Cost-sharing reductions have the meaning set forth in 45 CFR §155.20.

Data Matching Issue/Inconsistency: When an application filer provides information to the Marketplace as a part of the application process and the information the application filer provided does not match the information received by the Exchange from its trusted data sources, such as the Office of Personnel Management, Department of Homeland Security, or Social Security Administration, a data matching issue/inconsistency results. The application filer needs to resolve data matching issues related to citizenship or immigration within 95 days, and all other data matching issues within 90 days. Otherwise, the enrollee's enrollment through the Marketplace may be terminated and/or the enrollee's APTCs and CSR may be terminated or adjusted, if applicable.

Electronic Data Interchange (EDI): EDI is an automated transfer of data in a specific format following specific data content rules between a Marketplace and a QHP or QDP issuer. EDI transactions are transferred electronically through HealthCare.gov or an SBE.

Enrollee: Enrollee has the meaning set forth in 45 CFR §155.20.

Enrollment Group (in the individual market FFEs): All QIs enrolled and linked by the Marketplace-assigned policy identifier. Additional QIs may be linked by the policy Marketplace identifier, such as a custodial parent, but may not be considered part of the enrollment group.

Enrollment Data Alignment: The ongoing processes used to ensure consistency of enrollment and financial data between issuers and the FFEs. Since the Centers for Medicare & Medicaid Services (CMS) makes payment of APTCs to QHP issuers on the basis of the enrollment files, all entities' enrollment data must be reconciled. In addition, the enrollment data stored in the FFEs are used as the basis for annual generation of Form 1095-A tax data for QIs. Discrepancies can arise when an issuer accepts a change from an enrollee based on Health Insurance Casework System (HICS) instructions (i.e., a change that has not been reflected in the FFEs, but one that the reconciliation process identifies) and enters it directly into its system. By regulation, issuers are required to reconcile enrollment information with the FFEs at least monthly.

Full-time Employee: For SHOP eligibility purposes, an employee who is employed, on average, at least 30 hours of service per week (26 U.S.C. §4980H, 26 CFR §54.4980H-1(a)(21), and 45

CFR §155.20). For purposes of the Small Business Health Care Tax Credit, a full-time employee is an employee who is employed, on average, at least 40 hours of service per week (26 U.S.C. § 45R).

Health Insurance Casework System (HICS): The authorized and secure electronic system recognized and used by the FFEs to input, track, and monitor QIs' and enrollees' concerns, unresolved issues, complaints, and cases that are not able to be resolved by CMS. The FFEs use HICS to appropriately assign unresolved cases and communicate effective date changes to issuers for resolution, when appropriate.

Insurance Affordability Programs: APTCs and CSR, as well as Medicaid, CHIP, and, where applicable, the Basic Health Program (BHP).

Life Change (LC): A circumstance that could affect an applicant's or enrollee's eligibility for enrollment through the Marketplace or for insurance affordability programs (e.g., birth, adoption, foster care, change in household income). LCs that are not reported to the applicable Marketplace could potentially lead to an enrollee or applicable tax filer repaying all or some of the APTCs the enrollee received during the year.

Marketplace Account: The Marketplace account provides an individual with a user name and password to create an individual application and perform other functions related to obtaining health coverage through a Marketplace. A Marketplace Account user does not need to be the policyholder for coverage purchased from applications submitted by the Marketplace Account user.

Minimum Essential Coverage (MEC): MEC is the type of coverage an individual must have to meet the individual shared responsibility requirement under the PPACA. The MEC requirement can be fulfilled by a number of different types of coverage outlined in section 5000A(f) of the Internal Revenue Code and in 45 CFR §156.602, such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other types of coverage.

Modified Adjusted Gross Income (MAGI): MAGI is the figure used to determine eligibility for insurance affordability programs in the Marketplaces, and for Medicaid and CHIP. Generally, MAGI is an individual's adjusted gross income plus certain other income, including tax-exempt Social Security, interest, or foreign income, and without certain deductions allowed for adjusted gross income (26 CFR §1.36B-1(e)(2) and 42 CFR §435.603).

Open Enrollment Period (OEP): The period each year during which a QI may enroll or change coverage in an individual market QHP through the Marketplace (45 CFR §155.20).

Partial Month Premium/Premium Proration (PMP/PP): Occurs in the Exchange when an enrollee has periods of coverage that last less than a full month. In the FFEs and FF-SHOP, the pro-rated monthly premium for partial coverage months is calculated based on the actual number of days that the applicable enrollee or enrollees has/have coverage. Specifically, the premium is prorated as follows: the full month premium for one month of the coverage is divided by the

number of days in the month. The result of the calculation is multiplied by the number of days in which the enrollee had coverage during the partial coverage month.

Plan Year: Plan year has the meaning set forth in 45 CFR §155.20.

Plan Category Limitations (PCL): Established in the 2017 Market Stabilization Rule, enrollees and their dependents, including newly added household members, who qualify for common Special Enrollment Periods, like a loss of health insurance, moving, or a change in household size, are generally only able to enroll in a plan from their current plan category. See 45 CFR §155.420(a)(4).

Product: Product has the meaning set forth in 45 CFR §144.103.

Qualified Health Plan (QHP): A health insurance plan that meets certain requirements and, on the basis of meeting those requirements, is certified to be sold through an Exchange. A QHP must be certified by each Exchange through which it is sold. QHP has the meaning set forth in 45 CFR §155.20.

QHP Issuer: QHP issuer has the meaning set forth in 45 CFR §155.20.

Qualified Individual (QI): QI has the meaning set forth in 45 CFR §155.20.

Qualified Employee: Qualified employee has the meaning set forth in 45 CFR §155.20.

Qualified Employer: Qualified employer has the meaning set forth in 45 CFR §155.20.

Reinstatement: Reinstatement is the correction of an erroneous termination or cancellation action that results in the restoration of an enrollment with no break in coverage (45 CFR §155.430(e)(3).

Reenrollment (Active): An 834 enrollment transaction that continues enrollment in coverage through the individual market Exchange for an enrollee who actively returns to the Exchange, generally during the OEP, to make a plan selection for the new plan year.

SHOP application filer: SHOP application filer has the meaning set forth at 45 CFR §155.700(b).

Small employer: Small employer has the meaning set forth in 45 CFR §155.20.

Special Enrollment Period (SEP*):* SEP has the meaning set forth in 45 CFR §155.20.

Subscriber: A subscriber is the individual enrolling in coverage who has elected benefits for an enrollment group or the person for whom benefits have been elected by the application filer in the event that the application filer is not the person enrolling in coverage. There is always only one subscriber per enrollment group and each member of the enrollment group will be associated with the subscriber. The subscriber may also be referred to as the anchor for the group.

Tax Filer: A tax filer is an individual who will file taxes for the coverage year on behalf of a tax

household.

Web-broker: A web-broker is an individual A/B, group of A/Bs, or company that provides a non-FFEs website to assist QIs in the QHP selection and enrollment process as described in 45 CFR §155.220(c)(3).

Additional Resources

Exhibit 2 lists contact information for additional resources referenced throughout this manual.

Exhibit 2 – Additional Resources

Resources	Contact Information
CCIIO	www.cms.gov/cciio
Marketplace Call Center	1-800-318-2596 1-855-889-4325 (TTY)
HealthCare.gov	www.healthcare.gov
Medicaid	www.medicaid.gov
Medicare	www.medicare.gov
Registration for Technical Assistance Portal (REGTAP)	www.regtap.info
FF-SHOP Hotline	1-800-706-7893 (TTY: 1-888-201-6445)
CMS zONE	https://zone.cms.gov
Marketplace Service Desk (MSD)	CMS_FEPS@cms.hhs.gov 1-855-CMS-1515
Health Insurance Casework System (HICS)	hics@cms.hhs.gov 1-888-205-0684

For instructions on registering for CMS zONE visit:
https://www.regtap.info/reg_librarye.php?i=2466

6. SPECIAL ENROLLMENT PERIODS (APPLICABLE TO INDIVIDUAL MARKET FFEs, QHPs/QDPs)

Pursuant to 45 CFR §155.410(a)(2), and 45 CFR §155.20, Special Enrollment Periods (SEPs) allow a qualified individual or enrollee who experiences certain qualifying events to enroll in, or change enrollment in, a QHP through the Exchange outside of the annual open enrollment periods. Exchanges must adhere to the parameters for SEPs defined at 45 CFR §155.420.

Section 6 provides an overview of events that trigger SEPs and details about how the FFEs administer them. It includes material that applies to the FFEs and to the FF-SHOP; information on SEPs that apply only to the FF-SHOP is available in Section 4.4. Information on the applicability of binder payments rules is available in Section 7.1.

SEP Pre-Enrollment Verification

Pursuant to the preamble of the 2017 Market Stabilization Rule[27], the FFEs conduct pre- enrollment verification of newly enrolling individuals' SEP eligibility. This SEP verification, which applies to the most common SEP types, is intended to promote program integrity and continuous coverage, protect the risk pool, and stabilize rates. See Exhibit 15 below for details on which SEP types are subject to SEP verification. The preamble of the 2017 Market Stabilization Rule provided SBEs with flexibility to determine whether and how to implement SEP pre-enrollment verification.

SEP verification does not impact the individual's Exchange-generated effective date, which is typically determined by the SEP triggering event and the date the individual selects a QHP (see section 5.2 for more information on SEP triggering events and coverage effective dates).

Individuals subject to SEP verification have their enrollment "pended" until the FFEs complete verification of SEP eligibility either through automated electronic means or based on documentation that the individual submits. The requirement to verify SEP eligibility is referred to as a SEP verification issue (SVI).[28] If the FFEs cannot automatically verify an individual's SEP eligibility, then the individual must submit documentation within 30 calendar days of plan selection in order to verify eligibility. Once an individual's SEP eligibility has been verified, the FFEs will release his or her enrollment information to the relevant issuer. SEP verification currently applies to the following SEP types: Loss of qualifying coverage; permanent move; marriage; gaining or becoming a dependent through an adoption, foster care placement, or other court order; and Medicaid/CHIP denial.

Plan Category Limitations for SEPs

The 2017 Market Stabilization Rule also provided that while existing FFE enrollees are not subject to SEP verification, they may be limited in their ability to change plans during the benefit year if they qualify for a SEP. This "plan category limitations" (PCL) policy was codified in regulation at 45 CFR §155.420(a)(3) and (4). It applies to individuals who enroll in Exchange coverage, but not to those enrolling in individual market coverage off-Exchange. The FFEs

[27] https://www.regulations.gov/document?D=CMS-2017-0021-4021
[28] https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf

implemented PCL in February 2019; implementation timelines in SBEs may vary. Direct Enrollment (DE) partners that process enrollments through SEPs must implement functionality to ensure enrollees subject to PCL can only see plans for which they are eligible, and those requirements can be found in the DE API specs at: https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials

PCL Background

Health plans sold in the Exchange are divided into categories: Bronze, Silver, Gold, and Platinum. They range from Bronze plans, which have lower premiums and higher out-of-pocket costs, to Platinum plans, which have higher premiums and lower out-of-pocket costs. Catastrophic plans, which have lower monthly premiums and higher out-of-pocket costs, and which are not eligible for PTC, may also be available to people under age 30 and people who qualify for hardship exemptions.

Under PCL, enrollees who qualify for most SEP types and want to change plans during the year will have a limited number of plan categories to choose from. This means if an enrollee wants to change plans during a SEP for which they qualify, they may need to select a new plan within the same plan category as their current plan, or wait until the next OEP if they want to change to a plan in a different category.

- If an enrollee becomes newly eligible for cost-sharing reductions (CSR) and is not already enrolled in a Silver plan, that enrollee can choose a plan in the Silver category to use his/her CSR.
- If an enrollee gains a dependent due to marriage, birth, adoption, foster care, or court order, he or she can add the new dependent to his or her current plan, or enroll the new dependent in a plan of any plan category. To enroll the new dependent in a plan of any plan category, the enrollee must create a separate enrollment group for his or her dependent before proceeding to Plan Compare to view all plans available to the new dependent. Note: Only the new dependent may enroll in a plan of any plan category - Current enrollees generally cannot change plans.
- If an enrollee wishes to add a new dependent to the current plan, but the current plan's business rules do not allow it, the enrollee and dependent can enroll together in a different plan in the same category. If no other plans are available in the same category as the current plan, the enrollee can enroll together with the new dependent in a limited range of categories. For example, if the enrollee's existing Gold plan does not allow him or her to add a new dependent, and no other Gold plans are available, the enrollee and dependent can enroll together in a Platinum or Silver plan.

For more details about PCL rules by SEP type, see Exhibit 15 below.

6.1 AVAILABILITY AND LENGTH OF SEPS

The FFEs determine whether an individual is eligible for an SEP based on a qualifying event described in 45 CFR §155.420(d). Pursuant to 45 CFR §155.420(c), unless otherwise stated, SEPs in the FFEs and other Exchange individual markets last 60 days from the date of the triggering event. Exceptions to the 60-day availability period include:

- Certain SEPs for which the FFEs may define the length of the SEP based on the circumstances, such as SEPs related to enrollment errors, exceptional circumstances, and misrepresentation.[29] The SEPs for these situations may last less than 60 days, depending on the specific situation, but will not last for longer than 60 days.

In addition, it is important to note that the FFEs offer advanced availability of the SEP for loss of MEC for QIs or their dependents, so these individuals have up to 60 days before and up to 60 days after the loss of coverage to report a qualifying event and select a QHP.

Exchanges have the option to offer advanced availability to QIs and enrollees who qualify for an SEP due to a permanent move, becoming newly eligible for premium tax credits as a result of a move or increase in income above 100% FPL, or becoming newly eligible for QHP coverage; however, the FFEs do not currently offer advanced availability for these SEPs.

- SEPs in the FF-SHOP may apply differently and have different availability periods (see 45 CFR §155.726(c) and Section 4.4).

6.2 SEP TRIGGERING EVENTS AND COVERAGE EFFECTIVE DATES

Individuals may qualify for an SEP under 45 CFR §155.420(d) based on certain "triggering events." Certain SEPs are available to all QIs who experience a triggering event, while others are only available to current enrollees, or individuals who previously had MEC. Most triggering events apply to all individual (FFEs and SBEs) and SHOP Exchanges, however, in some cases triggering events are not applicable in the FF-SHOP or are at the option of the Exchange, and therefore may not be operationalized outside of the FFEs. Please see Exhibit 15 for a description of the applicability of each SEP. For more information on SEPs that apply only to the SHOP Exchanges, please see Section 4.4 and 45 CFR §155.726(c).

Coverage effective dates for individuals who enroll through an SEP are established in 45 CFR §155.420(b) and apply to SEPs offered in individual and SHOP Exchanges.

Regular Coverage Effective Dates

As described in 45 CFR §155.420(b)(1), **regular coverage effective dates** for enrollment during an SEP are the first day of the month following QHP selection if selection took place between the first and 15th day of any month or the first day of the second month following QHP selection if selection took place between the 16th and the last day of any month.

Other Coverage Effective Dates

Pursuant to 45 CFR §155.420(b)(2)(i), for a QI who gains a dependent or becomes a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, an Exchange must offer coverage **retroactive** to the date of birth, adoption, placement for adoption or in foster care, or the date of the child support or other court order. QIs may also elect a later coverage effective date (either the first of the month

[29] See 45 CFR §155.420(c)(3). In the case of QIs/enrollees eligible for an SEP based on criteria in 45 CFR §155.420(d)(4), (d)(5), or (d)(9), the Exchange may define the length of the SEP "as appropriate based on the circumstances of the SEP, but in no event shall the length of the SEP exceed 60 days."

following plan selection, or in accordance with paragraph (b)(1)) by calling the Marketplace Call Center.

Pursuant to 45 CFR §155.420(b)(2)(iii), an Exchange may provide for a coverage effective date that is appropriate based on the circumstances of the SEP. For example, when individuals or enrollees have experienced an Exchange error (per 45 CFR §155.420(d)(4)), they will be given the option for a retroactive coverage effective date back to their initially intended coverage effective date, absent the error.

45 CFR §155.420(b)(2)(iv) provides that certain SEPs offer "**accelerated coverage effective dates**," which is the date of the first day of the month following plan selection, regardless of whether plan selection takes place in the first or second half of the month. For example, individuals or enrollees who qualify for an SEP due to a loss of MEC (per 45 CFR §155.420(d)(1) and (d)(6)(iii)) may be eligible to enroll in coverage with an accelerated coverage effective date.

When an SEP is subject to pre-enrollment verification, the QI's effective date remains the normal assigned coverage effective date for the SEP. However, pursuant to 45 CFR §155.420(b)(5), the Exchange must offer the option for a later coverage effective date if the individual's enrollment is delayed due to verification SEP eligibility, and his/her assigned coverage effective date would require the enrollee to pay two or more months of retroactive premiums. In this circumstance, the enrollee may request a coverage effective date that is no more than one month later than the assigned effective date through the Marketplace Call Center. The record will be assigned to the issuer through HICS directing the issuer to change the coverage effective date. Additional discussion of the applicability of binder payment rules and SEP pre-enrollment verification processes is included in section 6.2 of this Manual.

Exhibit 14 summarizes the six categories of SEP triggering events from 45 CFR §155.420(d) as well as coverage effective dates for each SEP. It also includes information on:

- Whether the SEP is subject to pre-enrollment verification (SEP-V),
- Whether the SEP is subject to plan category limitations, and if so, what the specific limitation for the existing enrollee is,
- The applicability of the SEP to the FF-SHOP and other Exchanges,
- How QIs can access the SEP (i.e., through the FFEs application or through the Marketplace Call Center)
- SEP enrollment codes.

Exhibit 14 – SEP Triggering Events and Coverage Effective Dates Summary

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
1. Loss of qualifying health coverage	(d)(1)(i-iv) – Loss of minimum essential coverage * New Enrollees Subject to SEP-V **(d)(1)(ii) – Loss of non-calendar year group health coverage – is not applicable in SHOP Exchanges ***Existing enrollees will generally be limited to plan options within their current plan category.	A QI or his or her dependent loses minimum essential coverage, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage. For purposes of qualifying for this SEP, this includes: • The end of the plan year for any non-calendar year group health plan or individual health insurance coverage; • Losing pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act or access to health care services through coverage provided to a pregnant woman's unborn child; and/or • Losing medically needy coverage described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. **Note:** This does not include QIs who have lost their coverage due to nonpayment of premiums, voluntary termination, or as a result of an act of fraud by the QI (or other act that would qualify for rescission) (per 155.420(e)). **Coverage Effective Dates:** • Plan selection after Loss of MEC: 1st of the month after plan selection. • Plan selection prior to or on the date of the Loss of MEC: 1st of the month following the loss of MEC.	07	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
1. Loss of qualifying health coverage *(continued)*	(d)(6)(iii) – Become newly eligible for APTC due to changes to current employer–sponsored coverage *New enrollees subject to SEP-V **Not applicable in SHOP Exchanges ***Existing enrollees will generally be limited to plan options within their current plan category.	A QI or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3). **Coverage Effective Dates:** • Plan selection after loss of MEC: 1st of the month after plan selection. • Plan selection prior to or on the date of the loss of MEC: 1st of the month following the loss of MEC.	07	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
2. Change in household size	(d)(2)(i) – Gain a dependent or become a dependent *New enrollees subject to SEP-V if gaining / becoming a dependent through marriage, adoption, placement for adoption, placement in foster care, or a child support or other court order. (New enrollees gaining a dependent through birth are *not* currently subject to SEP-V.) **The SEP at (d)(2)(ii) – Loss of dependent due to divorce, legal separation or death- is offered at the option of the Exchange and is *not* currently available in the FFEs. ***Existing enrollees will generally be limited to their current plan.	A QI gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. **Coverage Effective Dates:** • Marriage: 1st of the month after plan selection. • Birth, adoption, foster care placement, court order: Retroactive back to the date of the event. **Note:** For birth, adoption, placement for adoption, or placement in foster care, or court order, individuals may alternatively request a coverage effective date of the first day of the month following the date of plan selection or following regular prospective coverage effective dates by calling the Marketplace Call Center. **Note:** For marriage, at least one spouse must have minimum essential coverage as described for 1 or more days during the 60 days preceding the date of marriage, or meets one of the following criteria: lived for 1 or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for 1 or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHP's were available on the Exchange; or is an Indian as defined by section 4 of the Indian Health Care Improvement Act. This requirement does not apply in the FF-SHOP. Verification of this requirement has not yet been implemented in the FFEs.	Birth: 02 Marriage: 32 Adoption/ Foster Care Placement/ Court Order: 05	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
3. Change in primary place of living	(d)(7) – Gain access to new QHPs due to a permanent move *New enrollees subject to SEP-V **Existing enrollees will generally be limited to plan options within their current plan category.	A QI or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move. The QI, enrollee, or dependent must also have had MEC for one or more days in the 60 days prior to the move, unless he or she meets one of the following criteria: lived for 1 or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for 1 or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHP's were available on the Exchange; or is an Indian as defined by section 4 of the Indian Health Care Improvement Act. . Note: Moving solely for medical treatment or vacation would not be considered a permanent move for purposes of qualifying for this SEP. **Coverage Effective Dates**: Regular prospective coverage effective dates. **Note:** At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.	43	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
4. Change in eligibility for Exchange coverage or help paying for coverage	(d)(3) – Become newly eligible for QHP coverage *Not applicable in SHOP Exchanges **Existing enrollees will generally be limited to plan options within their current plan category.	A QI or his or her dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration. **Note:** QIs who change from one legally present status to another do not qualify for this SEP. **Coverage Effective Dates:** Regular prospective coverage effective dates. **Note:** At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.	NE	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
4. Change in eligibility for Exchange coverage or help paying for coverage *(continued)*	(d)(6)(i-ii) – Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR *Not applicable in SHOP Exchanges **Current enrollees who are newly eligible for CSR are generally limited to either current plan category or Silver plans.	An enrollee or his or her dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for cost-sharing reductions (CSR). Note: This SEP is only available to current Exchange enrollees. **Coverage Effective Dates**: Regular prospective coverage effective dates.	FC	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
4. Change in eligibility for Exchange coverage or help paying for coverage *(continued)*	(d)(6)(iv) – Previously in the coverage gap and become newly eligible for APTC *Not applicable in SHOP Exchanges **Existing enrollees will generally be limited to plan options within their current plan category.	A QI who was previously ineligible for APTCs solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the QI becoming newly eligible for APTCs. **Coverage Effective Dates**: Regular prospective coverage effective dates. **Note:** At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.	EX	CMS Caseworker

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
4. Change in eligibility for Exchange coverage or help paying for coverage *(continued)*	(d)(6)(v) – Off-Exchange enrollee experiences a decrease in household income and new determination of eligibility for APTC *New enrollees are subject to SEP-V (to verify decrease in income and prior coverage) **Not applicable in SHOP Exchanges	At the option of the Exchange, a qualified individual and his or her dependent who experiences a decrease in household income and is (1) newly determined eligible for APTC by an Exchange, and (2) had MEC as described in 26 CFR §1.5000A-1(b) for one or more days during the 60 days preceding the change in circumstances. **Note:** This SEP has not yet been operationalized by the FFEs. **Coverage Effective Dates**: Regular prospective coverage effective dates.	EX	CMS Caseworker

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
4. Change in eligibility for Exchange coverage or help paying for coverage *(continued)*	(d)(8)(i-ii) – Gain or maintain status as a member of a federally-recognized tribe or a shareholder in an Alaska Native Corporation	A QI who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month. A QI who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian **Coverage Effective Dates**: Regular prospective coverage effective dates.	NE	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
5. Enrollment or plan error	(d)(4) – Experience an error of the Exchange	A QI's or his or her dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. **Coverage Effective Dates**: Appropriate date based on the circumstances of the special enrollment period. Typically, retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI. (Note: There are some exceptions for certain types of errors.)	EX	Marketplace Call Center
	(d)(5) – Experience a plan contract violation	An enrollee or his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee. **Coverage Effective Dates**: Appropriate date based on the circumstances of the special enrollment period. Typically retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI.	EX	CMS Caseworker

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
	(d)(12) – Material error related to plan benefits, service area, or premium	The QI, enrollee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange. **Coverage effective Dates:** Appropriate date based on the circumstances of the special enrollment period. Typically, retroactive back to the coverage effective date the QI would have gotten absent the material error or regular prospective coverage effective date, at the option of the QI.	EX	CMS Caseworker

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
6. Other qualifying changes	(d)(9) – Experience an exceptional circumstance	A QI's, enrollee's, or his or her dependent's, enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster. The enrollment or non-enrollment of a QI, enrollee, or his or her dependent in a QHP is the result of an unforeseen event or reflects a first-time requirement for Exchange enrollees (such as the Tax Season SEP for individuals impacted by the individual shared responsibility payment). The enrollment or non-enrollment of a QI, enrollee, or his or her dependent, enrollment or non-enrollment in a QHP is the result of a significant life event resulting in lack of access to his or her application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that he or she obtain minimum essential coverage. This includes victims of domestic abuse or spousal abandonment. This also includes AmeriCorps servicemen and women who are starting or ending their service. **Coverage Effective Dates**: Vary based on circumstances.	EX	CMS Caseworker, Marketplace Call Center (in some cases, Application)

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
6. Other qualifying changes *(Continued)*	(d)(10) – Domestic abuse/Spousal abandonment	A QI is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim **Coverage Effective Dates**: Regular prospective coverage effective dates.	EX	Marketplace Call Center
	(d)(11) – Determined ineligible for Medicaid/CHIP *New enrollees subject to SEP-V	A QI or dependent who applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or **A QI or dependent who** applies for coverage at the State Medicaid or CHIP agency during the Exchange annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended; **Coverage Effective Dates:** Appropriate date based on the circumstances of the special enrollment period. Typically, 1st of the month following plan selection	07	Application

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
6. Other qualifying changes ***(Continued)***	(d)(13) – Resolution of data matching issue or verification of citizenship/lawful presence status *This SEP is offered in the FFEs but is optional for Exchanges. ** Not applicable in SHOP.	The QI provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in §155.315 or is under 100% of the Federal Poverty Level and did not enroll in coverage while waiting for HHS to verify his or her citizenship status as a national or lawful presence. **Coverage Effective Dates:** Appropriate date based on the circumstances of the special enrollment period. Typically, retroactive coverage is back to date of termination.	NE	Marketplace Call Center

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
6. Other qualifying changes *(Continued)*	(d)(14) – Newly gains access to and enrolls in an HRA, or provided with a QSEHRA *New enrollees subject to SEP-V	The QI, enrollee, or dependent gains access to and enrolls in a health reimbursement arrangement (HRA) that will be integrated with individual health insurance coverage, or is provided a qualified small employer health reimbursement arrangement (QSEHRA), as defined in section 9831(d)(2) of the Internal Revenue Code. **Coverage Effective Dates:** • Plan selection after triggering event: 1st of the month after plan selection. Plan selection prior to triggering event: 1st of the month following the triggering event after plan selection; if the triggering event is on the first day of a month, on the date of the triggering event.	TBD	Application

Exhibit 15 provides examples of coverage effective dates for various SEPs within the FFEs.

Exhibit 15 – SEP Effective Date Examples

Triggering Event	Triggering Event Date	SEP Start Date	SEP End Date (FFEs- 60 days)	Plan Selection Date Examples	Enrollment Effective Dates
Permanent Move ◊	4/1	4/1	5/31	4/15	5/1
Permanent Move ◊	4/10	4/10	6/8	4/25	6/1
Permanent Move ◊+	4/1	4/1	5/31	4/15	6/1
*Birth**	6/1	6/1	7/31	6/29	6/1, 7/1 or 8/1
*Birth**	8/25	8/25	10/23	9/15	8/25 or 10/1
*Birth**	12/26	12/2	2/24	1/13	12/26, or 2/1
Loss of Coverage†	4/28	2/27	6/27	3/10	5/1
Loss of Coverage†	4/15	2/14	6/14	5/20	6/1
Loss of Coverage†	5/12	3/13	7/11	6/7	7/1
*Denied Medicaid/CHIP eligibility***	4/28	4/28	6/27	5/20	6/1
*Denied Medicaid/CHIP eligibility***	5/12	5/12	7/10*	7/10	8/1
Marriage	4/12	4/12	6/11	4/29	5/1
Marriage	7/1	7/1	8/30	7/20	8/1

◊ Per 45 CFR §155.420(c)(2), an Exchange has the option of offering the permanent move SEP to eligible consumers 60 days before the trigger event. This option is not available through the FFEs at this time.

+ Per 45 CFR §155.420(b)(5), the Exchange must offer the option for a later coverage effective date if the consumer's enrollment is delayed until after the verification of the consumer's eligibility for a special enrollment period, **and** the assignment of a regular coverage effective date would result in the consumer being required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation. . In this example, the consumer's plan selection date provides them an enrollment effective date of 5/1. However, due to a delay in their SEPV processing, their coverage was not effectuated until 7/1, resulting in them owing two months of retroactive premiums. The consumer is allowed to submit a later effective date of 6/1.

*Per 45 CFR §155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a QI or enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of the child support order or other court order. However, QIs may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection or following regular coverage effective rules.

†Per 45 CFR §155.420(c)(2)(i), QIs eligible for loss of coverage SEPs have up to 60 days before or up to 60 days after the triggering event to select a QHP.

**This SEP applies to individuals who applied for coverage during the OEP or due to a qualifying event and then were determined ineligible for Medicaid/CHIP outside of the enrollment period during which they applied. Note: For individuals who are eligible for this SEP, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the SEP. These individuals generally can request a retroactive coverage effective date back to the coverage effective date they would have received if the FFEs had originally determined them eligible for QHP coverage.

6.3 SEPs ACCESSED OUTSIDE OF THE APPLICATION PROCESS

SEPs Accessed Outside of the Application Process

The Exchange grants most SEPs through application questions or internal logic on the application. However, there are certain SEPs that eligible individuals must access through the Marketplace Call Center and, in some cases, by then having their information reviewed by a CMS Caseworker. These include:

- **Error of the Exchange or Misrepresentation in Enrollment Process SEP** (granted under 45 CFR §155.420(d)(4))
- **Experience a Plan or Contract Violation** (granted under 45 CFR §155.420(d)(5))
- **Material error related to plan benefits, service area, or premium** (granted under 45 CFR §155.420(d)(12)
- **Exceptional circumstance SEPs** (granted under 45 CFR §155.420(d)(9))
- **Victim of domestic abuse or spousal abandonment** (granted under 45 CFR§155.430(d)(10)

Some of these SEPs, such as the Exchange error and exceptional circumstance SEPs, can be granted when QIs have not yet enrolled in a QHP, while others, such as material errors or some misrepresentation SEPs, may be granted after an enrollment has been effectuated.

Individuals seeking one of these SEPs will need to call the Marketplace Call Center and explain their situation. Call center representatives may be able to determine whether an individual is eligible for an SEP, but in many situations, they forward cases to CMS Caseworkers to determine the individual's eligibility for an SEP. If the SEP is granted and a new enrollment is processed, a record is assigned to the issuer through HICS directing the issuer to change the coverage effective date, if applicable.

To terminate prior coverage on a date that will align with the new coverage effective date, the issuer will need to honor an enrollee's request to terminate their prior coverage the day before the new QHP's coverage effective date, pursuant to 45 CFR §155.430(d)(6).

6.4 PLAN DISPLAY ERRORS

Plan display errors occur when an issuer or Exchange error or change causes HealthCare.gov to display incorrect and potentially disadvantageous plan data to QIs. This can include, but is not limited to, premium, benefits, and cost-sharing errors or changes that display directly on Healthcare.gov. Plan display errors or changes that are made to external websites will not be considered triggering events for plan display error SEPs, but in certain circumstances may qualify a QI for an SEP under 45 CFR §155.420(d)(5). QIs affected by plan display errors or changes may be eligible for an SEP under 45 CFR §155.420(d)(12) to return to the Exchange and select another QHP.

QIs eligible for a plan display error SEP under 45 CFR §155.420(d)(12) are typically already enrolled in a QHP, which requires the SEP process to accommodate the additional complexity of

terminating enrollment in the original QHP if a QI enrolls in a different QHP during the SEP period. Additionally, QIs generally need to be notified of their eligibility for this SEP.

As we clarified in the HHS Notice of Benefit and Payment Parameters for 2018 Final Rule[30], this SEP only applies to material plan or benefit display errors or changes made through the Exchange, and does not include plan or benefit display errors or changes made outside of the Exchange. This SEP is intended for consumers who made the decision to purchase health coverage through the Exchange and their decision about which QHP to enroll into was impacted by this material plan or benefit display error. Through existing data correction processes, the Exchange will typically be made aware of these errors and any corrections that were made. For other plan errors that may exist outside of the Exchange, CMS will consider whether the error constitutes a material contract violation that would be eligible for an SEP pursuant to 45 CFR §155.420(d)(5).

In addition, provider directory and drug formulary errors and changes will not be considered triggering events for plan display error SEPs, regardless of whether they display on external websites or on HealthCare.gov. In these cases, other consumer protections might apply. For instance, if a drug is no longer on the plan's formulary, the plan is still required to have processes in place that allow the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by a health plan (a request for exception) in accordance with 45 CFR §156.122(c). For this reason, these cases do not qualify a consumer for the plan display error SEP.

6.4.1. Identifying and Resolving Plan Errors

Plan display errors are identified after CMS investigates potential display discrepancies on HealthCare.gov identified by issuers, QIs, or by CMS. Exchange plan display errors include situations where coding on HealthCare.gov causes benefits to display incorrectly, or where CMS identifies an incorrect QHP data submission or discrepancy between an issuer's QHP data and its state-approved form filings. If a coding error is identified, CMS determines whether other QHPs are affected by the same error and reaches out to other affected issuers. When a plan display error is identified on HealthCare.gov, CMS works with the issuer to correct the error as quickly as possible to ensure enrollments moving forward are based on accurate plan data. These errors are often corrected during data correction windows (DCWs). Once corrected, the data on HealthCare.gov will be updated to reflect the correct data and CMS will work with the issuer to notify impacted QIs. As discussed above, errors or changes made on external websites and documents linked on HealthCare.gov will not be considered triggering events for plan display error SEPs (i.e., corrections or updates to provider lists, drug formularies, or summaries of benefits and coverage).

CMS will consider the impact of the change on QIs who enrolled in the affected plan before it was corrected. In some cases, the corrected plan data either reduces a benefit or increases costs to QIs. If the corrected plan data is a benefit or cost that displays on HealthCare.gov, CMS works with the

[30] 81 FR 94058, 94129 accessible at https://www.govinfo.gov/content/pkg/FR-2016-12-22/pdf/2016-30433.pdf

issuer and state's Department of Insurance and the applicable state's regulatory authority to arrive at a solution that has a minimal impact on QIs and affirms, to the extent possible, that they are not negatively affected by this Exchange or issuer error.

Generally, the most straightforward and QI-friendly resolution is for issuers to honor the benefit as it was displayed incorrectly for affected enrollees, if permitted by the applicable state regulatory authority. If the issuer chooses to honor the benefit and administers the plan as it was incorrectly displayed for the affected enrollees, CMS will not provide enrollees with an SEP.

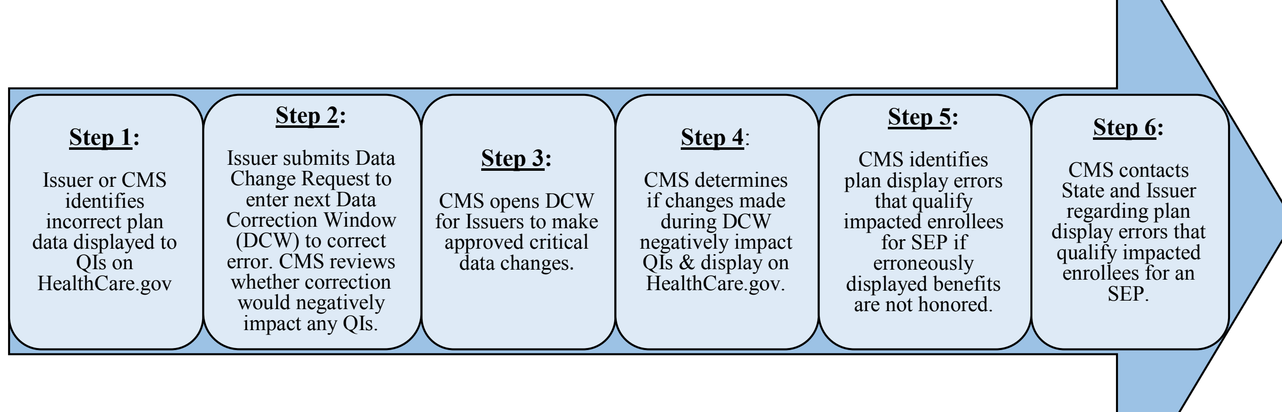
Issuers that Do Not Honor the Plan Information that Displayed Incorrectly

Depending on the significance of the plan display error, there are several options to mitigate the impact on the QI.

A plan display error is considered significant (i.e. a material error) if it is reasonable to expect that it has affected a QI's purchasing decision. For any such material plan display error, QIs are notified of the error and offered a plan display error SEP. The SEP will provide QIs with the option to select another plan, either from the same issuer or another issuer available to the QI, but does not require them to do so if they wish to stay enrolled in their existing plan with the correct benefits.

Exhibit 16 outlines the steps issuers take to identify and correct plan display errors, and the process by which CMS reviews these changes for potential plan display error SEPs.

Exhibit 16 – Identifying and Correcting Plan Display Errors That May Qualify for SEPs



Processing Plan Display Error SEPs

Under 45 CFR §156.1256, as of May 9, 2016, directed by the FFEs, issuers must notify their enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period within 30 calendar days after being notified by the FFEs that the error has been fixed, if directed to do so by the FFEs.

CMS allows an SEP-qualified individual already enrolled in a QHP to select a new QHP by calling the Marketplace Call Center. The Marketplace Call Center will help the QI update his or her information as needed and complete the process of selecting a QHP. QIs generally have 60 days from when they are notified by their issuer of the plan display error to select a new plan.

Under 45 CFR §155.420(b)(2)(iii), an Exchange may provide for a coverage effective date that is either: (1) based on the date of the SEP-triggering event, which provides the enrollee his or her initially intended coverage effective date; or (2) based on the date of the plan selection during the SEP window, which provides the enrollee regular effective dates under 45 CFR §155.420(b)(1).

In the case of a retroactive coverage date or retroactive termination date, the former issuer repays premiums and reverses claims payments. The gaining issuer collects premiums for all months of coverage and adjudicates the claims from previous months. With prospective coverage, QI's deductibles and accumulations towards the maximum out-of-pocket limit are reset starting with the new date of coverage.

The coverage effective date for the new QHP is communicated to the gaining issuer through HICS if it is different from what the system automatically assigns. The former issuer must terminate the coverage when the QI has selected another QHP during an SEP.

Exhibit 17 outlines action steps and the timeline that CMS and issuers follow to resolve plan display errors through the SEP process.

Exhibit 17 - Resolving Plan Display Error SEPs

CMS Action Steps	Issuer Action Steps
CMS takes following initial action steps: • Notifies issuer they made a change that requires either honoring the benefit or offering an SEP • Advises Issuer of the SEP process • Provides sample QI and employer notice language to the Issuer	Within 5 business days of CMS notification, the Issuer: • Communicates to CMS its preference for either honoring the benefit or offering an SEP • Provides draft QI and employer notices to CMS for review, if Issuer prefers to offer an SEP Within 10 business days of CMS notification, an Issuer that prefers to honor the benefit rather than offer an SEP: • Provides CMS with evidence of state authorization to honor the benefit • Takes no additional action steps unless notified otherwise
Within 2 business days of Issuer providing CMS with draft QI and employer notices for offering an SEP, CMS takes following action steps: • Reviews draft QI and employer notices • Provides Issuer with either approval or necessary revisions of draft notices	Within 5 business days of CMS approval, the Issuer: • Sends approved notices to SEP-qualified enrollees and employers • Sends notices, mailing date, and impacted enrollee count to CMS
Upon receipt of notices, mailing date, and impacted enrollee account from issuer, CMS: • Sends notice, mailing date, and impacted enrollee count to the FF-SHOP Hotline	The Issuer has completed its SEP action steps, unless notified otherwise.

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DATE:	August 9, 2018
TO:	All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers
FROM:	Randy Pate Director, Center for Consumer Information and Insurance Oversight
SUBJECT:	Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (FEMA) – Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities, Effective August 9, 2018

Special Enrollment Periods. The FFEs offer SEPs outside of the annual Open Enrollment Period (OEP) to individuals who experience qualifying events. Typically, individuals have 60 days from the date of the qualifying event to enroll in a Qualified Health Plan (QHP). However, if an individual or his or her dependents are affected by an emergency or major disaster that is recognized with a formal declaration from the Federal Emergency Management Agency (FEMA) and that emergency or major disaster prevents the individual or his or her dependents from enrolling within 60 days of the qualifying event, the individual and his or her dependents will be eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) that allows them to complete their Exchange enrollment.

Additionally, an individual or his or her dependents who are affected by an emergency or major disaster that is recognized with a formal declaration from FEMA and that emergency or major disaster prevents the qualified individual or his or her dependents from enrolling during the OEP will also be eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9).

Individuals will be considered "affected by a FEMA-declared emergency or major disaster" (hereinafter referred to as FEMA-emergency affected) and eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) if they were unable to enroll in an enrollment period for which they were eligible (i.e., either the OEP or a SEP) due to a FEMA-declared emergency or major disaster. To demonstrate this, individuals will be required to attest that they meet the following eligibility requirements: 1) they resided in any of the counties that are eligible to apply for "individual assistance" or "public assistance" by FEMA either during the FEMA-designated incident period of the emergency or major disaster, or at the time of application for enrollment; and 2) they were affected by the emergency or disaster, and that it prevented them from completing enrollment. See https://www.fema.gov/disasters for all FEMA declarations of emergency and major disasters.

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Length of SEP and Coverage Effective Dates. FEMA-emergency affected individuals will have up to 60 days from the end of the FEMA-designated incident period to select a new QHP through the FFE or make changes to their existing QHP enrollment. FEMA-emergency affected individuals can choose to have coverage start in the future, pursuant to regular effective date rules outlined in 155.420(b)(1), or can request an effective date that would have applied if they had selected a plan during their original enrollment opportunity on or after the FEMA-designated incident start date. Coverage effective date rules vary based on the date of plan selection and the qualifying event for the enrollment opportunity. For more information regarding coverage effective date rules, see Special Enrollment Period Overview at https://marketplace.cms.gov/technical-assistance-resources/special-enrollment-periods-.html.

For example, Mary Smith's employer-sponsored health insurance coverage ended on June 1. Because Mary lost minimum essential coverage (MEC), she qualifies for an SEP under 45 CFR §155.420(d)(1)(i) and has 60 days from the loss of MEC, through July 31st, to select a QHP. However, Mary was unable to complete her FFE application and QHP selection by July 31st because a severe tropical storm flooded the ground floor of her home in Mobile County, Alabama (AL). She stayed with relatives in nearby Clark County for several days until the flood waters receded, and then spent the next several weeks cleaning up the damage.

On July 7th, FEMA announced a Major Disaster Declaration related to the storm and flooding, with an incident period of June 20th-22nd. FEMA designated several AL counties, including Mobile, as eligible to apply for public assistance. As such, even though her SEP for loss of MEC has expired, Mary is now eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) and may apply for and select FFE coverage through August 21st (60 days from June 22nd). If Mary selects a QHP between August 1st and August 15th, she will be eligible to start coverage in the future (on September 1st, per regular effective date rules) or in the past (on July 1st or August 1st – effective dates that would have been available if she had chosen a plan during the loss of MEC SEP window, but after June 20th, the FEMA incident start date). Additionally, if Mary selects a plan under this Exceptional Circumstances SEP between August 16th and August 21st, she will be eligible to start retroactive coverage on July 1st or August 1st (effective dates that would have been available if she had chosen a plan during the loss of MEC SEP window, but after June 20th, the FEMA incident start date), or choose to start coverage in the future, on October 1st, per regular effective date rules.

Table 1 provides additional samples of qualifying events and coverage dates for FEMA-emergency affected individuals.

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Table 1. Sample SEP Coverage Effective Dates for FEMA-Emergency Affected Individuals

Qualifying Event	Date of Qualifying Event	Qualifying Enrollment Period End Date	FEMA Incident Start Date	FEMA Incident End Date	Exceptional Circumstance SEP End Date	Plan Selection Date Example	Available Coverage Effective Date(s)
Birth or Adoption*	6/1	7/31	6/20	6/22	8/21	8/3	6/1,7/1, 8/1, or 9/1
Birth or Adoption*	6/1	7/31	7/5	7/23	9/22	9/21	6/1, 8/1, 9/1, or 11/1
Loss of Coverage	6/1	7/31	6/20	6/22	8/21	8/5	7/1, 8/1,or 9/1
Loss of Coverage	6/23	8/22	6/20	7/22	9/21	9/3	7/1, 8/1, 9/1 or 10/1
Annual OEP	n/a	12/15	11/2	11/15	1/14	12/19	1/1 or 2/1
Annual OEP	n/a	12/15	11/30	12/10	2/9	2/3	1/1 or 3/1

*Per 45 CFR §155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a qualified individual on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of the child support order or other court order. However, qualified individuals may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection or following regular coverage effective rules.

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How to Enroll in Coverage. To request an Exceptional Circumstances SEP, FEMA-emergency affected individuals must contact the Marketplace Call Center at 1-800-318-2596 or TTY at 1-855-889-4325 and indicate they were eligible for another enrollment window, but were unable to complete their enrollment due to a FEMA-designated emergency or disaster. To expedite the SEP process, in advance of calling the Marketplace Call Center, FEMA-emergency affected individuals can complete an application on HealthCare.gov directly or with the assistance of a Navigator, Agent/Broker, Certified Application Counselor, or Direct Enrollment Partner. The initial eligibility results may show the individual is not eligible to enroll because the OEP or SEP has ended. Each SEP request must be individually re-evaluated by a caseworker, which may take several days. Caseworkers will review an individual's eligibility for the SEP using available information from Marketplace consumer records and public information on FEMA declarations. Individuals will be notified of the SEP eligibility determination by mail. Once an individual receives notice he or she is eligible for the SEP, he or she may visit HealthCare.gov (or call the Marketplace Call Center) to select a plan.

Additional Special Enrollment Period Information. Individuals impacted by natural disasters that do not receive FEMA designations may be considered for eligibility individually for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9). For example, if an individual was a victim of a house fire and was displaced during OEP, he or she may be eligible for an Exceptional Circumstances SEP. Individuals impacted by any natural disaster such that they are unable to enroll during an enrollment opportunity for which they qualify may contact the Marketplace Call Center at 1-800-318-2596 or TTY at 1-855-889-4325 to request enrollment.

Additionally, individuals may experience qualifying events due to a natural disaster that make them eligible for other SEPs allowing them to access a new QHP. For example, an individual who temporarily relocated due to a hurricane and is now residing outside of his or her current QHP's service area may be eligible for an SEP due to this move. See https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf for more information on what circumstances and situations allow for an SEP. Consumers eligible for one of the other SEPs listed at that link can apply for coverage directly through https://www.healthcare.gov/.

Termination of Enrollment or Coverage. The FFEs permit an individual to choose to terminate his or her coverage through the FFE for any reason. Enrollees who terminate their coverage due to hardship from a FEMA-designated or other natural disaster may be exempted from associated tax penalties. Further, the Tax Cuts and Jobs Act of 2017 will eliminate the individual mandate penalty owed by consumers who do not maintain minimum essential coverage (MEC) or obtain an exemption, effective beginning in tax year 2019. For more information regarding hardship exemptions, see: https://marketplace.cms.gov/technical-assistance-resources/exemption-general-hardship.pdf

Consumer Payments and Grace Period Extensions. If issuers comply with a state regulatory authority's request, in reaction to a natural disaster or other emergency disruption within a state,

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to extend premium payment deadlines and delay cancellations for non-payment of premium, CMS may exercise enforcement discretion with regard to regulatory requirements such as the deadline for payment to effectuate coverage and the deadline for payment of premiums under grace periods, including for individuals receiving APTCs.

Relief from Compliance Standards (e.g., enrollment processing). CMS will consider refraining from taking compliance actions in instances where a QHP issuer's failure to comply was the direct result of the conditions created by a FEMA-designated natural disaster, and the issuer could not have taken reasonable steps in advance to prevent the compliance failure.

Please direct any questions to your CMS Account Manager.

HealthCare.gov

SELECT AN ARTICLE

Getting health coverage outside Open Enrollment

Enroll in or change 2020 plans — only with a Special Enrollment Period

Since the 2020 Open Enrollment Period is over, you can now enroll in or change your Marketplace plan **only** if you have a life event that qualifies you for a Special Enrollment Period.

See if you qualify for a 2020 Special Enrollment Period

Answer a few questions to find out if you can enroll in or change a plan for 2020.

- Already know you qualify? Create an account (/create-account/) or log into (/login/) an existing one to apply and enroll.
- Before you apply, you can preview 2020 plans and prices (/see-plans/) based on your income.
- If you're not eligible to apply with a Special Enrollment Period for the rest of 2020, you can apply for a 2021 health plan Sunday, November 1 through Tuesday, December 15, 2020.

Life changes that can qualify you for a Special Enrollment Period

Changes in household

You may qualify for a Special Enrollment Period if you or anyone in your household **in the past 60 days**:

- **Got married.** Pick a plan by the last day of the month and your coverage can start the first day of the next month.
- **Had a baby, adopted a child, or placed a child for foster care.** Your coverage can start the day of the event — even if you enroll in the plan up to 60 days afterward.
- **Got divorced or legally separated and lost health insurance. Note:** Divorce or legal separation without losing coverage doesn't qualify you for a Special Enrollment Period.
- **Died.** You'll be eligible for a Special Enrollment Period if someone on your Marketplace plan dies and as a result you're no longer eligible for your current health plan.

Changes in residence

Household moves that qualify you for a Special Enrollment Period:

- Moving to a new home in a new ZIP code or county
- Moving to the U.S. from a foreign country or United States territory
- If you're a student, moving to or from the place you attend school
- If you're a seasonal worker, moving to or from the place you both live and work
- Moving to or from a shelter or other transitional housing

Note: Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period.

Important: You must confirm you had qualifying health coverage for one or more days during the 60 days before your move. You don't need to provide confirmation if you're moving from a foreign country or U.S. territory.

Loss of health insurance

You may qualify for a Special Enrollment Period if you or anyone in your household lost qualifying health coverage **in the past 60 days** OR expects to lose coverage **in the next 60 days**.

Coverage losses that may qualify you for a Special Enrollment Period:

Losing job-based coverage

Losing individual health coverage for a plan or policy you bought yourself

Losing eligibility for Medicaid or CHIP

Losing eligibility for Medicare

Losing coverage through a family member

An employer offer to help with the cost of coverage

You may qualify for a Special Enrollment Period if you or anyone in your household newly gained access to an individual coverage HRA (/ichra/) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) (/qsehra/) **in the past 60 days** OR expects to **in the next 60 days**.

Note: Your employer may refer to an individual coverage HRA by a different name, like the acronym "ICHRA."

Generally, you'll need to apply for and enroll in individual health insurance before your individual coverage HRA or QSEHRA starts. However, your employer may offer different options for when your individual coverage HRA or QSEHRA can start so you have more time to enroll. Contact them or check the notice you got from your employer for more information. If you're currently enrolled in a Marketplace plan with savings, these savings may change because of the help you get through a job. Get more information on how your savings may change if you have an individual coverage HRA (/ichra/#savings) or QSEHRA (/qsehra/#savings) offer.

If you qualify to enroll in Marketplace coverage through this Special Enrollment Period, call the Marketplace Call Center (/contact-us) to complete your enrollment. You can't do this online.

More qualifying changes

Other life circumstances that may qualify you for a Special Enrollment Period:

- Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder
- Becoming newly eligible for Marketplace coverage because you became a U.S. citizen
- Leaving incarceration
- Starting or ending service as an AmeriCorps State and National, VISTA, or NCCC member

Learn about Special Enrollment Periods for complex issues. (/sep-list/)

Important: You may have to confirm your information

When you apply, you must attest that the information you provide on the application is true, including the facts that qualify you for a Special Enrollment Period. You may be required to submit documents that confirm your eligibility to enroll based on the life event you experience.

More answers: Enroll in or change 2020 plans — only with a Special Enrollment Period

What if I'm turned down for a Special Enrollment Period, but I think I qualify?

What if something outside my control prevented me from getting coverage during the Open Enrollment Period?

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President Donald J. Trump Directs FEMA Support Under Emergency Declaration for COVID-19

Release date: March 13, 2020

Release Number: HQ-20-017

The federal government continues to take aggressive and proactive steps to address the COVID-19 threat as the health and safety of the American people remain a top priority.

Today, President Trump declared a nationwide emergency pursuant to Sec. 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the “Stafford Act”). This increases federal support to the Department of Health and Human Services (HHS) in its role as the lead federal agency for the ongoing COVID-19 pandemic response. As a result of the President’s decisive, unprecedented action, FEMA is directed to assist state, local, tribal, territorial governments and other eligible entities with the health and safety actions they take on behalf of the American public. Today’s declaration does not make direct financial assistance available to individuals.

The emergency declaration does not change measures authorized under other federal statutes and HHS remains the lead federal agency directing the federal response to

COVID-19. FEMA actions will be in support of HHS and in coordination with state, tribal and territorial governments. Eligible emergency protective measures taken at the direction or guidance of public health officials in response to this emergency, and not supported by the authorities of another federal agency, will be reimbursed strictly under the FEMA Public Assistance program. FEMA assistance will be provided at a 75 percent Federal cost share. Reimbursable activities typically include emergency protective measures such as the activation of State Emergency Operations Centers, National Guard costs, law enforcement and other measures necessary to protect public health and safety.

For more information, visit the COVID-19 Emergency Declaration Fact Sheet (/news-release/2020/03/13/covid-19-emergency-declaration).

# # #

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Related Content:

COVID-19 Emergency Declaration (/news-release/2020/03/13/covid-19-emergency-declaration)
El presidente Donald J. Trump dirige a FEMA a proporcionar apoyo bajo la Declaración de Emergencia por COVID-19 (/node/357573)

Last Updated: March 14, 2020 - 11:33

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Official website of the Department of Homeland Security

Visit **cdc.gov/coronavirus** for the latest Coronavirus Disease (COVID-19) updates.

HHS.gov U.S. Department of Health & Human Services

FOR IMMEDIATE RELEASE
April 22, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Announces Additional Allocations of CARES Act Provider Relief Fund

President Donald J. Trump signed the bipartisan CARES Act legislation to provide relief to American families, workers, and the heroic healthcare providers on the frontline of the COVID-19 outbreak. $100 billion is being distributed by the Administration to healthcare providers, including hospitals battling this disease.

"The healthcare providers on the frontlines of the pandemic are heroic, and President Trump recognizes that every American healthcare provider has pitched in for this fight in some way," said HHS Secretary Alex Azar. "Our goal in all of the decisions we're making is to get the money from the Provider Relief Fund out the door as quickly as possible while targeting it to those suffering the most from the pandemic. We will continue using every regulatory and payment flexibility we have to help providers continue doing their vital work until we've defeated this virus.""

In allocating the funds, the Administration is working to address both the economic harm across the entire healthcare system due to the stoppage of elective procedures, and addressing the economic impact on providers incurring additional expenses caring for COVID-19 patients, and to do so as quickly and transparently as possible.

GENERAL ALLOCATION

- $50 billion of the Provider Relief Fund is allocated for general distribution to Medicare facilities and providers impacted by COVID-19, based on eligible providers' 2018 net patient revenue.

  - To expedite providers getting money as quickly as possible, $30 billion was distributed immediately, proportionate to providers' share of Medicare fee-for- service reimbursements in 2019. On Friday, April 10, $26 billion was delivered to bank accounts. The remaining $4 billion of the expedited $30 billion distribution was sent on April 17.

  - This simple formula, working with the data we had, was used to get the money out the door as quickly as possible. We were very clear that additional funds would be going out quickly to help providers with a relatively small share of their revenue coming from Medicare fee-for-service, such as children's hospitals.

  - Those funds are beginning to be delivered this week. HHS will begin distribution of the remaining $20 billion of the general distribution to these providers to augment their allocation so that the whole

$50 billion general distribution is allocated proportional to providers' share of 2018 net patient revenue.

- On April 24, a portion of providers will automatically be sent an advance payment based off the revenue data they submit in CMS cost reports. Providers without adequate cost report data on file will need to submit their revenue information to a portal opening this week at https://www.hhs.gov/providerrelief for additional general distribution funds.

  - Providers who receive their money automatically will still need to submit their revenue information so that it can be verified.

- Payments will go out weekly, on a rolling basis, as information is validated, with the first wave being delivered at the end of this week (April 24, 2020).

• Providers who receive funds from the general distribution have to sign an attestation confirming receipt of funds and agree to the terms and conditions of payment and confirm the CMS cost report.

• The terms and conditions also include other measures to help prevent fraud and misuse of the funds. All recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus. There will be significant anti-fraud and auditing work done by HHS, including the work of the Office of the Inspector General.

• President Trump is committed to ending surprise bills for patients. As part of this commitment, as a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a presumptive or actual COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

TARGETED ALLOCATIONS

ALLOCATION FOR COVID-19 HIGH IMPACT AREAS

• $10 billion will be allocated for a targeted distribution to hospitals in areas that have been particularly impacted by the COVID-19 outbreak. As an example, hospitals serving COVID-19 patients in New York, which has a high percentage of total confirmed COVID-19 cases, are expected to receive a large share of the funds.

- Hospitals should apply for a portion of the funds by providing four simple pieces of information via an authentication portal before midnight PT, Thursday April 23. This portal is live, and hospitals have already been contacted directly to provide this information.

- Hospitals will need to provide:

  - Tax Identification Number

  - National Provider Identifier

- Total number of Intensive Care Unit beds as of April 10, 2020

- Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020

- The authentication and data-sharing process should take less than five minutes via a system that should be familiar to most hospitals.

- This information is necessary for the government to determine what facilities will qualify for a targeted distribution. Supplying this information does not guarantee receipt of funds from this distribution.

- The Administration will use the data it receives to distribute the targeted funds to where the impact from COVID-19 is greatest. The distribution will take into consideration the challenges faced by facilities serving a significantly disproportionate number of low-income patients, as reflected by their Medicare Disproportionate Share Hospital (DSH) Adjustment.

ALLOCATION FOR TREATMENT OF THE UNINSURED

- The Trump Administration is committed to ensuring that Americans are protected against financial obstacles that might prevent them from getting the treatment they need for COVID-19.
- As announced in early April, a portion of the $100 billion Provider Relief Fund will be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured.
- Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding.
- Steps will involve: enrolling as a provider participant, checking patient eligibility and benefits, submitting patient information, submitting claims, and receiving payment via direct deposit.
- Providers can register for the program on April 27, 2020, and begin submitting claims in early May 2020. For more information, visit coviduninsuredclaim.hrsa.gov.

ALLOCATION FOR RURAL PROVIDERS

- $10 billion will be allocated for rural health clinics and hospitals, most of which operate on especially thin margins and are far less likely to be profitable than their urban counterparts.

  - This money will be distributed as early as next week on the basis of operating expenses, using a methodology that distributes payments proportionately to each facility and clinic.

  - This method recognizes the precarious financial position of many rural hospitals, a significant number of which are unprofitable.

- Rural hospitals are more financially exposed to significant declines in revenue or increases in expenses related to COVID-19 than their urban counterparts.

ALLOCATION FOR INDIAN HEALTH SERVICE

- Recognizing the strain experiences by the Indian Health Service, $400 million will be allocated for Indian Health Service facilities, distributed on the basis of operating expenses. Indian Country is also being impacted by COVID-19.

  - This money will be distributed as early as next week on the basis of operating expenses for facilities.

  - This complements other funding provided to IHS and work we've done to expand IHS capacity for telehealth.

ADDITIONAL ALLOCATIONS

- There are some providers who will receive further, separate funding, including skilled nursing facilities, dentists, and providers that solely take Medicaid.

HELPING ENSURE ALL AMERICANS HAVE ACCESS TO CARE

- The *Families First Coronavirus Response Act*, as amended by the *CARES Act*, requires private insurers to waive an insurance plan member's cost-sharing payments for COVID-19 testing. The President also secured funding to cover COVID-19 testing for uninsured Americans.

- President Trump has also secured commitments from private insurers, including Humana, Cigna, UnitedHealth Group, and the Blue Cross Blue Shield system, to waive cost-sharing payments for treatment related to COVID-19 for plan members.

- Additionally, President Trump is committed to ending surprise bills for patients. As part of this commitment, as a condition to receiving general funds, providers must agree not to seek collection of out-of-pocket payments from a presumptive or actual COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news.

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Last revised: April 22, 2020

Visit **cdc.gov/coronavirus** for the latest Coronavirus Disease (COVID-19) updates.

FOR IMMEDIATE RELEASE
April 27, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Launches COVID-19 Uninsured Program Portal

Today, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), launched a new COVID-19 Uninsured Program Portal, allowing health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 to submit claims for reimbursement. Providers can access the portal at COVIDUninsuredClaim.HRSA.gov.

The Trump Administration is committed to ensuring that individuals are protected against financial obstacles that might prevent them from getting the testing and treatment they need for COVID-19. As part of the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, health care providers can request claims reimbursement electronically through the COVID-19 Uninsured Program Portal and receive reimbursement, generally at Medicare rates for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis.

"President Trump has promised to cover COVID-19 testing and treatment for uninsured individuals, and today, HHS is launching the tools needed to do that," said HHS Secretary Alex Azar. "Congress appropriated funding for COVID-19 testing for the uninsured and also appropriated funding for a general fund to support providers affected by COVID-19. The President and HHS made the bold decision to ensure that some of this money is specifically devoted to covering care for the uninsured, going to providers at the front lines of the pandemic response. Providers will be able to bill the government for this care at Medicare rates, and uninsured individuals will be protected from any balance-billing for COVID-19 testing and treatment."

Today's announcement for uninsured individuals is part of the Trump Administration's effort to support health care providers in fighting the COVID-19 pandemic. The CARES Act Provider Relief Fund provides $100 billion in relief funds to hospitals and other health care providers.

"We have seen the heroic actions from health care providers serving on the frontlines of the pandemic," said Tom Engels, HRSA Administrator, "these reimbursements help meet the growing demand for testing and health care provider services related to the COVID-19 pandemic, and ensure that uninsured individuals get the care they need"

For more information about the CARES Act Provider Relief Fund, visit: https://www.hhs.gov/providerrelief.

For more information on the HRSA COVID-19 Uninsured Program, visit: COVIDUninsuredClaim.HRSA.gov.

For more information about COVID-19, visit: http://coronavirus.gov.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news.

Like HHS on Facebook, follow HHS on Twitter @HHSgov, and sign up for HHS Email Updates.

Last revised: April 27, 2020

Cente
rs for
Medicare & Medicaid Services

Press release

Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic

Apr 30, 2020 | Hospitals, Policy, Telehealth

At President Trump's direction, and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services today issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens. These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

CMS is taking action to ensure states and localities have the flexibilities they need to ramp up diagnostic testing and access to medical care, key precursors to ensuring a phased, safe, and gradual reopening of America.

Today's actions are informed by requests from healthcare providers as well as by the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act. CMS's goals during the pandemic are to 1) expand the healthcare workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community or other states; 2) ensure that local hospitals and health systems have the capacity to handle COVID-19 patients through temporary expansion sites (also known as the CMS Hospital Without Walls initiative); 3) increase access to telehealth for Medicare patients so they can get care from their physicians and other clinicians while staying safely at home; 4) expand at-home and community-based testing to minimize transmission of COVID-19 among Medicare and Medicaid beneficiaries; and 5) put patients over paperwork by giving providers, healthcare facilities, Medicare Advantage and Part D plans, and states temporary relief from many reporting and audit requirements so they can focus on patient care.

"I'm very encouraged that the sacrifices of the American people during the pandemic are working. The war is far from over, but in various areas of the country the tide is turning in our favor," said CMS Administrator Seema Verma. "Building on what was already extraordinary, unprecedented relief for the American healthcare system, CMS is seeking to capitalize on our gains by helping to safely reopen the American healthcare system in accord with President Trump's guidelines."

Made possible by President Trump's recent emergency declaration and emergency rule making, many of CMS's temporary changes will apply immediately for the duration of the Public Health Emergency declaration. They build on an unprecedented array of temporary regulatory waivers and new rules CMS announced March 30 and April 10. Providers and states do not need to apply for the blanket waivers announced today and can begin using the flexibilities immediately. CMS also is requiring nursing homes to inform residents, their families, and representatives of COVID-19 outbreaks in their facilities.

New rules to support and expand COVID-19 diagnostic testing for Medicare and Medicaid beneficiaries

"Testing is vital, and CMS's changes will make getting tested easier and more accessible for Medicare and Medicaid beneficiaries," Verma said.

Under the new waivers and rule changes, Medicare will no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests required as part of a COVID-19 diagnosis. During the Public Health Emergency, COVID-19 tests may be covered when ordered by any healthcare professional

authorized to do so under state law. To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written practitioner's order is no longer required for the COVID-19 test for Medicare payment purposes.

Pharmacists can work with a physician or other practitioner to provide assessment and specimen collection services, and the physician or other practitioner can bill Medicare for the services. Pharmacists also can perform certain COVID-19 tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law. With these changes, beneficiaries can get tested at "parking lot" test sites operated by pharmacies and other entities consistent with state requirements. Such point-of-care sites are a key component in expanding COVID-19 testing capacity.

CMS will pay hospitals and practitioners to assess beneficiaries and collect laboratory samples for COVID-19 testing, and make separate payment when that is the only service the patient receives. This builds on previous action to pay laboratories for technicians to collect samples for COVID-19 testing from homebound beneficiaries and those in certain non-hospital settings, and encourages broader testing by hospitals and physician practices.

To help facilitate expanded testing and reopen the country, CMS is announcing that Medicare and Medicaid are covering certain serology (antibody) tests, which may aid in determining whether a person may have developed an immune response and may not be at immediate risk for COVID-19 reinfection. Medicare and Medicaid will cover laboratory processing of certain FDA-authorized tests that beneficiaries self-collect at home.

Additional highlights of the waivers and rule changes announced today:

Increase Hospital Capacity - CMS Hospitals Without Walls

Under its Hospitals Without Walls initiative. CMS has taken multiple steps to allow hospitals to provide services in other healthcare facilities and sites that aren't part of the existing hospital, and to set up temporary expansion sites to help address patient needs. Previously, hospitals were required to provide services within their existing departments.

- CMS is giving providers flexibility during the pandemic to increase the number of beds for COVID-19 patients while receiving stable, predictable Medicare payments. For example, teaching hospitals can increase the number of temporary beds without facing reduced payments for indirect medical education. In addition, inpatient psychiatric facilities and inpatient rehabilitation facilities can admit more patients to alleviate pressure on acute-care hospital bed capacity without facing reduced teaching status payments. Similarly, hospital systems that include rural health clinics can increase their bed capacity without affecting the rural health clinic's payments.

- CMS is excepting certain requirements to enable freestanding inpatient rehabilitation facilities to accept patients from acute-care hospitals experiencing a surge, even if the patients do not require rehabilitation care. This makes use of available beds in freestanding inpatient rehabilitation facilities and helps acute-care hospitals to make room for COVID-19 patients.

- CMS is highlighting flexibilities that allow payment for outpatient hospital services -- such as wound care, drug administration, and behavioral health services -- that are delivered in temporary expansion locations, including parking lot tents, converted hotels, or patients' homes (when they're temporarily designated as part of a hospital).

- Under current law, most provider-based hospital outpatient departments that relocate off-campus are paid at lower rates under the Physician Fee Schedule, rather than the Outpatient Prospective Payment System (OPPS). CMS will allow certain provider-based hospital outpatient departments that relocate off-campus to obtain a temporary exception and continue to be paid under the OPPS. Importantly, hospitals may also relocate outpatient

departments to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site.

- Long-term acute-care hospitals can now accept any acute-care hospital patients and be paid at a higher Medicare payment rate, as mandated by the CARES Act. This will make better use during the pandemic of available beds and staffing in long-term acute-care hospitals.

Healthcare Workforce Augmentation:

To bolster the U.S. healthcare workforce amid the pandemic, CMS continues to remove barriers for hiring and retaining physicians, nurses, and other healthcare professionals to keep staffing levels high at hospitals, health clinics, and other facilities. CMS also is cutting red tape so that health professionals can concentrate on the highest-level work they're licensed for.

- Since beneficiaries may need in-home services during the COVID-19 pandemic, nurse practitioners, clinical nurse specialists, and physician assistants can now provide home health services, as mandated by the CARES Act. These practitioners can now (1) order home health services; (2) establish and periodically review a plan of care for home health patients; and (3) certify and re-certify that the patient is eligible for home health services. Previously, Medicare and Medicaid home health beneficiaries could only receive home health services with the certification of a physician. These changes are effective for both Medicare and Medicaid.

- CMS will not reduce Medicare payments for teaching hospitals that shift their residents to other hospitals to meet COVID-related needs, or penalize hospitals without teaching programs that accept these residents. This change removes barriers so teaching hospitals can lend available medical staff support to other hospitals.

- CMS is allowing physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants in outpatient settings. This frees up physical and occupational therapists to perform other important services and improve beneficiary access.

- Consistent with a change made for hospitals, CMS is waiving a requirement for ambulatory surgery centers to periodically reappraise medical staff privileges during the COVID-19 emergency declaration. This will allow physicians and other practitioners whose privileges are expiring to continue taking care of patients.

Put Patients Over Paperwork/Decrease Administrative Burden

CMS continues to ease federal rules and institute new flexibilities to ensure that states and localities can focus on caring for patients during the pandemic and that care is not delayed due to administrative red tape.

- CMS is allowing payment for certain partial hospitalization services – that is, individual psychotherapy, patient education, and group psychotherapy – that are delivered in temporary expansion locations, including patients' homes.

- CMS is temporarily allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes. Previously, clients

had to travel to a clinic to get these intensive services. Now, Community Mental Health Centers can furnish certain therapy and counseling services in a client's home to ensure access to necessary services and maintain continuity of care.

- CMS will not enforce certain clinical criteria in local coverage determinations that limit access to therapeutic continuous glucose monitors for beneficiaries with diabetes. As a result, clinicians will have greater flexibility to allow more of their diabetic patients to monitor their glucose and adjust insulin doses at home.

Further Expand Telehealth in Medicare:

CMS directed a historic expansion of telehealth services so that doctors and other providers can deliver a wider range of care to Medicare beneficiaries in their homes. Beneficiaries thus don't have to travel to a healthcare facility and risk exposure to COVID-19.

- For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

- Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology.

- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

- CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, CMS is broadening that list to include many behavioral health and patient education services. CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020.

- Until now, CMS only added new services to the list of Medicare services that may be furnished via telehealth using its rulemaking process. CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services.

- As mandated by the CARES Act, CMS is paying for Medicare telehealth services provided by rural health clinics and federally qualified health clinics. Previously, these clinics could not be paid to provide telehealth expertise as "distant sites." Now, Medicare beneficiaries located in rural and other medically underserved areas will have more options to access care from their home without having to travel

- Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get these services.

In addition, CMS is making changes to the Medicare Shared Savings Program to give the 517 accountable care organizations (ACOs) serving more than 11 million beneficiaries greater financial stability and predictability during the COVID-19 pandemic.

ACOs are groups of doctors, hospitals, and other healthcare providers, that come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending healthcare dollars more wisely, it may share in any savings it achieves for the Medicare program.

Because the impact of the pandemic varies across the country, CMS is making adjustments to the financial methodology to account for COVID-19 costs so that ACOs will be treated equitably regardless of the extent to which their patient populations are affected by the pandemic. CMS is also forgoing the annual application cycle for 2021 and giving ACOs whose participation is set to end this year the option to extend for another year. ACOs that are required to increase their financial risk over the course of their current agreement period in the program will have the option to maintain their current risk level for next year, instead of being advanced automatically to the next risk level.

CMS is permitting states operating a Basic Health Program to submit revised BHP Blueprints for temporary changes tied to the COVID-19 public health emergency that are not restrictive and could be effective retroactive to the first day of the COVID-19 public health emergency declaration. Previously, revised BHP Blueprints could only be submitted prospectively.

CMS sets and enforces essential quality and safety standards for the nation's healthcare system. It is also the nation's largest health insurer, serving more than 140 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and federal Health Insurance Exchanges.

For additional background information on the waivers and rule changes, go to: https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

For more information on the COVID-19 waivers and guidance, and the Interim Final Rule, please go to the CMS COVID-19 flexibilities webpage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

WHERE MEDICARE BENEFICIARIES CAN GET TEST

DOCTOR'S OFFICE, HOSPITAL

- Medicare is separately paying hospitals and practitioners to assess patie laboratory samples for COVID-19 testing even when that is the only service t This approach supports both hospitals and physician practices to opera
- To ensure that Medicare beneficiaries have broad access to testing, for Mec purposes, Medicare no longer requires an order from the treating physiciar practitioner for beneficiaries to get both COVID-19 testing and laboratory t and respiratory syncytial virus that may be part of a COVID-19 diagnosis. C be covered when ordered by any healthcare professional authorized to do
- Medicare is covering serology (or antibody) tests, which may be helpful practitioners, and communities in making decisions on medical treatmen social distancing policies.

HOME (INCLUDING NURSING HOMES)

- For beneficiaries who are homebound and unable to travel, Medicare pay technicians to a beneficiary's home, including a nursing home when a be Part A skilled nursing stay, to collect a lab sample.
- A home health nurse could collect a lab sample as part of a normal visit receiving home health services.
- A visiting nurse working for a Rural Health Clinic or Federally Qualified H making a home visit can collect a lab sample under certain conditions.

PHARMACY

- Medicare will pay for COVID-19 tests performed by pharmacists as part c enrolled laboratory.
- A pharmacist also may furnish basic clinical services, such as collect lab contract with a doctor or practitioner, in accordance with a pharmacist's and state law.
- Beneficiaries can get tested at "parking lot" test sites operated by pharn with state requirements.

DRIVE-THROUGH TESTING OR ALTERNATIVE SITES

- Healthcare facilities like hospitals, doctor's offices, labs can set up off-sit drive- through testing to collect samples. Medicare pays these healthcar normally would.

MEDICARE PAYMENT FOR LAB SERVICES

LAB SERVICE	MEDICARE PAYMENT	BILLIN
CDC RNA Based Lab Test	**Approx. $36**	HCPCS coc
Non- CDC Lab Test that uses any technique, multiple types or subtypes (includes all targets)	**Approx. $51**	HCPCS coc
Non CDC Lab Test using RNA based technique	**Approx. $51**	CPT cod
Serology (antibody) test	**TBD**	CPT code CPT code
Lab Test Using High Through-Put Technology	**$100** *(effective 4/14)*	HCPCS coc HCPCS coc
Lab Specimen Collection from a Patient	**Approx $23-$25**	HCPCS code C98C outpatient HCPCS code by a physi HCPCS code for home/nursing by a lab or on b health

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A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

7500 Security Boulevard, Baltimore, MD 21244

Press release

CMS NEWS ALERT May 19, 2020

May 19, 2020 | Policy

As part of the ongoing White House Task Force efforts taken in response to coronavirus disease 2019 (COVID-19), following is a summary of recent Centers for Medicare & Medicaid Services (CMS) actions. To keep up with the important Task Force work being done in response to COVID-19, click here www.coronavirus.gov. For information specific to CMS, please visit the CMS News Room and Current Emergencies Website. CMS updates these resources on an ongoing basis throughout the day; the information below is current as of May 19, 2020 at 4:00 pm ET.

Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes

CMS announced new guidance for state and local officials to ensure the safe reopening of nursing homes across the country. The guidance released today is part of President Trump's Guidelines for Opening Up America Again. It details critical steps nursing homes and communities should take prior to relaxing restrictions implemented to prevent the spread of COVID-19, including rigorous infection prevention and control, adequate testing, and surveillance. The recommendations allow states to make sure nursing homes are continuing to take the appropriate and necessary steps to ensure resident safety and are opening their doors when the time is right.

Press Release

Guidance

Frequently Asked Questions

CMS Releases Additional Waivers for Hospitals and Ground Ambulance Organizations

CMS continues to release waivers for the healthcare community that provide the flexibilities needed to take care of patients during the COVID-19 public health emergency (PHE). CMS recently provided additional blanket waivers for the duration of the PHE that:

- Modify existing physical environment waivers to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and critical access hospitals as a result of COVID-19; and
- Modify the data collection period and data reporting period for ground ambulance organizations.

Emergency Declaration Blanket Waivers

Medicare Payment for COVID-19 Diagnostic Tests

Earlier this year, CMS took action to ensure America's patients, health care facilities, and clinical laboratories were prepared to respond to COVID-19. To help increase testing, CMS developed two codes that laboratories can use to bill for certain COVID-19 lab tests, including serology tests. CMS has updated its guidance to include payment details for additional CPT codes created by the American Medical Association. There is no cost-sharing for Medicare patients.

Guidance

CMS Gives States Additional Flexibility to Address Coronavirus Pandemic

CMS has approved over 200 requests for state relief in response to the COVID-19 pandemic, including recent approvals for Alaska, Iowa, Hawaii, New Jersey, North Carolina, Pennsylvania, Rhode Island, Utah, and Virginia. These approvals help to ensure that states have the tools they need to combat COVID-19. This is done through a wide variety of waivers, amendments, and Medicaid state plan flexibilities, including support for programs that care for the elderly and people with disabilities. CMS also developed a toolkit to expedite the application and review of each request and has approved these requests in record time. These approved flexibilities support President Trump's commitment to a COVID-19 response that is locally executed, state managed, and federally supported.

Section 1135 Waivers

Section 1115(a) Waivers

1915(c) Waiver Appendix K Amendments

Medicaid State Plan Amendments

CHIP State Plan Amendments

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7500 Security Boulevard, Baltimore, MD 21244

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

March 12, 2020

FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)

Q1. Do the Essential Health Benefits (EHB) currently include coverage for the diagnosis and treatment of COVID-19?

A1. Yes. EHB generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered. Non-grandfathered health insurance plans purchased by individuals and small employers, including qualified health plans purchased on the Exchanges, must provide coverage for ten categories of EHB.[1] These ten categories of benefits include, among other things, hospitalization and laboratory services. Under current regulation, each state and the District of Columbia generally determines the specific benefits that plans in that state must cover within the ten EHB categories. This standard set of benefits determined by the state is called the EHB-benchmark plan. All 51 EHB-benchmark plans currently provide coverage for the diagnosis and treatment of COVID-19.[2]

Many health plans have publicly announced that COVID-19 diagnostic tests are covered benefits and will be waiving any cost-sharing that would otherwise apply to the test. Furthermore, many states are encouraging their issuers to cover a variety of COVID-19 related services, including testing and treatment, without cost-sharing, while several states have announced that health plans in the state must cover the diagnostic testing of COVID-19 without cost-sharing and waive any prior authorization requirements for such testing.

Q2. Is isolation and quarantine for the diagnosis of COVID-19 covered as EHB?

A2. All EHB-benchmark plans cover medically necessary hospitalizations. Medically necessary isolation and quarantine required by and under the supervision of a medical provider during a hospital admission are generally covered as EHB. The cost-sharing and specific coverage limitations associated with these services may vary by plan. For example, some plans may require prior authorization before these services are covered or may apply other limitations. Quarantine outside of a hospital setting, such as a home, is not a medical benefit, nor is it required as EHB. However, other medical benefits that occur in the home that are required by and under the supervision of a medical provider, such as home health care or telemedicine, may be covered as EHB, but may require prior authorization or be subject to cost-sharing or other limitations.

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[1] Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of Patient Protection and Affordable Care Act (PPACA), and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules.

[2] For information on the EHB-benchmark plans, see: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

Q3. When a COVID-19 vaccine is available, will it be covered as EHB, and will issuers be permitted to require cost-sharing?

A3. A COVID-19 vaccine does not currently exist. However, current law and regulations require specific vaccines to be covered as EHB without cost-sharing, and before meeting any applicable deductible, when the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends them. Under current regulations, if ACIP recommends a new vaccine, plans are not required to cover the vaccine until the beginning of the plan year that is 12 months after ACIP issues the recommendation. However, plans may voluntarily choose to cover a vaccine for COVID-19, with or without cost-sharing, prior to that date.

In addition, as part of a plan's responsibility to cover prescription drugs as EHB, as described above to cover ACIP-recommended vaccines, if a plan does not provide coverage of a vaccine (or other prescription drugs) on the plan's formulary enrollees may use the plan's drug exceptions process to request that the vaccine be covered under their plan, pursuant to 45 CFR 156.122(c).

Information Related to COVID–19
Individual and Small Group Market Insurance Coverage

Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Diagnostics & Laboratory Services

Laboratory services are a category of Essential Health Benefits (EHB) that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular diagnostic or laboratory service is covered by a plan varies, and is based on the specific benchmark plan selected by each state and the terms of the plan. Large group market plans and self-insured plans are not subject to EHB coverage requirements. You should check with your health insurance company to determine coverage for lab tests and related services for the diagnosis and treatment of COVID-19. Standard cost sharing may apply for these services.

Vaccines

If a vaccine is developed for COVID-19 and approved for use by the FDA, further guidance may be issued regarding whether the vaccine would need to be covered as a preventive service for which no cost sharing would be charged.

Hospitalization & Ambulatory Patient Services

Hospitalization, ambulatory patient, and emergency services are categories of EHB that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular hospitalization, ambulatory patient, or emergency service is covered by plans varies, and is based on the specific benchmark plan selected by each state and the terms of the plan. Large group market plans and self-insured plans are not subject to EHB coverage requirements. You should check with your health insurance company to determine coverage for physician and hospital related services for the diagnosis and treatment of COVID-19. Standard cost sharing may apply for these services.

Telehealth

Telehealth services or home health visits may already be covered by many health insurance companies. You should check with your health insurance company to determine whether these services are covered and whether any cost-sharing requirements apply.

Prescription Drugs

Prescription drugs are a category of EHB that individual and small group market issuers are generally required by law to include in their benefit packages. However, whether any particular prescription drug is covered by plans varies and is based on the specific benchmark plan selected by each state and the terms of the plan. Prior authorization for prescription drugs, including for any treatment for COVID-19 that may become available, may still apply, so you should check with your health insurance company to clarify any future changes to prior authorization requirements. Plans and issuers may elect to apply prior

authorization for treatment and or refills flexibly, as circumstances warrant. Large group market plans and self-insured plans are not required to cover EHBs, so coverage would depend on the terms of the plan.

Resources

Under federal law, for most health plans and health insurance coverage, if your health plan refuses to pay a claim or ends your coverage, you have the right to appeal the decision to the health plan and, if the plan upholds its denial, you have the right to have that decision reviewed by a third party. In urgent situations, a health plan must make a decision within 72 hours, or less, depending on the medical urgency of the case. Your explanation of benefits (EOB) and plan documents should have instructions on how to appeal a denied claim.

If you aren't currently enrolled in coverage, you can see if you qualify for a Special Enrollment Period to enroll in a private health plan through HealthCare.gov. As a reminder, federal law and regulations provide protections against preexisting condition exclusions in health insurance coverage. Health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Marketplace plans may not terminate coverage due to a change in health status, including diagnosis or treatment of COVID-19. CMS remains firmly committed to maintaining protections for all Americans with pre-existing conditions.

- HealthCare.gov
- CDC COVID-19
- https://content.naic.org/naic_coronavirus_info.htm

CMS.gov
Centers for Medicare & Medicaid Services

Current emergencies

Here's information and updates about natural disasters, man-made incidents, and public health emergencies that are happening now. Find more information on ongoing or past emergencies.

2020

Coronavirus Disease 2019

When President Trump declared a national emergency on March 13, 2020, CMS took action nationwide to aggressively respond to COVID-19. See all that we've accomplished (PDF) since then in the fight against COVID-19.

- You can read the blanket waivers for COVID-19 in the List of Blanket Waivers (PDF) UPDATED (6/25/20).

Secretary Azar used his authority in the Public Health Service Act to declare a public health emergency (PHE) in the entire United States on January 31, 2020 giving us the flexibility to support our beneficiaries, effective January 27, 2020

Get waiver & flexibility information

General information & updates:

- Coronavirus.gov is the source for the latest information about COVID-19 prevention, symptoms, and answers to common questions.
- USA.gov has the latest information about what the U.S. Government is doing in response to COVID-19.
- CDC.gov/coronavirus has the latest public health and safety information from CDC and for the overarching medical and health provider community on COVID-19.

Read our Coronavirus disease 2019 press releases

Telehealth guidance:

- HHS telehealth guidance & information
- VIDEO-MLN Medicare Coverage and Payment of Virtual Services UPDATED (5/8/20)
- General Telemedicine Toolkit (PDF) (3/20/20)
- Medicare Telehealth Frequently Asked Questions (3/17/20)
- Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet (3/17/20)
- Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF) (3/27/20)
- End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit (PDF) (3/20/20)
- State Medicaid & CHIP Telehealth Toolkit (4/23/20)

- Medicaid Telehealth Guidance (3/17/20)
- CMS Coronavirus Partner Virtual Toolkit (3/17/20)
- FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19) (PDF) (3/26/20)

Clinical & technical guidance:

For all clinicians

- Quality Payment Program—COVID-19 Response (4/30/20)
- CMS letter to Clinicians participating in MIPS (PDF) (4/28/20)
- CMS Dear Clinician Letter (PDF) (4/6/20)

For all health care providers

- Providing Mental Health and Substance Use Disorder Resources During the COVID-19 Public Health Emergency (PDF) (7/1/20)
- Our COVID-19 Medicare data snapshot (6/22/20)
- Recommendations for Reopening Facilities to Provide Non-Emergent Non-COVID-19 Health Care (PDF) (6/9/20)
- Price Transparency: Requirements for Providers to Make Public Cash Prices for COVID-19 Diagnostic Testing (PDF) (5/12/20)
- CMS Recommendations for Re-opening Facilities to Provide Essential Non-COVID-19 Healthcare (PDF) (4/19/20)
- CMS Non-Emergent, Elective Medical Services, and Treatment Recommendations (PDF) (4/6/20)
- CMS Adult Elective Surgery and Procedures Recommendations (PDF) (3/19/20)
- Fact sheet: Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (3/30/20)
- Guidance memo - Exceptions and Extensions for Quality Reporting and Value-based Purchasing Programs (PDF) (3/27/20)

For health care facilities

- VIDEO-Five Things About Nursing Homes During COVID-19: learn about the 5 things we're doing to stop the spread of Coronavirus in nursing homes (7/9/20)
- Toolkit for States to Mitigate COVID-19 in Nursing Homes (PDF) UPDATED (6/29/20)
- Phase II Hospital Visitation for Patients who are Covid-19 Negative (PDF) (6/26/20)
- Memo to States and Nursing Home Stakeholders About Changes to Staffing Information and Quality Measures (6/25/20)
- FAQs About Visitation Considerations for Nursing Home Residents (PDF) (6/24/20)
- QIP ESRD FAQs (PDF) (6/17/20)
- FAQs for Non Long-Term Care Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (PDF)(6/10/20)
- COVID Nursing Home Compare Data (6/4/20)
- Nursing Home Data Release FAQs (PDF) (6/4/20)
- Infographic: Nursing Home Reporting Numbers for 5/31/20 (PDF) (6/4/20)
- Posting Nursing Home Inspections (6/4/20)
- Releasing COVID Nursing Home Data (6/4/20)
- COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control Deficiencies, and Quality Improvement Activities in Nursing Homes (6/1/20)

- Fact sheet for State and Local Governments About CMS Programs and Payment for Hospital Alternate Care Sites (PDF) (5/26/20)
- Nursing Home Reopening Recommendation FAQs (PDF) (5/18/20)
- CMS letter to Nursing Home Facility Management & Staff (PDF) (5/11/20)
- Guidance on Notification Requirements of Confirmed and Suspected COVID-19 Cases Among Nursing Home Residents and Staff (5/6/20)
- Accelerated and Advanced Payments Fact Sheet (PDF) UPDATED (4/26/2020)
- Nursing Home Five-Star Quality Rating Updates, Nursing Home Staff Counts, and Frequently Asked Questions (4/24/20)
- Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid during the COVID-19 Public Health Emergency (4/21/20)
- New Nursing Home Requirements for Notification of Confirmed COVID-19 Among Residents and Staff (PDF) (4/19/20)
- 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios (PDF) (4/13/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers (4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations (4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs) (4/8/20)
- Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19) and FAQs UPDATED (4/28/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Dialysis Facilities UPDATED (4/8/20)
- COVID-19 Long-Term Care Facility Guidance (PDF) (4/3/20)
- Letter requesting hospitals report data in connection with their efforts to fight the 2019 Novel Coronavirus (COVID-19) (PDF) (3/30/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes-REVISED (PDF) (3/13/20)
- Guidance for Use of Certain Industrial Respirators by Health Care Personnel (3/10/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Home Health Agencies (3/10/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies (3/9/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge (3/4/20)
- Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV) (2/6/20)

For labs

- Frequently Asked Questions About SARS-CoV-2 Surveillance Testing (PDF) (6/19/20)
- HHS Announces New Laboratory Data Reporting Guidance for COVID-19 Testing (6/5/20)
- SARS-CoV-2 Laboratory Testing Comparison Graphic (PDF) (4/30/20)

- Announcement: Medicare increases payment for high-production Coronavirus lab tests (PDF) (4/15/20)
- Frequently Asked Questions (FAQs), CLIA Guidance During the COVID-19 Emergency (PDF) (3/27/20)
- Notification to Surveyors of the Authorization for Emergency Use of the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Assay and Guidance for Authorized Laboratories (2/6/20)

For Programs of All-Inclusive Care for the Elderly (PACE) Organizations

- Frequently Asked Questions from the PACE Community (PDF) (4/23/20)
- Guidance for PACE Organizations Regarding Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) (PDF) (3/17/20)

Billing & coding guidance:

- Frequently Asked Questions to Assist Medicare Providers (PDF) UPDATED (6/19/20)
- Fact sheet for State and Local Governments About CMS Programs and Payment for Hospital Alternate Care Sites (PDF) (5/26/20)
- Fact sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency (PDF) UPDATED (4/26/20)
- CMS Dear Clinician Letter (PDF) (4/6/20)
- Fact sheet: Medicare Coverage and Payment Related to COVID-19 (PDF) UPDATED (3/23/20)
- Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet (3/17/20)
- Medicare Telehealth Frequently Asked Questions (3/17/20)
- MLN Matters article: Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (PDF) (3/17/20)
- Frequently Asked Questions about Medicare Fee-for-Service Emergency-Related Policies and Procedures **With** an 1135 Waiver (PDF) (3/16/20)
- Fact sheet: Medicare Administrative Contractor (MAC) COVID-19 Test Pricing (PDF) (3/13/20)
- Fact sheet: Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF) (3/5/20)
- COVID-19: New ICD-10-CM Code and Interim Coding Guidance (2/20/20)

Survey & certification guidance:

- Toolkit for States to Mitigate COVID-19 in Nursing Homes (PDF) UPDATED (6/29/20)
- Memo to States and Nursing Home Stakeholders About Changes to Staffing Information and Quality Measures (6/25/20)
- Posting Nursing Home Inspections (6/4/20)
- Releasing COVID Nursing Home Data (6/4/20)
- COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control Deficiencies, and Quality Improvement Activities in Nursing Homes (6/1/20)
- CARES Act Financial Guidance to State Survey Agencies (PDF) (4/30/20)
- Coronavirus Commission for Safety and Quality in Nursing Homes (PDF) (4/30/20)
- Nursing Home Five-Star Quality Rating Updates, Nursing Home Staff Counts, and Frequently Asked Questions (4/24/20)
- Clinical Laboratory Improvement Amendments (CLIA) Laboratory Guidance During COVID-19 Public Health Emergency (3/27/20)
- Prioritization of Survey Activities (3/23/20)

- Frequently Asked Questions for State Survey Agency and Accrediting Organization Coronavirus Disease 2019 (COVID-19) (PDF) (3/10/20)
- Frequently Asked Questions and Answers on EMTALA (PDF) (3/9/20)
- Suspension of Survey Activities (3/4/20)

Coverage guidance:

- Frequently Asked Questions to Assist Medicare Providers (PDF) UPDATED (6/19/20)
- VIDEO-MLN Medicare Coverage and Payment of Virtual Services UPDATED (5/8/20)
- CMS Dear Clinician Letter (PDF) (4/6/20)
- Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF) (3/27/20)
- Fact sheet: Medicare Coverage and Payment Related to COVID-19 (PDF) UPDATED (3/23/20)
- General Telemedicine Toolkit (PDF) (3/20/20)
- End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit (PDF) (3/20/20)
- FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19) (PDF) (3/19/20)
- Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet (3/17/20)
- Medicare Telehealth Frequently Asked Questions (3/17/20)
- FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19) (PDF) (3/13/20)
- Guidance to help Medicare Advantage and Part D Plans Respond to COVID-19 (PDF) (3/10/20)
- Fact sheet: Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF) (3/5/20)
- Fact sheet: Individual and Small Group Market Insurance Coverage (PDF) (3/5/20)

Provider enrollment guidance:

- Guidance for Processing Attestations from Ambulatory Surgery Centers (ASCs) Temporarily Enrolling as Hospitals During the COVID-19 Public Health Emergency (4/3/20)
- Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)-UPDATED (3/30/20) (PDF)

Medicaid & CHIP guidance:

- COVID-19 Frequently Asked Questions for State Medicaid and CHIP Agencies-UPDATED (6/30/20)
- State Medicaid Director Letter on CY 2020 Phased-Down State Contribution Amounts (PDF) (6/23/20)
- Fact sheet for State and Local Governments About CMS Programs and Payment for Hospital Alternate Care Sites (PDF) (5/26/20)
- State Medicaid & CHIP Telehealth Toolkit (4/23/20)
- Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs) (4/15/20)
- Federal Medical Percentage Map (FMAP) & Families First Coronavirus Response Act – Increased FMAP FAQs 3/27/20

- State Medicaid Director Letter (SMDL) #20-002 with New Section 1115 Demonstration Opportunity to Aid States With Addressing the Public Health Emergency (3/22/20)
- Section 1135 Waiver Checklist (3/22/20)
- Section 1915 Waiver, Appendix K Template (3/22/20)
- State Plan Flexibilities (3/22/20)
- COVID-19 Disaster Response Toolkit (3/12/20)
- Medicaid Telehealth Guidance (3/17/20)

Marketplace plan guidance:

- FAQs About Families First Coronavirus Response Act & Coronavirus Aid, Relief, & Economic Security Act Implementation Part 43 (6/23/20)
- Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency (PDF) 3/26/20
- FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19) (PDF) (3/26/20)
- FAQs on Prescription Drugs and the Coronavirus Disease 2019 (COVID-19) for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets (PDF) (3/26/20)

Medicare Advantage plan guidance:

- Postponement of 2019 Benefit Year HHS-operated Risk Adjustment Data Validation (HHS-RADV) (PDF) (4/15/20)

Open Payments guidance:

- Frequently Asked Questions (FAQs) on Enforcing Open Payments Deadlines (PDF) (3/26/20)

Partner & stakeholder resources:

- Open Door Forum Stakeholder Call podcasts & transcripts
- HHS telehealth guidance & information
- Memo to States and Nursing Home Stakeholders About Changes to Staffing Information and Quality Measures (6/25/20)
- What Patients Should Know About Seeking Health Care in English (PDF) & Spanish (PDF) (6/9/20)
- COVID Nursing Home Compare Data (6/4/20)
- CMS Coronavirus Partner Virtual Toolkit (3/17/20)
- Medicare Accelerated and Advance Payments by State and Provider Type (PDF) (PDF) UPDATED (5/8/20)
    - Medicare Accelerated and Advance Payments Provider Detail by State (ZIP) (5/8/20)

Consumer information:

- For people with Medicare
- For people with Marketplace coverage

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- Twitter: @CMSGov @MedicareGov @Medicaid.gov
- Facebook: Facebook.com/Medicare

Puerto Rico earthquake

Secretary Azar used his authority in the Public Health Service Act to declare a public health emergency (PHE) in Puerto Rico on January 8, 2020 giving us the flexibility to support our beneficiaries, effective December 28, 2019.

- Puerto Rico earthquake 1135 waiver
- Puerto Rico earthquake 1812(f) waiver (PDF)

You can read the blanket waivers (PDF) for Puerto Rico earthquake

You can also see:

- Our Provider Message and MLN Matters article, "Medicare Fee-for-Service (FFS) Response to the 2020 Commonwealth of Puerto Rico Earthquakes (PDF)"
- Provider survey and certification frequently asked questions (FAQs) (PDF) about declared public health emergencies.
- FAQs about the Medicare fee-for-service emergency-related policies and procedures that may be implemented only with an 1135 waiver (PDF).
- Provider enrollment FAQs (PDF)
- Guidance about Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) during an emergency or disaster (PDF)
- More details about waivers and flexibilities
- Requesting an 1135 waiver (PDF)

2019

Hurricane Dorian

Find information about Hurricane Dorian on our Past Emergencies Hurricanes page.

Tropical Storm Barry

Find information about Tropical Storm Barry on our Past Emergencies Hurricanes page.

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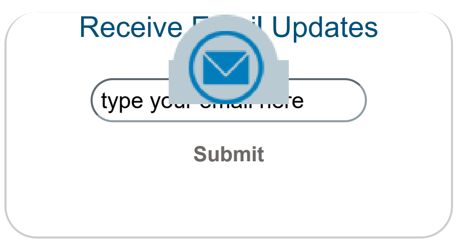

Connect with CMS

HealthCare.gov

Marketplace coverage & Coronavirus

If you already have coverage through the Marketplace, the rules in your Marketplace health plan for treatment for the coronavirus 2019 (or COVID-19) emergency remain the same as any other viral infection, but your health insurance company may have added benefits.

- See what Marketplace plans cover (/coverage/what-marketplace-plans-cover). All Marketplace plans cover treatment for pre-existing medical conditions and can't terminate coverage due to a change in health status, including diagnosis or treatment of COVID-19.
- Check with your health insurance company for their specific benefits and coverage policy.
- Log in (/login) to update your Marketplace application if COVID-19 impacts your income or household. You may be able to change your plan if certain situations apply.

If I lost my job or experienced a reduction in hours due to COVID-19

- **If you lost your job-based health plan:** You may qualify for a Special Enrollment Period if you lost health coverage through your employer or the employer of a family member **in the past 60 days** OR you expect to lose coverage **in the next 60 days**, including if you lose health coverage through a parent or guardian because you're no longer a dependent. **Note:** Losing coverage you have as a dependent doesn't qualify you for a Special Enrollment Period if you voluntarily drop the coverage. You also don't qualify if you or your family member loses coverage because you don't pay your premium.
- **If your employer reduced the hours you work and you're enrolled in a Marketplace plan:** Update your application immediately within **30 days** to report any household income changes. You may qualify for more savings than you're getting now. Learn how to report changes (/reporting-changes/).
- **If you were furloughed:** In some situations depending on the status of your health coverage from your employer, you may qualify for a Special Enrollment Period. You may be eligible for a premium tax credit to help pay for Marketplace coverage too. Create an account (/create-account) or log in (/login) to start your Marketplace application to find out if you qualify.

- **Need help estimating your income?** Use this income calculator to make your best estimate (/income-calculator).
- **If you have COBRA continuation coverage:**
  - If you're entitled to COBRA continuation coverage after you lost your job-based coverage, you may still qualify for a Special Enrollment Period due to loss of coverage. You have **60 days** after your loss of pre-COBRA job-based coverage to enroll in Marketplace coverage. You may also qualify for premium tax credits if you end your COBRA continuation coverage, or if you didn't accept it to begin with.
  - If you're enrolled in COBRA continuation coverage, you may qualify for a Special Enrollment Period if your COBRA continuation coverage costs change because your former employer stopped contributing, so you have to pay full cost. Learn more about COBRA continuation coverage and the Marketplace (/unemployed/cobra-coverage).
- **If you lost your job, but didn't also lose health coverage, because your former job didn't offer coverage:** You generally won't qualify for a Special Enrollment Period. By itself, a job loss (or a change in income) doesn't make you eligible for a Special Enrollment Period to enroll in Marketplace coverage. See if you qualify for a Special Enrollment Period another way (/screener).

Coverage start dates with a Special Enrollment Period due to loss in coverage

- **If you've already lost coverage,** your Marketplace coverage can start the first of the month after you apply and enroll.
- **If you know you'll lose coverage within the next 60 days,** you can submit an application on HealthCare.gov before you actually lose your coverage to help make sure there's no gap in coverage. For example, if you know you'll lose coverage on April 30, and apply and enroll in a Marketplace plan April 10, your new coverage will start May 1.

If I can't pay my premiums because of a hardship due to COVID-19

- Check with your insurance company about extending your premium payment deadline or ask if they will delay terminating your coverage if you can't pay your premiums.

- Most of the time, if you aren't receiving financial assistance with your premiums, you have a grace period (/glossary/grace-period) determined by state law (often one month). If you're getting financial assistance, you have a three-month grace period during which your coverage can't be terminated for not paying your premiums.
- If your household income has changed, update your application immediately. You could qualify for more savings than you're getting now.

If I'm enrolled in a Marketplace plan and my income has changed

- If you're enrolled in a Marketplace plan and your household income has changed, update your application immediately. If your income goes down or you gain a household member:
  - You could qualify for more savings than you're getting now. This could lower what you pay in monthly premiums.
  - You could qualify for free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP).
  - Need help estimating your new income? Use our income calculator to make your best estimate (/income-calculator).

If I previously qualified for a Special Enrollment Period, but missed the deadline because I was impacted by the COVID-19 national emergency

If you qualified for a Special Enrollment Period but missed the deadline due to COVID-19 (like if you were sick with COVID-19 or were caring for someone who was sick with COVID-19), you may be eligible for another Special Enrollment Period. Visit FEMA.gov for information about emergencies in your state (https://www.fema.gov/disasters).

To see if you're eligible for this Special Enrollment Period, contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

If I want to change my current Marketplace plan or enroll for the first time

- If you've had qualifying life changes (/glossary/qualifying-life-event), like if you move, have a baby, or lose other health coverage, you may be able to enroll in Marketplace coverage for the first time or change your current plan through a Special Enrollment Period (/glossary/special-enrollment-period).
- Answer a few questions (/screener) to find out if you can enroll in or change your coverage.

If my child is now living with me after their college sent them home early

- Your child can generally qualify for a Special Enrollment Period due to change in residence if they're:
  - Still enrolled in a student health plan, but the coverage and benefits don't extend to your area, or if your child's move home means that they moved to a new ZIP code or county.
  - Had qualifying health coverage or lived in a foreign country or a U.S. territory for at least one of the 60 days before the date of their move. **Note:** This requirement doesn't apply to members of a federally recognized tribe or Shareholders of Alaska Native Corporations.
- If your child is under 26 and you're already enrolled in Marketplace coverage, you may be able to add your child to your plan.
  - If you have Marketplace coverage with savings and **don't** plan to claim your child as a tax dependent on your federal tax return, your child should set up their own Marketplace account (/create-account) and submit a separate application.
  - If you plan to claim your child as a tax dependent on your federal tax return, and you currently have Marketplace savings with your coverage, you can update your Marketplace application and add your child.
  - If you have Marketplace coverage without requesting savings, you can put everyone on one application.

If I get a direct deposit or check from the IRS that is called an economic impact payment

The Coronavirus Aid, Relief, and Economic Security (CARES) Act calls for the IRS to make economic impact payments of up to $1,200 per taxpayer and $500 for each qualifying child. If you get one of these payments, you don't need to include it in the income you report on your HealthCare.gov application. These payments don't impact your eligibility for financial assistance for health care coverage through the Marketplace, or your eligibility for Medicaid or the Children's Health Insurance Program (CHIP). For more information, visit IRS Coronavirus Tax Relief (https://www.irs.gov/coronavirus-tax-relief-and-economic-impact-payments) information.

For the latest coronavirus information

- CDC.gov/coronavirus (https://www.cdc.gov/coronavirus) has the latest public health and safety information from CDC and for the overarching medical and health provider community on COVID-19.
- Coronavirus.gov (https://www.coronavirus.gov) is the source for the latest information about COVID-19 prevention, symptoms, and answers to common questions.
- USA.gov/coronavirus (https://www.usa.gov/coronavirus) to see what the U.S. Government is doing in response to COVID-19.

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Affordable coverage

A job-based health plan covering only the employee that costs 9.78% or less of the employee's household income. If a job-based plan is "affordable," and meets the "minimum value" standard, you're not eligible for a premium tax credit if you buy a Marketplace insurance plan instead.

- The plan used to define affordability is the lowest priced "self-only" plan the employer offers — meaning a plan covering **only** the employee, not dependents. This is true even if you're enrolled in a plan that costs more or covers dependents.
- The cost is **the amount the employee would pay** for the insurance, not the plan's total premium.
- The employee's **total household income** is used. Total household income includes income from everybody in the household who's required to file a tax return.

Example 1

- Employee's monthly **household** income = $4,083 (about $49,000 per year)
- 9.78% of the employee's monthly household income = $399
- Monthly cost to the employee of the lowest-priced plan the employer offers for self-only coverage = $300
- **Is the plan affordable?** YES. The employee's share of the lowest cost self-only plan ($300) is **less** than 9.78% of the employee's household income ($399).

Example 2

- Employee's monthly **household** income = $2,333 (about $28,000 per year)
- 9.78% of the employee's monthly household income = $228
- Monthly cost to the employee of the lowest-priced plan the employer offers for self-only coverage = $275

- **Is the plan affordable?** NO. The employee's share of the lowest-cost self-only plan ($275) is **more** than 9.78% of the employee's household income ($228).

To find out if your employer's plan meets the affordability standard, ask your employer. You can also ask them to fill out the Employer Coverage Tool (PDF) (https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf).

Related content

- If you'd like to buy a Marketplace plan instead of accepting job-based coverage (/have-job-based-coverage/change-to-marketplace-plan/)
- How to estimate your household income (/income-and-household-information/how-to-report/)
- How to know if a plan meets the "minimum value" standard (/glossary/minimum-value/)

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SELECT AN ARTICLE

Unemployed people

COBRA coverage and the Marketplace

When you lose job-based insurance, you may be offered COBRA continuation coverage by your former employer.

- If you're losing job-based coverage and haven't signed up for COBRA, learn about your rights and options under COBRA (https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra) from the U.S. Department of Labor.
- If you decide not to take COBRA coverage, you can enroll in a Marketplace plan instead. Losing job-based coverage qualifies you for a Special Enrollment Period (/glossary/special-enrollment-period). This means you have 60 days to enroll in a health plan, even if it's outside the annual Open Enrollment Period. (/glossary/open-enrollment-period)

See 2020 plans and prices (/see-plans/) to compare them to your COBRA coverage or offer.

If you already have COBRA coverage

If you're already enrolled in COBRA, you may have options in the Marketplace.

Can you change from COBRA to a Marketplace plan?

	If your COBRA is running out	**If you're ending COBRA early**	**If your COBRA costs change because your former employer stops contributing and you must pay full cost**
During Open Enrollment	Yes, you can change.	Yes, you can change.	Yes, you can change.
Outside Open Enrollment	Yes, you can change — you qualify for a Special Enrollment Period.	No, you can't change until the next Open Enrollment Period, your COBRA runs out, or you qualify for a Special Enrollment Period another way.	Yes, you can change — you qualify for a Special Enrollment Period.

More answers

Does COBRA count as qualifying health coverage (or "minimum essential coverage")?

What if I already signed up for COBRA but it's too expensive?

Can I switch from COBRA to Medicaid outside Open Enrollment?

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HealthCare.gov

How to change, update, or cancel your Marketplace plan

Open Enrollment for 2020 is over. You now have limited opportunities to change your health plan.

Change health plans: Only with a Special Enrollment Period

You can change health plans now only if you experience a qualifying life event (/glossary/qualifying-life-event) — like losing other coverage, having a baby, or getting married — that makes you eligible for a Special Enrollment Period. (/glossary/special-enrollment-period)

Find out if you qualify to change plans

Answer a few fast questions. We'll tell you if you qualify for a Special Enrollment Period. If you do, you can change your health plan.

Ready to change plans with a Special Enrollment Period? Log into your account. (/login)

Update your health plan: Report changes, keep plan up-to-date

If you experience a change to your income or household — like a pay raise, a new household member, or a dependent getting other coverage — you must update your Marketplace application.

- Some changes will qualify you for a Special Enrollment Period, allowing you to change your plan.

- Some changes, like an increase or decrease in income, may affect your savings or coverage eligibility. If you don't update, you may miss out on additional savings or pay money back when you file your taxes.

See what changes to report and how to do it. (/reporting-changes/)

Cancel your health plan: Any time

You can cancel your Marketplace coverage any time. You may need to do this if you get other health coverage, or for another reason.

You can end coverage for:

- **Everyone on the application after your coverage has started.** Your termination can take effect as soon as the day you cancel, or you can set the Marketplace coverage end date to a day in the future — like if you know your new coverage will start on the first day of the following month.
- **Just some people on the application.** In most cases, their coverage will end immediately.

Learn how to cancel your coverage. (/how-to-cancel-a-marketplace-plan/)

More Answers: Change, update, or cancel your plan

Where can I see all qualifying life events that qualify for a Special Enrollment Period?

Why should I report changes if I don't qualify for a Special Enrollment Period?

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HealthCare.gov

The Marketplace in your state

No matter what state you live in, you can enroll in affordable, quality health coverage.

State Medicaid expansion

Some states have expanded their Medicaid programs to cover more people. Choose your state and household size (/lower-costs/) and we'll tell you if your state has expanded and if you may qualify.

Where to apply for health coverage

People in most states use HealthCare.gov to apply for and enroll in health coverage.

If your state appears on the list below, you won't use HealthCare.gov. You'll use your state's website to enroll in individual/family or small business health coverage, or both.

- California (/marketplace-in-your-state/#ca)
- Colorado (/marketplace-in-your-state/#co)
- Connecticut (/marketplace-in-your-state/#ct)
- District of Columbia (/marketplace-in-your-state/#dc)
- Idaho (/marketplace-in-your-state/#idaho)
- Maryland (/marketplace-in-your-state/#md)
- Massachusetts (/marketplace-in-your-state/#ma)
- Minnesota (/marketplace-in-your-state/#mn)
- Nevada (/marketplace-in-your-state/#nv)
- New York (/marketplace-in-your-state/#ny)
- Rhode Island (/marketplace-in-your-state/#ri)
- Vermont (/marketplace-in-your-state/#vt)

- Washington (/marketplace-in-your-state/#wa)

California

Covered California is your state's Marketplace. Visit California's website. (http://www.coveredca.com/) (https://www.healthcare.gov/links-to-other-sites/)

Colorado

Connect for Health Colorado is your state's Marketplace. Visit Colorado's website. (http://www.connectforhealthco.com/) (https://www.healthcare.gov/links-to-other-sites/)

Connecticut

Access Health CT is your state's Marketplace. Visit Connecticut's website. (http://www.accesshealthct.com/) (https://www.healthcare.gov/links-to-other-sites/)

District of Columbia

DC Health Link is your state's Marketplace. Visit the District of Columbia's website. (https://dchealthlink.com/) (https://www.healthcare.gov/links-to-other-sites/)

Idaho

Your Health Idaho is your state's Marketplace. Visit Idaho's website. (http://www.yourhealthidaho.org/) (https://www.healthcare.gov/links-to-other-sites/)

Small business employers and employees interested in SHOP coverage: You'll use HealthCare.gov to apply for SHOP any time (/small-businesses/).

Maryland

Maryland Health Connection is your state's Marketplace. Visit Maryland's website. (http://www.marylandhealthconnection.gov/)

Massachusetts

Health Connector is your state's Marketplace. Visit Massachusetts' website. (https://www.mahealthconnector.org/) (https://www.healthcare.gov/links-to-other-sites/)

Minnesota

MNsure website is your state's Marketplace. Visit Minnesota's website. (http://mn.gov/hix/)

Nevada

Nevada Health Link is your state's Marketplace. Visit Nevada's website. (https://www.nevadahealthlink.com/) (https://www.healthcare.gov/links-to-other-sites/)

New York

New York State of Health is your state's Marketplace. Visit New York's website. (http://nystateofhealth.ny.gov/)

Rhode Island

HealthSource RI is your state's Marketplace. Visit Rhode Island's website. (http://www.healthsourceri.com/) (https://www.healthcare.gov/links-to-other-sites/)

Vermont

Vermont Health Connect is your state's Marketplace. Visit Vermont's website. (http://healthconnect.vermont.gov/)

Washington

Washington Healthplanfinder is your state's Marketplace. Visit Washington's website. (http://www.wahealthplanfinder.org/) (https://www.healthcare.gov/links-to-other-sites/)

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Press release

CMS Issues Special Trends Report on Health Insurance Exchange Enrollment Data During COVID-19

Jun 25, 2020 Policy

The Centers for Medicare & Medicaid Services (CMS) today released a trends report that provides data on the number of individuals who signed up for coverage on HealthCare.gov through a special enrollment period (SEP) during the Coronavirus Disease 2019 (COVID-19) pandemic. As a result of the economic disruption that followed COVID-19 outbreaks, many consumers experienced life changes—particularly related to employment—that allowed them to enroll in health coverage through the Exchange. Enrollment data for April and May of this year show that thousands of Americans who lost job-based coverage due to COVID-19 are successfully taking advantage of existing SEPs to enroll in coverage.

As Americans consider their health insurance options during this crisis and as the country re-opens, CMS will continue to provide assistance to help inform those choices. CMS strongly encourages individuals to visit HealthCare.gov to explore their coverage options.

To view the Special Trends Report, visit: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency

June 2020

This special trends report provides enrollment data for consumers in states with Exchanges using the HealthCare.gov platform who made a plan selection through a special enrollment period (SEP), from the end of the Open Enrollment Period (OEP) through May of the 2017-2020 coverage years. Because of the coronavirus disease 2019 (COVID-19) emergency, many consumers have experienced life changes that allow them to enroll in health coverage through the Exchanges using existing SEPs. This report examines coverage gains through SEPs, with a particular focus on the SEP for people who recently lost other qualifying health coverage (i.e., the "loss of minimum essential coverage" or loss of MEC SEP).

Key Findings

- The number of consumers gaining coverage in states with Exchanges using the HealthCare.gov platform through the loss of MEC SEP is higher for the 2020 coverage year than for any of the prior coverage years in this report with approximately 487,000 consumers gaining coverage through the loss of MEC SEP, an increase of 46 percent from the same time period last year.
- By month, the largest gain in loss of MEC SEP enrollments occurred in April 2020, with enrollments increasing by 139 percent when compared to April 2019.
- The number of consumers gaining Exchange coverage through the loss of MEC SEP dropped by about one-third from April 2020 to May 2020, but continued to be significantly higher—by 43 percent—than in May of 2019.
- Looking at enrollments across all SEP types, there was a 27 percent increase in total SEP enrollments from the end of OE through May from 2019 to 2020. The percentage change was actually higher during the period from 2017 to 2018, with an increase of 33 percent. However, the higher increase in SEP enrollments from 2017 to 2018 could be attributed to the longer open enrollment period for 2017, which extended to January 31 and substantially shortened the period of time SEPs were available after the end of 2017 OE.

Trend Analysis: Impact of COVID-19 Job Losses on Demand for SEPs Remains Unclear

Millions of individuals have lost their jobs as a result of the COVID-19 pandemic and the associated suspension of many routine business activities. Some number of these recently unemployed individuals have also lost their job-based health coverage and may want to transition to a new source of coverage. Based on current regulations, anyone who loses job-based minimum essential coverage (MEC) will qualify for a SEP, and would be eligible to enroll in individual market coverage through the Exchange serving their state, if they meet the applicable

criteria for enrollment through an Exchange. Consumers typically have up to 60 days following the loss of job-based coverage to enroll in a plan.

Bureau of Labor Statistics (BLS) data show that nonfarm payroll employment dropped by an unprecedented 20.7 million people from March to April as states across the country issued stay-at-home orders.[1] In May, the number of employed increased by 2.5 million compared to April, and the unemployment rate declined to 13.3 percent from a high of 14.7 percent in April.[2]

However, looking more closely, the BLS data shows that when job losses spiked in April, 97 percent of those surveyed identified their job loss as a temporary layoff[3]—meaning either they had been given a date to return to work by their employer or that they expected to be back to work within the next six months.[4] In addition, many of the newly unemployed may be able to maintain their prior job-based health coverage due to the fact that many employers have reported they are continuing to provide coverage to laid-off and furloughed employees.[5]

Overall, due to a combination of factors including expectations of eventually returning to work, employers' ongoing contributions to their furloughed or laid-off employees' health insurance premiums during the public health emergency, COBRA continuation coverage through their former employer, and access to other coverage such as through a spouse, it remains unclear how many people will eventually look to Exchanges using HealthCare.gov to replace job-based coverage. As discussed below, while the magnitude may be unclear, job losses due to COVID-19 have led to increased enrollments on HealthCare.gov through the loss of MEC SEP. CMS has taken a number of steps, detailed below, to assist consumers who may have lost their coverage or experienced another SEP qualifying event in obtaining coverage through an Exchange using HealthCare.gov.

CMS Actions to Help People Enroll through Exchanges Using HealthCare.gov

For people who have lost coverage through their jobs and need new health coverage, CMS has taken a number of actions to help them understand their options and make it easier to gain coverage through Exchanges using HealthCare.gov. Individuals who lose qualifying employer coverage and live in a state with an Exchange using HealthCare.gov can enroll in health coverage using a special enrollment period by visiting HealthCare.gov, if otherwise eligible to enroll through an Exchange; calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325); contacting an agent, broker or other assister (who can be located on Find Local Help); or visiting a certified enrollment partner.

Any consumers who qualified for a SEP but missed the deadline as a result of the COVID-19 pandemic—for example, if they were sick with COVID-19 or were caring for someone who was

[1] The Employment Situation Summary, Table B-1, Bureau of Labor Statistics, June 5, 2020. Available at: https://www.bls.gov/news.release/empsit.nr0.htm
[2] The Employment Situation Summary, Bureau of Labor Statistics, June 5, 2020. Available at: https://www.bls.gov/news.release/empsit.nr0.htm
[3] The Employment Situation Summary, Table A-11, Bureau of Labor Statistics, June 5, 2020. Available at: https://www.bls.gov/news.release/empsit.nr0.htm
[4] Frequently asked questions: The impact of the coronavirus (COVID-19) pandemic on The Employment Situation for April 2020, Bureau of Labor Statistics, May 8, 2020. Available at: https://www.bls.gov/cps/employment-situation-covid19-faq-april-2020.pdf
[5] Poll Results Furloughs, Lay-offs, and Health Benefit Decisions, Mercer: https://www.mercer.us/our-thinking/healthcare/poll-results-furloughs-lay-offs-and-health-benefit-decisions.html#

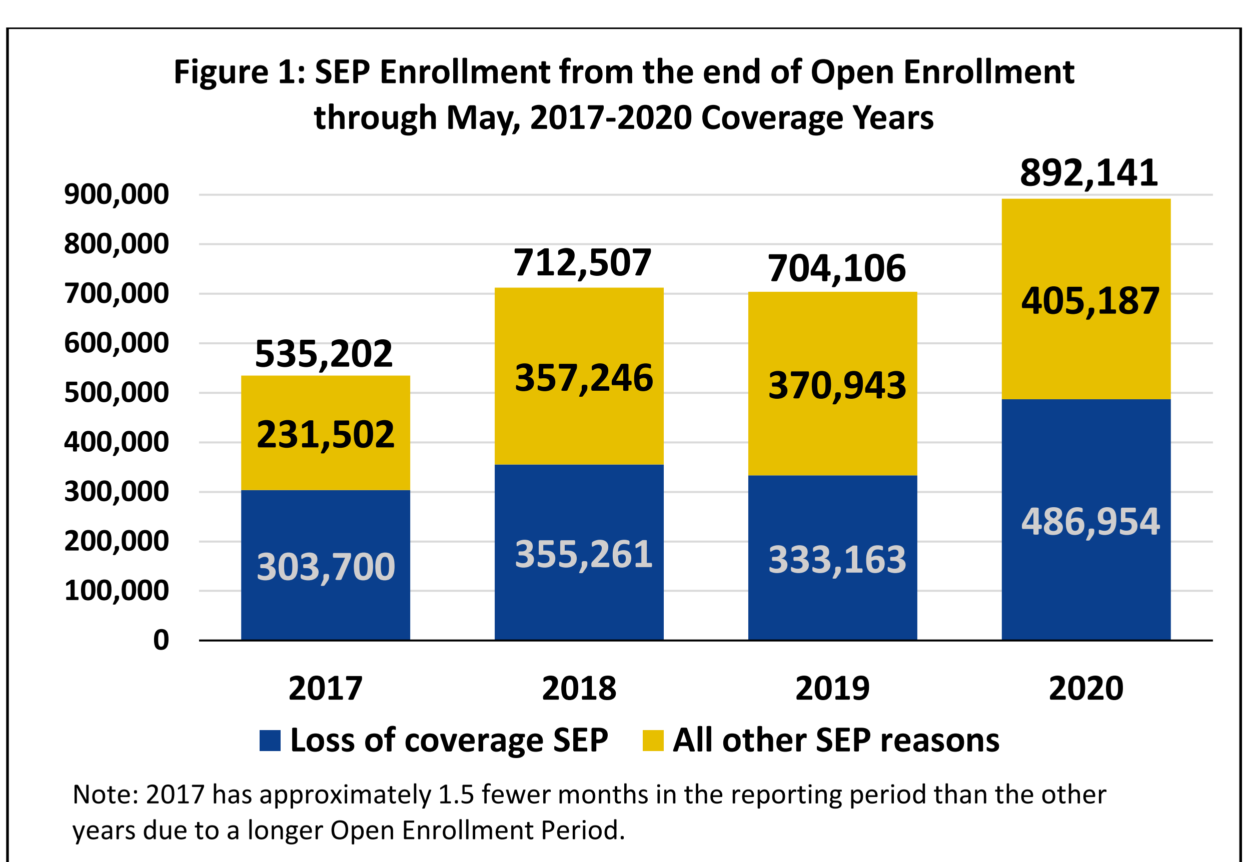
sick with COVID-19—may also be eligible for another SEP. Consumers should contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to see if they are eligible for this SEP.

To further support people during this public health emergency, CMS updated HealthCare.gov to make it easier for consumers to find important information on how to best take advantage of existing SEP opportunities in light of the COVID-19. These updates to HealthCare.gov include the addition of a webpage on HealthCare.gov specifically designated for COVID-19 information as it relates to Exchange coverage. Additionally, CMS released new resources for assisters, agents/brokers and other partners who are helping consumers during this time.

Along with helping people determine whether they are eligible for advance payments of the premium tax credit (APTC) to help lower the cost of Exchange coverage, HealthCare.gov also helps people assess if they or their family members may qualify for coverage from Medicaid or the Children's Health Insurance Program (CHIP).

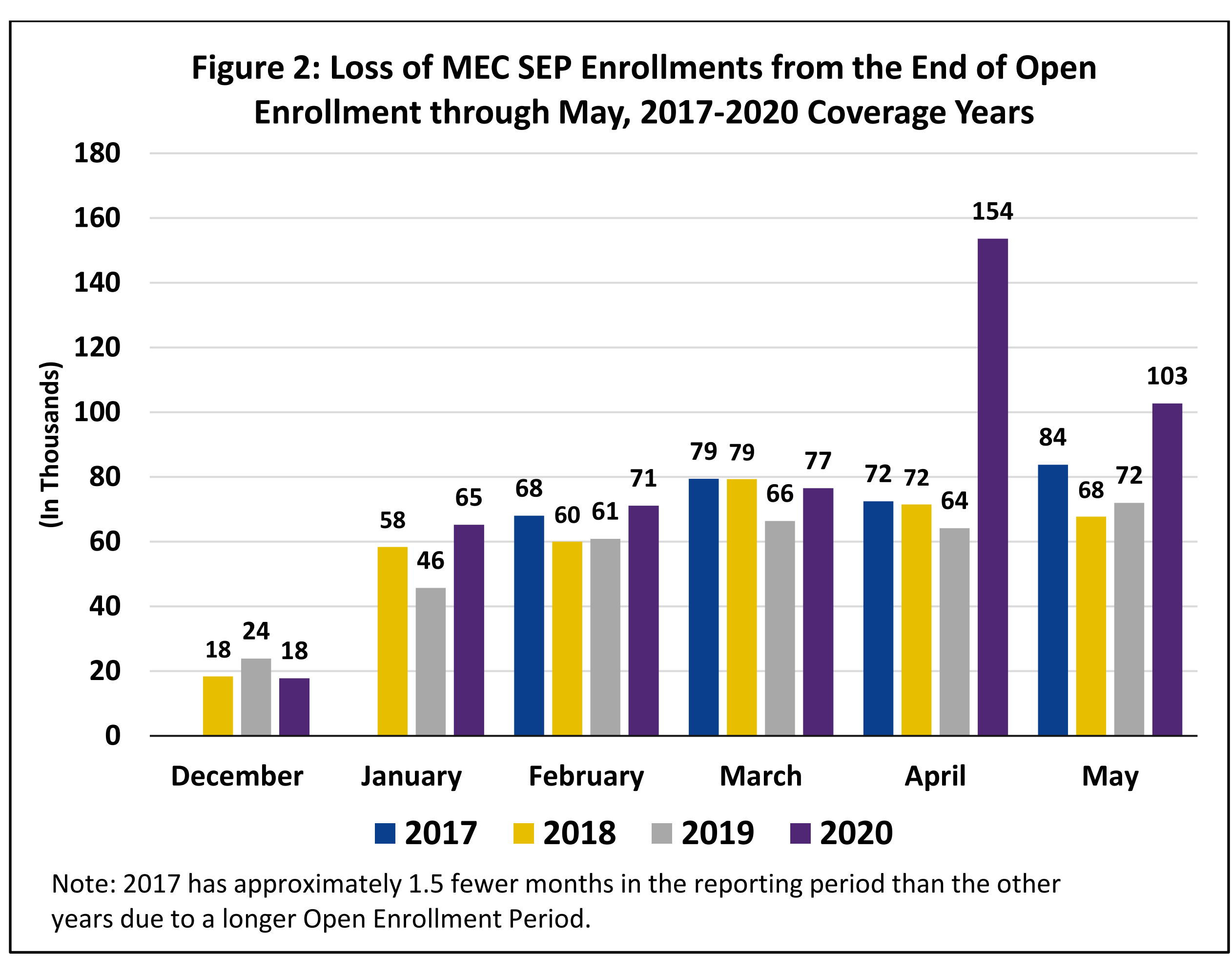
Data Show that People Who Need Coverage are Enrolling Through Exchanges Using HealthCare.gov

As of June 2, enrollment data for 2020 show that thousands of individuals who lost their health coverage through jobs due to COVID-19 are using existing SEPs to enroll in coverage through the Exchanges using the HealthCare.gov platform. Figure 1 shows that more consumers used SEPs for the 2020 coverage year than in any other year of the reporting period, from 2017-2020. Compared to last year, 188,000 more people enrolled in coverage through a SEP; the loss of MEC SEP is responsible for 82 percent of this increase.



Focusing on SEP enrollment data for April and May of this year provides a clearer picture of the increased use of the loss of MEC SEP at the time job losses due to COVID-19 rose sharply. In April 2020, approximately 225,000 consumers enrolled in coverage through Exchanges using HealthCare.gov through an existing SEP. As shown in Figure 2, this includes 154,000 consumers who enrolled through the loss of MEC SEP, a 139 percent increase from the same month last year.

In May, as the labor market improved, the number of people using the loss of MEC SEP declined by 33 percent from April to 103,000. However, this still represents a 43 percent increase from May 2019, showing more people were continuing to use the loss of MEC SEP in May 2020 when compared to last year.



Conclusion

These enrollment numbers show that individuals who lost their jobs or experienced other qualifying life events due to the COVID-19 pandemic are using existing SEPs to enroll in coverage through HealthCare.gov. As Americans consider their health insurance options during this crisis and as the country re-opens, CMS will continue to provide assistance to help inform those choices. CMS strongly encourages individuals to visit HealthCare.gov to explore their coverage options.

Background

In the Exchanges, most consumers select a plan during the Open Enrollment Period (OEP). Consumers who experience one of six types of life events can also select a plan during a Special Enrollment Period (SEP).

SEPs are a longstanding feature of employer-sponsored health coverage, giving people who lose coverage during the year (for example, through non-voluntary loss of MEC provided through an employer), or who experience other qualifying life events (for example, marriage or the birth or adoption of a child) the opportunity to enroll in new coverage or make changes to their existing coverage. While the annual OEP allows uninsured individuals to enroll in new coverage, SEPs are intended, in part, to promote continuous enrollment in health coverage during the plan year by allowing those who were previously enrolled in coverage to obtain new coverage or make changes to existing coverage without experiencing a gap in coverage. The application of SEPs helps protect the risk pool by minimizing the opportunity for individuals to wait until they are sick to enroll in coverage.

Methodology for Counting SEP Enrollments

This special trends report provides SEP enrollment counts from the end of the OEP through May for the 2017-2020 coverage years (see below for OEP end dates for each coverage year), broken down by: coverage year, month of plan selection, and loss of MEC SEP versus all other SEPs reasons. Consumers were only included if they "gained coverage" through a SEP, meaning the application was submitted after the end of the OEP (including the extra 36 hours provided to certain consumers after the 2020 OEP), the consumer did not have coverage at the time of application submission, and the consumer made a plan selection that was sent to the issuer (i.e., plan selections that were pended—for example, while the Exchange waited to receive documents from an applicant to prove a SEP-qualifying event—but that were not ultimately sent to an issuer, were excluded). We counted each consumer only once. If a consumer enrolled through multiple SEPs, we only counted the first SEP enrollment. In addition, consistent with our reporting during the OEP, plan selection counts do not reflect whether a consumer has paid any initial premium amount, if applicable.

Other methodological notes:

- Open Enrollment for 2017 ended January 31, 2017; Open Enrollment for 2018, 2019, and 2020 ended December 15 of the year preceding the coverage year.[6] Therefore, 2017 has approximately 1.5 fewer months in the reporting period than the other years.
- Nevada became a state-based Exchange for coverage year 2020, and therefore has no HealthCare.gov SEP enrollments for that year. NV SEP volume across all SEP types was about 5,300 for 2017; about 7,500 for 2018; and about 6,600 for 2019.

[6] The 2020 OEP includes the period from December 16-18, 2019 provided to consumers who were unable to enroll by the December 15 deadline.

Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

Explanation of Methodology:

*The following pages provide counts of consumers in states using the Federal Exchange platform who gained coverage through a special enrollment period (SEP). These numbers include plan selections associated with an application submitted after the Open Enrollment Period (OEP) and for consumers without coverage at the time of application submission.

*Each consumer was only counted once, in the month of plan selection. If a consumer enrolled through multiple SEPs meeting the criteria above, the consumer was only counted at the first SEP enrollment.

Year-Specific or Month-Specific Events That Impacted the Data:

*Open Enrollment for 2017 ended January 31, 2017; Open Enrollment for 2018, 2019, and 2020 ended December 15 of the year preceding the coverage year. Therefore, 2017 has approximately 1.5 months less in the reporting period than the other years.

*Nevada became a state-based Exchange for coverage year 2020, and therefore has no SEPs for that year through the federal Exchange platform.

*SEP verification began in the summer of 2017. SEP verification flexibilities were implemented starting in April 2020 in response to the COVID-19 pandemic.

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

SEP Type by Plan Year

SEP Type	2017	2018	% change from 2017 to 2018	2019	% change from 2018 to 2019	2020	% change from 2019 to 2020
Loss of qualifying coverage	303,700	355,261	17%	333,163	-6%	486,954	46%
Medicaid or Children's Health Insurance Program denial	165,821	154,891	-7%	162,287	5%	182,362	12%
Newly eligible for a QHP due to change in legal status	8,975	61,137	581%	97,872	60%	107,069	9%
Exceptional Circumstances	9,063	71,030	684%	38,962	-45%	27,838	-29%
Change in eligibility for financial assistance for Exchange coverage	7,435	20,441	175%	21,516	5%	24,049	12%
Change in Household Size (marriage, adoption, birth)	17,119	21,915	28%	21,691	-1%	23,132	7%
Move to a new service area	18,546	15,795	-15%	11,462	-27%	20,698	81%
Other SEP types	4,543	12,037	165%	17,153	43%	20,039	17%
Grand Total	**535,202**	**712,507**	**33%**	**704,106**	**-1%**	**892,141**	**27%**

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

Plan Year 2020 SEP Type by month of plan selection												
SEP Type	**Dec-19**	**Jan-20**	**% change from Dec to Jan**	**Feb-20**	**% change from Jan to Feb**	**Mar-20**	**% change from Feb to Mar**	**Apr-20**	**% change from Mar to Apr**	**May-20**	**% change from Apr to May**	**Total**
Loss of coverage	17,834	65,196	266%	71,126	9%	76,531	8%	153,578	101%	102,689	-33%	**486,954**
Medicaid / CHIP denial	12,702	41,844	229%	39,370	-6%	33,632	-15%	33,755	0%	21,059	-38%	**182,362**
Newly eligible for a QHP due to change in legal status	10,379	21,008	102%	22,132	5%	25,012	13%	15,663	-37%	12,875	-18%	**107,069**
Exceptional Circumstances	13,856	4,014	-71%	3,328	-17%	2,699	-19%	2,284	-15%	1,657	-27%	**27,838**
Change in eligibility for financial assistance	5,025	5,867	17%	3,752	-36%	3,811	2%	3,081	-19%	2,513	-18%	**24,049**
Change in Household Size	1,425	4,557	220%	4,223	-7%	4,401	4%	4,647	6%	3,879	-17%	**23,132**
Move to a new service area	291	1,912	557%	2,387	25%	3,117	31%	9,141	193%	3,850	-58%	**20,698**
Other SEP types	1,354	4,242	213%	4,270	1%	4,485	5%	3,369	-25%	2,319	-31%	**20,039**
Grand Total	**62,866**	**148,640**	**136%**	**150,588**	**1%**	**153,688**	**2%**	**225,518**	**47%**	**150,841**	**-33%**	**892,141**

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

Plan Year 2019 SEP Type by month of plan selection

SEP Type	Dec-18	Jan-19	% change from Dec to Jan	Feb-19	% change from Jan to Feb	Mar-19	% change from Feb to Mar	Apr-19	% change from Mar to Apr	May-19	% change from Apr to May	Total
Loss of coverage	23,945	45,712	91%	60,941	33%	66,387	9%	64,150	-3%	72,028	12%	**333,163**
Medicaid / CHIP denial	17,808	38,320	115%	29,565	-23%	28,853	-2%	24,651	-15%	23,090	-6%	**162,287**
Newly eligible for a QHP due to change in legal status	7,328	16,824	130%	17,404	3%	18,225	5%	19,076	5%	19,015	0%	**97,872**
Exceptional Circumstances	19,932	5,153	-74%	4,170	-19%	4,154	0%	2,882	-31%	2,671	-7%	**38,962**
Change in eligibility for financial assistance	4,352	4,378	1%	3,103	-29%	3,307	7%	3,419	3%	2,957	-14%	**21,516**
Change in Household Size	2,042	4,078	100%	3,692	-9%	3,756	2%	3,982	6%	4,141	4%	**21,691**
Move to a new service area	849	1,123	32%	1,800	60%	2,040	13%	2,390	17%	3,260	36%	**11,462**
Other SEP types	1,460	3,332	128%	3,053	-8%	3,289	8%	3,194	-3%	2,825	-12%	**17,153**
Grand Total	**77,716**	**118,920**	**53%**	**123,728**	**4%**	**130,011**	**5%**	**123,744**	**-5%**	**129,987**	**5%**	**704,106**

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

Plan Year 2018 SEP Type by month of plan selection

SEP Type	Dec-17	Jan-18	% change from Dec to Jan	Feb-18	% change from Jan to Feb	Mar-18	% change from Feb to Mar	Apr-18	% change from Mar to Apr	May-18	% change from Apr to May	Total
Loss of coverage	18,405	58,377	217%	60,008	3%	79,259	32%	71,493	-10%	67,719	-5%	**355,261**
Medicaid / CHIP denial	16,600	42,540	156%	29,780	-30%	25,055	-16%	21,672	-14%	19,244	-11%	**154,891**
Newly eligible for a QHP due to change in legal status	6,112	9,580	57%	10,850	13%	10,768	-1%	11,046	3%	12,781	16%	**61,137**
Exceptional Circumstances	40,208	10,836	-73%	5,769	-47%	4,851	-16%	3,862	-20%	5,504	43%	**71,030**
Change in eligibility for financial assistance	3,600	3,585	0%	2,898	-19%	3,390	17%	3,460	2%	3,508	1%	**20,441**
Change in Household Size	2,283	4,226	85%	3,699	-12%	3,796	3%	3,784	0%	4,127	9%	**21,915**
Move to a new service area	726	2,116	191%	2,558	21%	3,292	29%	3,618	10%	3,485	-4%	**15,795**
Other SEP types	1,347	2,060	53%	2,207	7%	2,313	5%	1,984	-14%	2,126	7%	**12,037**
Grand Total	**89,281**	**133,320**	**49%**	**117,769**	**-12%**	**132,724**	**13%**	**120,919**	**-9%**	**118,494**	**-2%**	**712,507**

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

Plan Year 2017 SEP Type by month of plan selection

SEP Type	Dec-16	Jan-17	% change from Dec to Jan	Feb-17	% change from Jan to Feb	Mar-17	% change from Feb to Mar	Apr-17	% change from Mar to Apr	May-17	% change from Apr to May	Total
Loss of coverage	-	-	n/a	68,035	n/a	79,377	17%	72,486	-9%	83,802	16%	**303,700**
Medicaid / CHIP denial	-	1	n/a	48,221	n/a	46,833	-3%	35,628	-24%	35,138	-1%	**165,821**
Newly eligible for a QHP due to change in legal status	-	-	n/a	1,491	n/a	2,361	58%	2,436	3%	2,687	10%	**8,975**
Exceptional Circumstances	-	-	n/a	2,030	n/a	2,203	9%	2,006	-9%	2,824	41%	**9,063**
Change in eligibility for financial assistance	-	-	n/a	1,588	n/a	1,896	19%	1,882	-1%	2,069	10%	**7,435**
Change in Household Size	-	-	n/a	3,476	n/a	4,615	33%	4,218	-9%	4,810	14%	**17,119**
Move to a new service area	-	-	n/a	3,439	n/a	5,177	51%	4,769	-8%	5,161	8%	**18,546**
Other SEP types	-	-	n/a	968	n/a	1,311	35%	1,087	-17%	1,177	8%	**4,543**
Grand Total	**0**	**1**	**n/a**	**129,248**	**n/a**	**143,773**	**11%**	**124,512**	**-13%**	**137,668**	**11%**	**535,202**

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Consumers in States Using the Federal Exchange Platform
Who Gained Coverage Through A Special Enrollment Period
End of Open Enrollment Period through May, Plan Years 2017-2020

SEP Totals by Plan Year and State							
State	**2017**	**2018**	**% change**	**2019**	**% change**	**2020**	**% change**
AK	1,321	1,462	11%	1,461	0%	1,566	7%
AL	9,351	10,977	17%	10,346	-6%	13,177	27%
AR	5,857	7,279	24%	7,482	3%	7,521	1%
AZ	12,018	14,959	24%	15,005	0%	16,539	10%
DE	1,985	2,352	18%	2,251	-4%	2,962	32%
FL	91,539	155,112	69%	170,974	10%	234,129	37%
GA	24,734	32,455	31%	32,145	-1%	45,104	40%
HI	1,650	2,111	28%	2,107	0%	2,812	33%
IA	4,176	5,166	24%	6,219	20%	7,799	25%
IL	21,589	28,290	31%	26,440	-7%	29,301	11%
IN	11,204	15,707	40%	13,467	-14%	14,851	10%
KS	6,332	7,910	25%	7,299	-8%	8,901	22%
KY	9,126	12,233	34%	10,644	-13%	11,392	7%
LA	6,987	8,220	18%	8,809	7%	9,003	2%
ME	3,934	5,620	43%	4,542	-19%	5,271	16%
MI	18,065	21,359	18%	23,209	9%	25,953	12%
MO	12,722	15,601	23%	13,362	-14%	17,166	28%
MS	4,541	5,208	15%	6,079	17%	8,810	45%
MT	2,516	2,915	16%	3,339	15%	4,652	39%
NC	28,885	33,471	16%	34,093	2%	42,820	26%
ND	1,580	2,002	27%	1,978	-1%	2,327	18%
NE	4,711	6,933	47%	7,312	5%	8,321	14%
NH	3,421	4,533	33%	4,165	-8%	4,898	18%
NJ	20,510	25,378	24%	24,765	-2%	30,823	24%
NM	3,437	4,621	34%	3,672	-21%	3,684	0%
NV	7,129	8,848	24%	8,054	-9%	0	-100%
OH	16,895	21,361	26%	18,403	-14%	22,624	23%
OK	9,439	14,764	56%	15,703	6%	20,335	29%
OR	11,061	13,336	21%	13,481	1%	15,181	13%
PA	28,822	36,716	27%	32,894	-10%	36,931	12%
SC	10,480	12,147	16%	11,787	-3%	16,932	44%
SD	1,737	2,527	45%	2,611	3%	3,036	16%
TN	12,900	15,173	18%	13,109	-14%	20,286	55%
TX	67,065	83,111	24%	81,754	-2%	126,753	55%
UT	13,646	18,647	37%	19,855	6%	21,304	7%
VA	23,461	28,982	24%	22,268	-23%	23,540	6%
WI	16,882	20,870	24%	19,082	-9%	20,640	8%
WV	1,989	2,129	7%	1,858	-13%	2,167	17%
WY	1,505	2,022	34%	2,082	3%	2,630	26%
Grand Total	**535,202**	**712,507**	**33%**	**704,106**	**-1%**	**892,141**	**27%**

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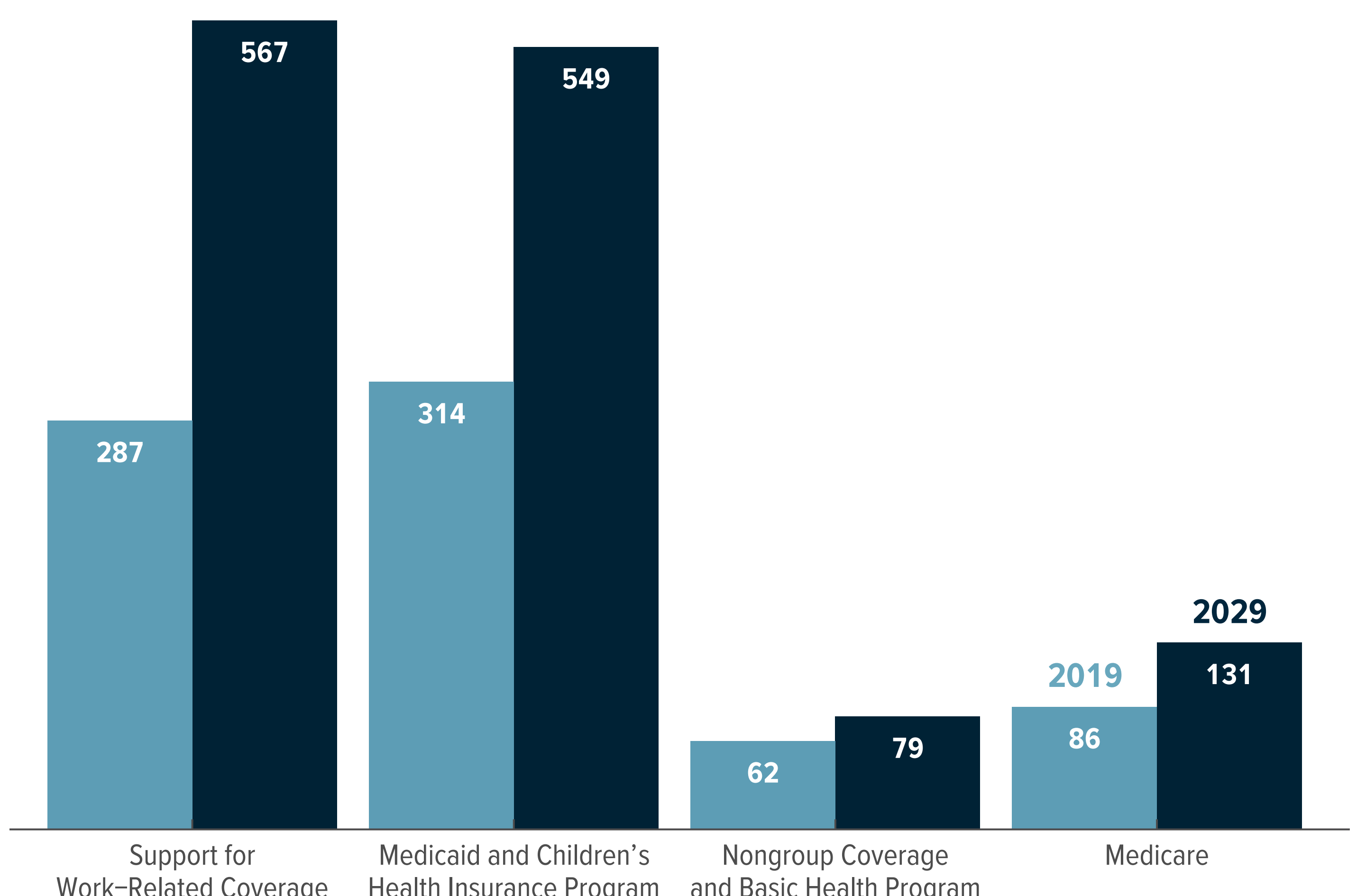
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029



MAY 2019

At a Glance

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. This report, which describes the Congressional Budget Office's updated baseline projections, provides estimates for the 2019–2029 period of the number of noninstitutionalized civilians under age 65 with health insurance and the federal costs associated with each kind of subsidy.

- In an average month for each year during that period, between 240 million and 242 million such people are projected to have health insurance, mostly from employment-based plans. But the number of people without health insurance is projected to rise from 30 million in 2019 to 35 million in 2029.
- Net federal subsidies for insured people will total $737 billion in 2019, according to estimates by CBO and the staff of the Joint Committee on Taxation (JCT). That annual sum is projected to reach $1.3 trillion in 2029.
- In each year during the period, Medicaid and the Children's Health Insurance Program account for between 40 percent and 45 percent of the federal subsidies, as do subsidies in the form of tax benefits for work-related insurance. Medicare accounts for about 10 percent, and subsidies for coverage obtained through the marketplaces established by the Affordable Care Act or through the Basic Health Program account for less than 10 percent.
- Since CBO's most recent report comparable to this one was published in May 2018, the projection of the number of people with employment-based coverage has risen by 3 million, on average, for the 2019–2028 period spanned by both reports. The projection of the average number of uninsured people has fallen by 1 million over that period. Projected net federal subsidies for health insurance from 2019 to 2028 have risen by 2 percent.
- Compared with actual amounts of spending in 2018, CBO's projections for that year made in September 2017 were generally close—with the largest error being an overestimate of $15 billion (or 5 percent) for Medicaid spending.

In preparing the current projections, CBO and JCT used a new version of CBO's health insurance simulation model, HISIM2. It incorporates new sources of survey and administrative data, better accounts for employers' and consumers' selection among different types of insurance plans, and can more easily simulate the effects of new insurance products. CBO and JCT use HISIM2 to estimate the major sources of health insurance coverage and associated premiums. On the basis of those estimates, the agencies use other models (for related taxes, Medicaid, and Medicare, for example) to estimate the associated budgetary costs.

www.cbo.gov/publication/55085

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As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the text, tables, and figures may not add up to totals because of rounding.

Unless the report indicates otherwise, all years referred to in describing estimates of spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

In most states, the federal poverty level is $12,490 for a single person in 2019. For each additional person in a household, $4,420 is added. Income levels reflect modified adjusted gross income (MAGI) for the calendar year. MAGI equals gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and the income of dependent filers.

The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds the estimate of the total population under age 65 by between 11 million and 12 million every year of the projection period, because some people will have multiple sources of coverage. To arrive at the estimates given in this report, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proved more useful for that purpose.)

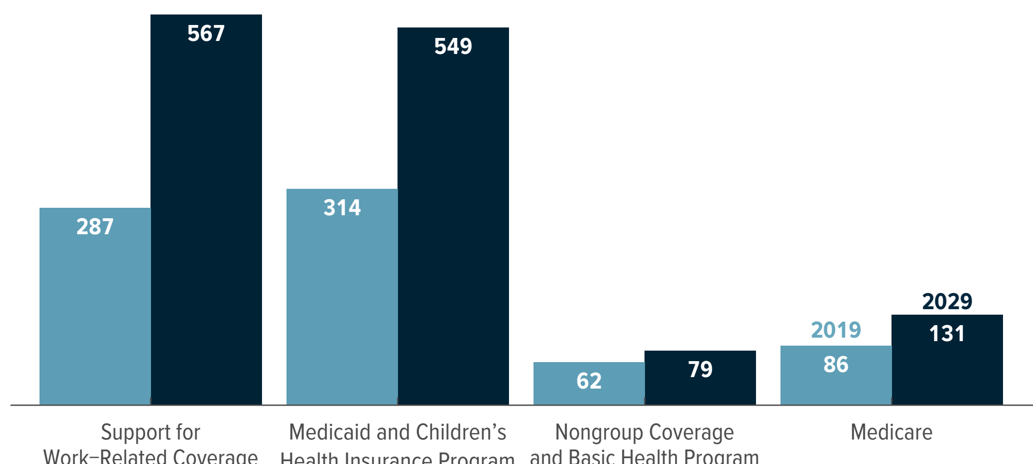
The projections in this report do not incorporate the effects of the following judicial decision and administrative action, which occurred too recently to fully analyze: a decision issued by the District Court for the District of Columbia in the case of *New York v. United States Department of Labor*, No. CV 18-1747, 2019 WL 1410370 (D.D.C. Mar. 28, 2019), that voided major provisions of the Department of Labor's June 2018 regulation entitled "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans," 83 Fed. Reg. 28912 (June 21, 2018), and a proposed rule by the Centers for Medicare & Medicaid Services entitled "Basic Health Program, Federal Funding Methodology for Program Years 2019 and 2020," 84 Fed. Reg. 12552 (April 2, 2019). A preliminary analysis suggests that the effects in subsequent projections would be noticeable but small.

Visual Summary

In a report issued each year, the Congressional Budget Office and the staff of the Joint Committee on Taxation provide projections of health insurance coverage for noninstitutionalized civilians under age 65 and the federal costs of that coverage for that year and the following decade. Net federal subsidies for health insurance coverage for people under age 65 are projected to total $737 billion in 2019 and $9.9 trillion over the 2020–2029 period.

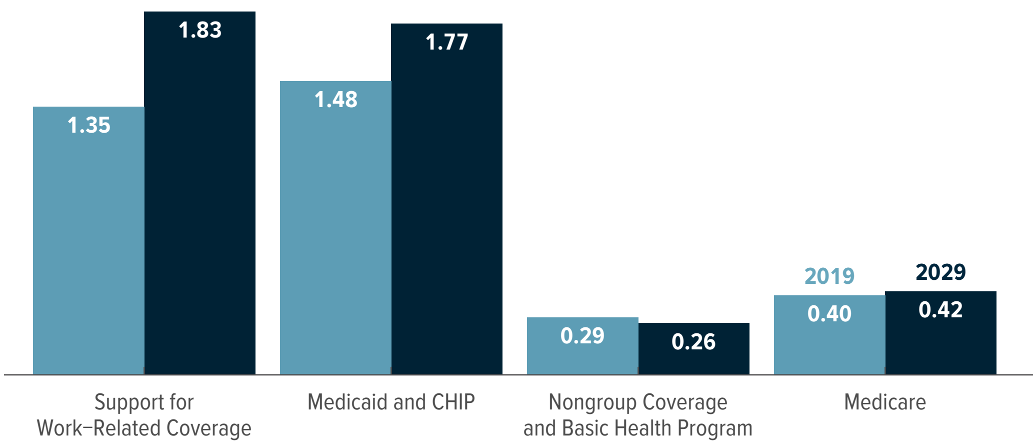
Federal Health Insurance Subsidies

Billions of Dollars



In 2019, the federal government is projected to spend $314 billion for Medicaid and the Children's Health Insurance Program (CHIP) and $287 billion on support for work-related coverage for people under age 65.

Percentage of Gross Domestic Product



As a share of gross domestic product, total federal subsidies are projected to grow over the coming decade; subsidies for work-related coverage are projected to grow the fastest.

See Figure 2-1 on page 18

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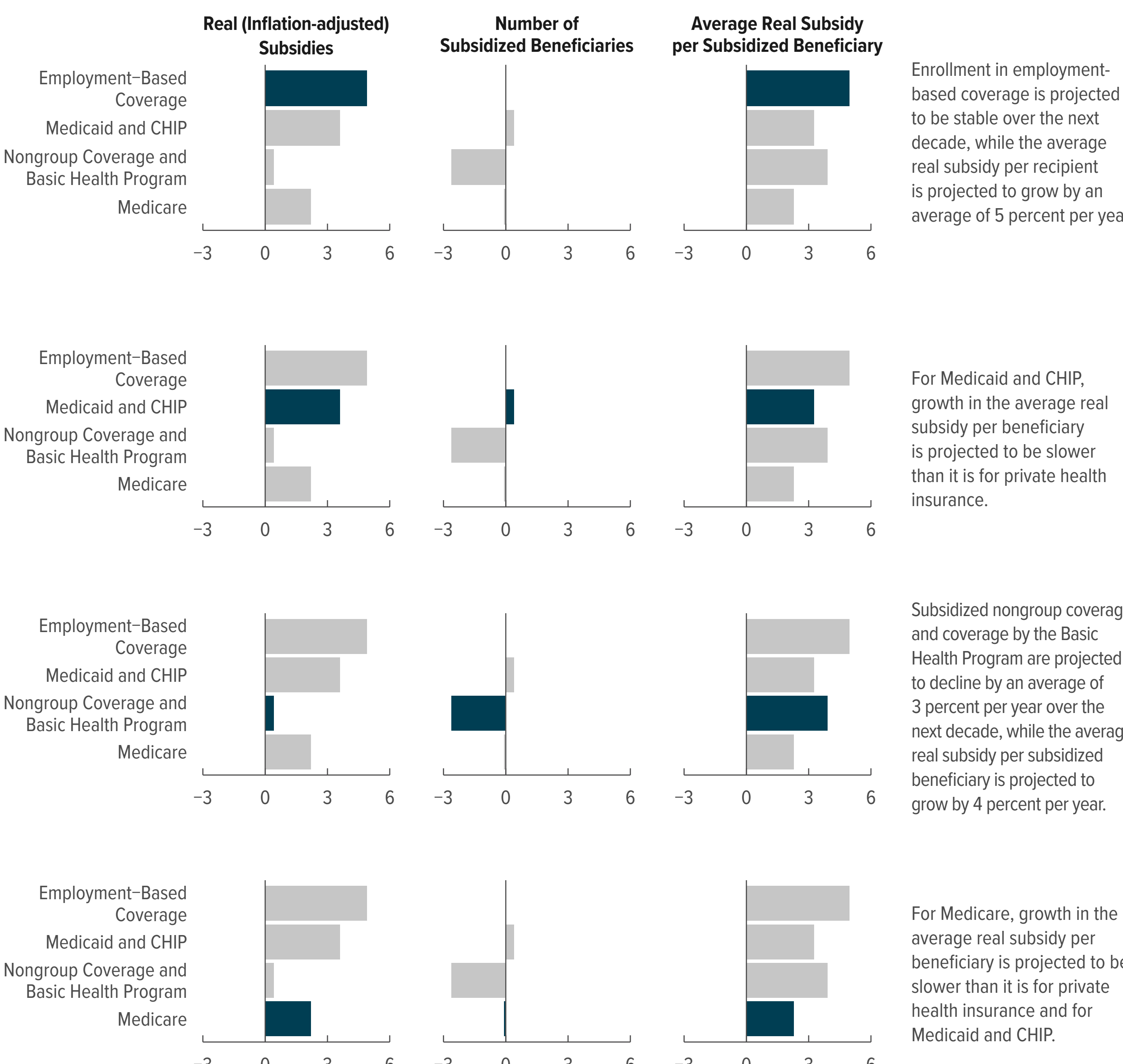
Average Annual Percentage Change in Health Insurance Coverage and Federal Subsidies, 2020 to 2029



Enrollment in employment-based coverage is projected to be stable over the next decade, while the average real subsidy per recipient is projected to grow by an average of 5 percent per year.

For Medicaid and CHIP, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance.

Subsidized nongroup coverage and coverage by the Basic Health Program are projected to decline by an average of 3 percent per year over the next decade, while the average real subsidy per subsidized beneficiary is projected to grow by 4 percent per year.

For Medicare, growth in the average real subsidy per beneficiary is projected to be slower than it is for private health insurance and for Medicaid and CHIP.

See Figure 1-2 on page 8

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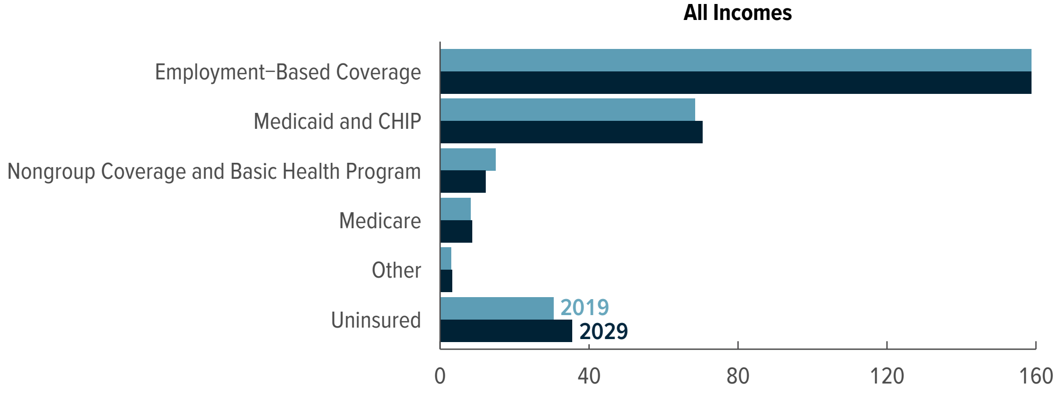
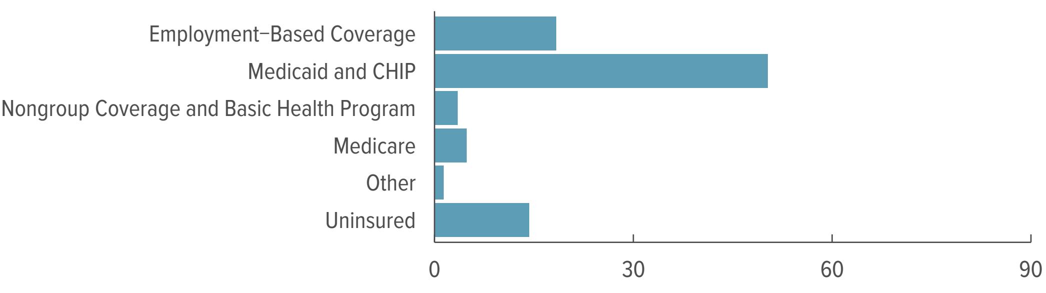
Health Insurance Coverage by Type and Income

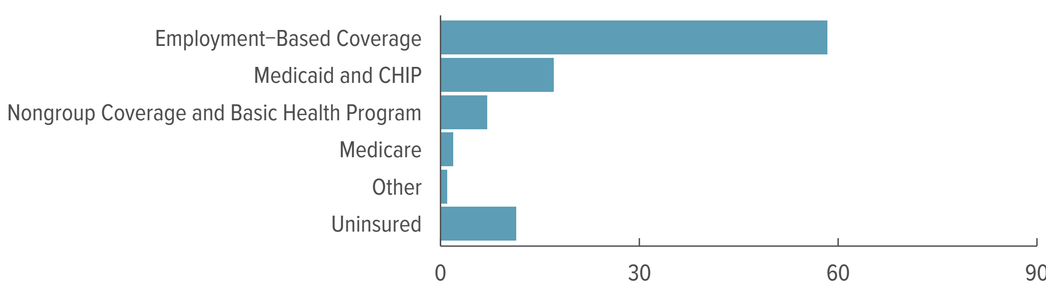
Millions of People



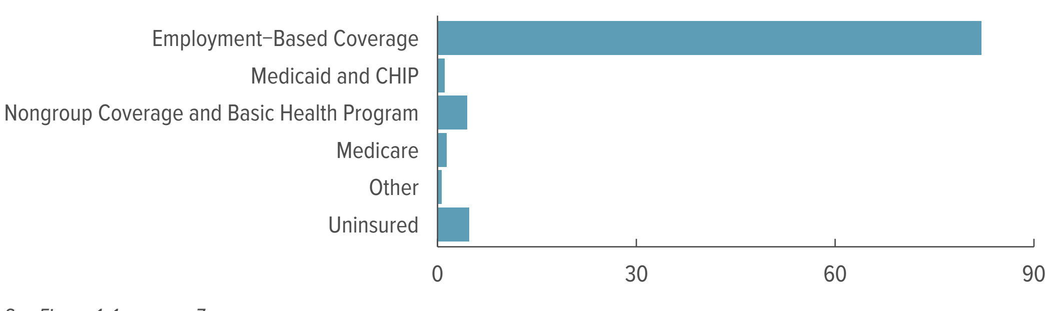
Of the 273 million people under age 65 in 2019, 159 million are projected to have coverage through an employer, and 30 million are projected to be uninsured.



Of the 87 million people under age 65 with income below 150 percent of the FPL in 2019, 58 percent are estimated to be enrolled in Medicaid or CHIP.



Of the 93 million people under age 65 with income between 150 percent and 400 percent of the FPL, 63 percent are estimated to be enrolled in employment-based insurance.

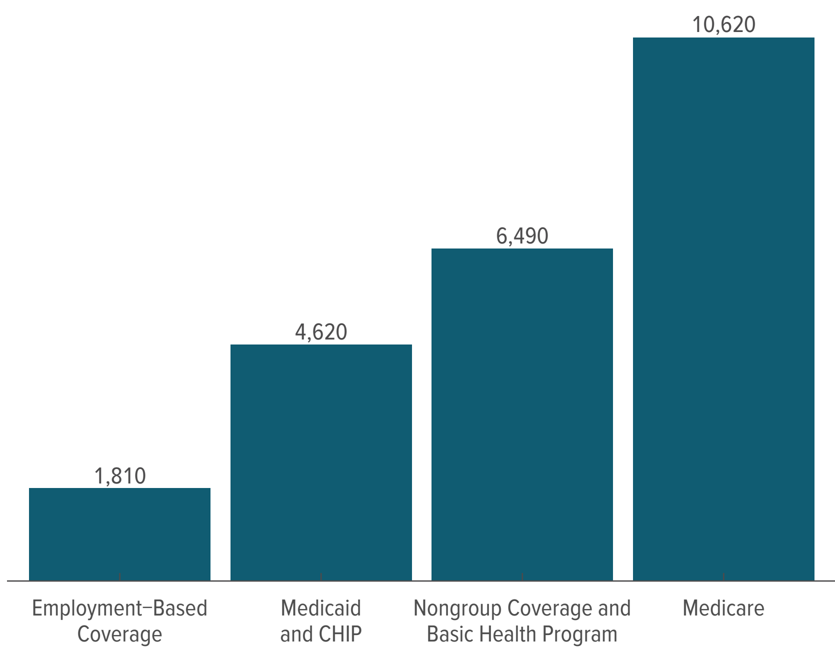


Of the 93 million people under age 65 with income above 400 percent of the FPL, the vast majority are estimated to be enrolled in employment-based insurance.

See Figure 1-1 on page 7

Average Federal Subsidies for Recipients by Type of Health Insurance, Calendar Year 2019

Dollars



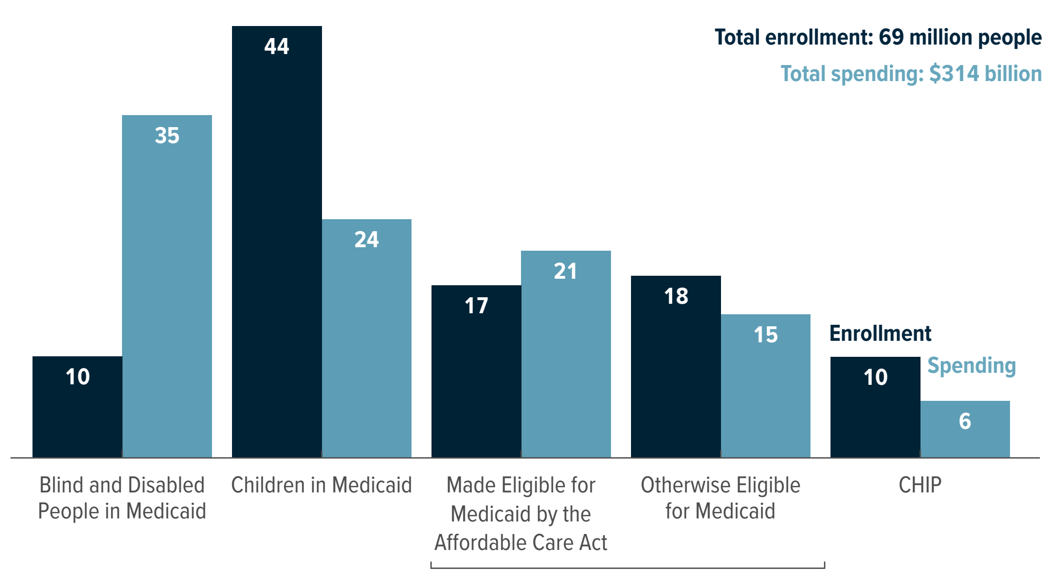
The average federal subsidy for health insurance costs per recipient varies substantially by type of health insurance. The variation occurs because the people who are eligible for each type of insurance differ by age, health status, income, and disability status; because the federal government subsidizes the coverage to different extents; and because the prices paid to providers differ for different types of coverage.

The amounts shown cannot be used to estimate the costs of shifting a group of people from one type of coverage to another because the average cost for each type of coverage depends on the characteristics of the people who are eligible for and enroll in it.

See Figure 2-2 on page 19

Share of Enrollment in and Spending for Medicaid and CHIP by Eligibility Category, 2019

Percentage of Total



Different eligibility categories for Medicaid and CHIP account for very different shares of enrollment and spending. For example, children in Medicaid are projected to constitute 44 percent of enrollment but only 24 percent of spending in 2019, whereas people with disabilities account for 10 percent of enrollment and 35 percent of spending.

See Figure 2-3 on page 20

Projected Health Insurance Coverage

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In order to estimate the net effects that those subsidies have on the federal budget, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project the number of people with different types of health insurance coverage.[1]

By the agencies' estimates, 89 percent of the noninstitutionalized civilian population under age 65 will have health insurance in 2019, on average, mostly from employment-based plans and Medicaid (see Table 1-1). Other major sources of coverage include the Children's Health Insurance Program (CHIP), nongroup policies, and Medicare. Over the 2019–2029 period, on average, 88 percent of that population is projected to be insured, under an assumption that current laws affecting health care generally remain unchanged.

The types of coverage that people enroll in vary substantially depending on their income (see Figure 1-1). Of the total population under age 65, 58 percent of people are estimated to obtain employment-based insurance in 2019. That number is 21 percent for people with income below 150 percent of the federal poverty guidelines (known as the federal poverty level, or FPL), 63 percent for people with income between 150 percent and 400 percent of the FPL, and 88 percent for people with income above 400 percent of the FPL. Enrollment in Medicaid and CHIP also varies substantially by income: 58 percent of people with income below 150 percent of the FPL are estimated to enroll in such coverage in 2019. That share declines to an estimated 18 percent for people with income between 150 percent and 400 percent of the FPL (many of whom had higher income over the course of a year than they did when they enrolled in Medicaid).

Over the 2020–2029 period, the number of enrollees in each of the types of coverage used by the most people is projected to be generally stable (see Figure 1-2 on page 8). Enrollment in employment-based coverage, CHIP, and Medicare by noninstitutionalized people under age 65 is estimated to be roughly the same, enrollment in nongroup coverage is estimated to decline slightly, and enrollment in Medicaid to increase slightly.

Projecting insurance coverage is an inherently uncertain endeavor, so CBO and JCT's estimates presented here could be either too high or too low when compared with actual outcomes in the future. But the estimates reflect the best data available and aim to represent the average of possible outcomes under current law.

CBO and JCT's Methods for Developing Baseline Projections of Insurance Coverage and Federal Subsidies

To make projections of enrollment in health insurance coverage and federal subsidies for that coverage, CBO and JCT complete five main steps. Analysts at the agencies use a variety of different models, including CBO's health insurance simulation model.

First, CBO analysts update that model to incorporate new information, including the most recent administrative and survey data on enrollment and premiums; recently enacted legislation, judicial decisions, or changes in regulations; and CBO's most recent macroeconomic forecast. Second, analysts use the model to project coverage distributions for the next 10 years and carefully review the output from the model. Third, because some aspects of current law are simplified in the simulation model, analysts use separate models, such as models of Medicaid enrollment, to adjust output from the simulation model. For use beginning with this year's projections, CBO has developed a new and improved version

1. Adopting a widely held definition, CBO and JCT consider private health insurance coverage to be a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage is often referred to as comprehensive major medical coverage. See Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

Table 1-1.

Health Insurance Coverage, 2019 to 2029

Millions of People, by Calendar Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Total Population Under Age 65	273	273	273	274	274	275	275	276	276	276	277
Employment-Based Coverage	159	159	159	159	158	158	158	158	158	159	159
Medicaid and CHIP[a]											
Blind and disabled	7	7	7	7	7	7	7	7	7	7	7
Children	30	30	30	30	30	30	30	30	30	30	30
Adults made eligible for Medicaid by the ACA	12	12	12	13	13	13	14	14	14	14	14
Adults otherwise eligible for Medicaid	13	12	12	12	13	13	13	13	13	13	13
CHIP	7	7	7	7	7	7	7	7	7	7	7
Subtotal	69	68	68	69	70	70	70	71	71	71	71
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces[b]											
Subsidized	8	8	7	7	7	7	7	6	6	6	6
Unsubsidized	1	1	1	1	1	1	1	1	1	1	1
Subtotal	9	9	8	8	8	8	8	7	7	7	7
Nongroup coverage purchased outside marketplaces	5	5	4	4	4	4	4	4	4	4	4
Total, nongroup coverage	14	13	13	12	12	12	12	12	12	11	11
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	8	8	8	8	8	8	8	8	8	8	8
Other Coverage[e]	3	3	3	3	3	3	3	3	3	3	3
Uninsured[f]	30	32	33	33	34	34	34	34	35	35	35
Memorandum:											
Number of Insured People	242	241	240	240	241	241	241	241	241	241	242
Insured as a Percentage of the Population											
Including all U.S. residents	89	88	88	88	88	88	88	88	87	87	87
Excluding noncitizens not lawfully present	91	90	90	90	90	89	89	89	89	89	89

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The table shows coverage for the noninstitutionalized civilian population under age 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in every year of the projection period, between 11 million and 12 million people (or about 5 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation.

a. Includes only noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

b. Many people can purchase subsidized health insurance coverage through marketplaces established under the ACA, which are operated by the federal government, state governments, or partnerships between the federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

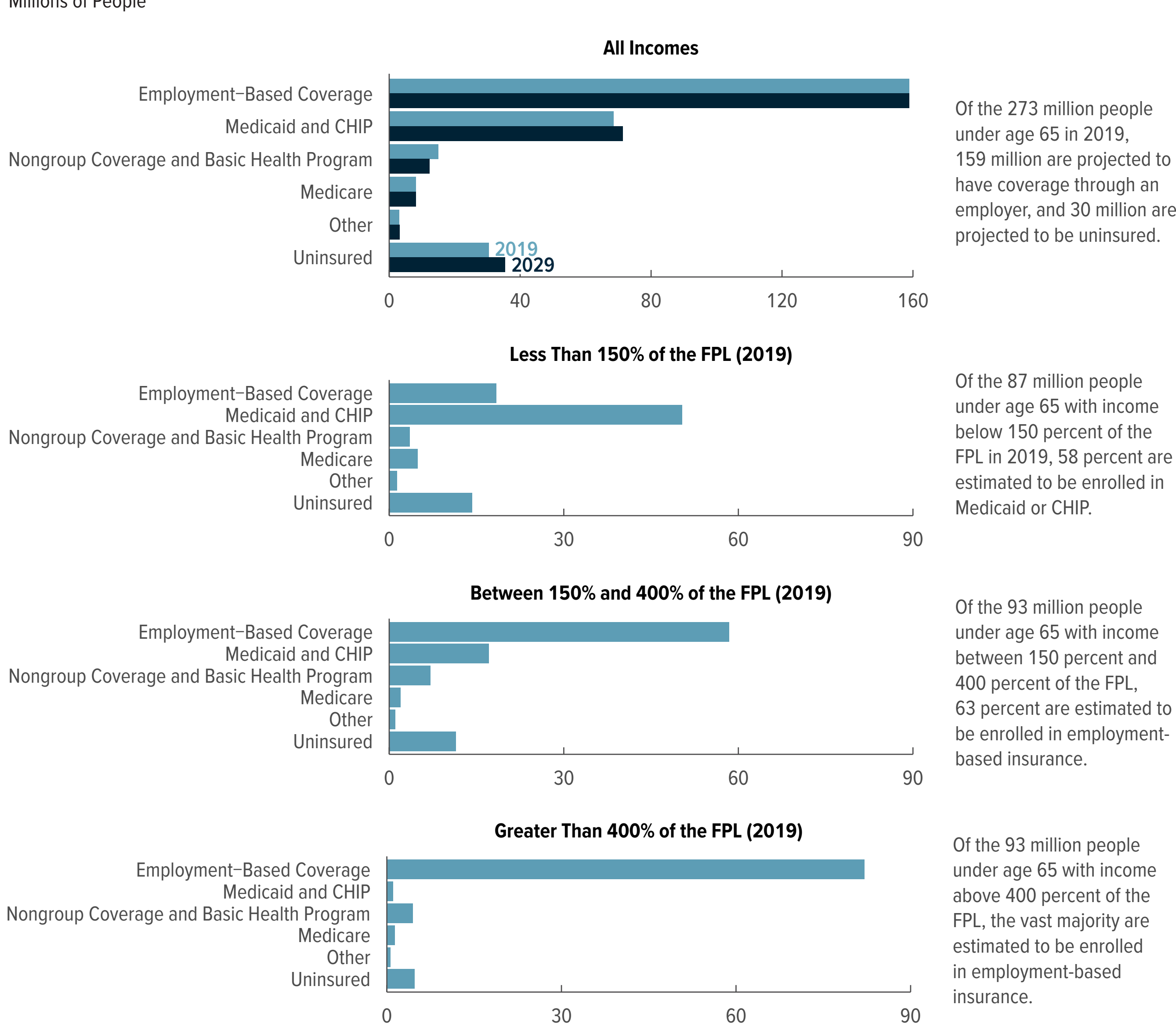
e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, or coverage from foreign sources.

f. Includes noncitizens not lawfully present in this country, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid or CHIP who do not enroll; people who purchase nongroup insurance policies that do not meet the agencies' definition of comprehensive health insurance; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

Figure 1-1.

Health Insurance Coverage by Type and Income

Millions of People



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows coverage for the noninstitutionalized civilian population under age 65.

Estimates by income are calculated using the projected income distribution from CBO's health insurance model, HISIM2. Income in HISIM2 is based on income reported in the Current Population Survey—with various adjustments to better match tax data—that is then extended over the projection period to be consistent with CBO's macroeconomic forecast of economic growth and projections of employment.

In most states, the FPL is $12,490 for a single person in 2019. For each additional person in a household, $4,420 is added.

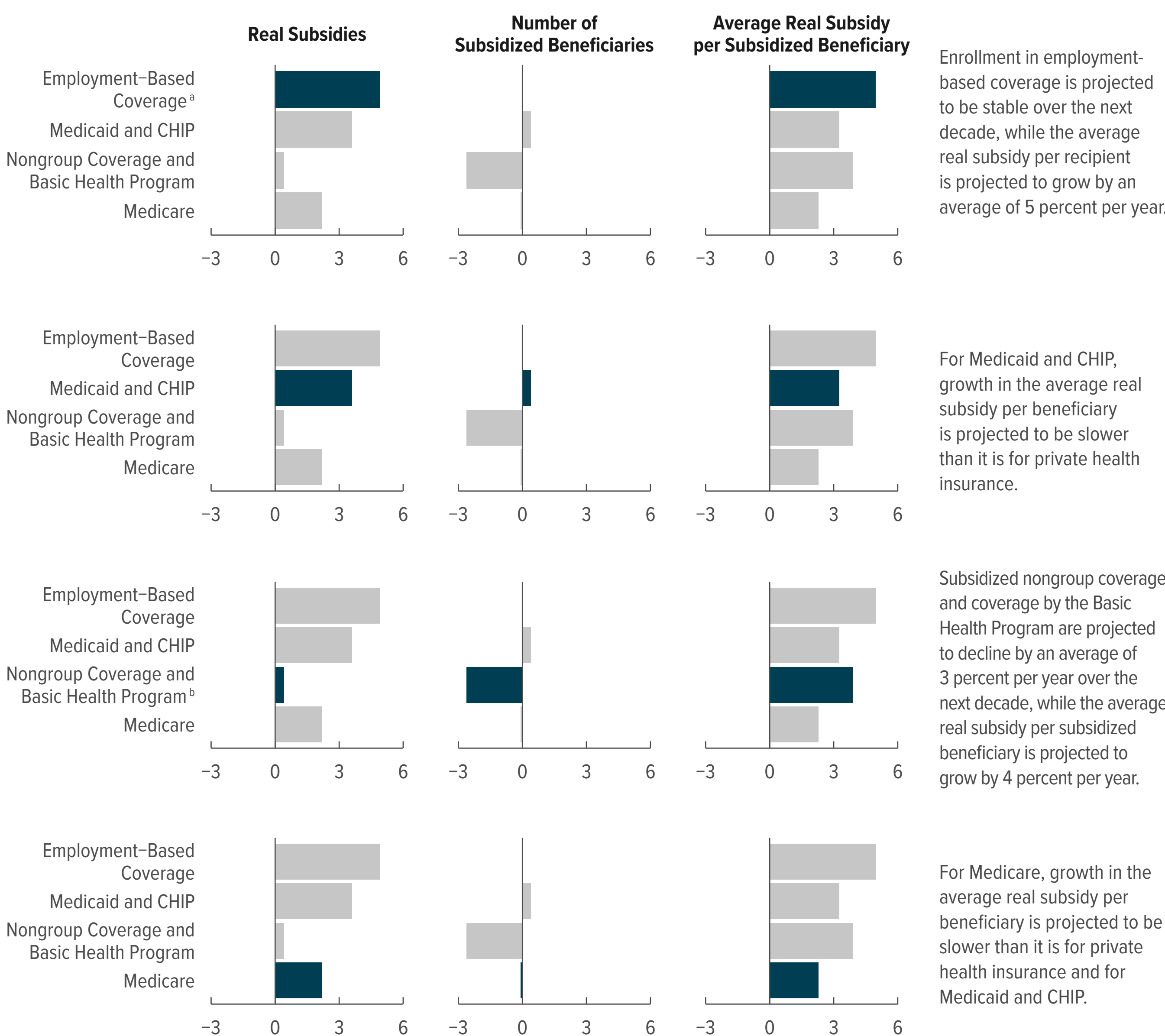
The income of some Medicaid and CHIP enrollees appears higher that the programs' upper income limits because they were probably enrolled for only part of the year and their income exceeded eligibility thresholds before or after being enrolled. CBO and JCT expect that those individuals' income met eligibility criteria when they applied for and enrolled in Medicaid or CHIP.

CHIP = Children's Health Insurance Program; FPL = federal poverty level; JCT = Joint Committee on Taxation.

Figure 1-2.

Average Annual Percentage Change in Health Insurance Coverage and Federal Subsidies, 2020 to 2029

Percent



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows subsidies for the noninstitutionalized civilian population under age 65. Real subsidies are adjusted to remove the effects of inflation and are measured in 2019 dollars.

CHIP = Children's Health Insurance Program.

a. Real subsidies include the tax exclusion for employment-based coverage, tax credits for small employers, and the income tax deduction for self-employment health insurance. The average real subsidy per subsidized beneficiary is calculated using only the tax exclusion for employment-based coverage.

b. Real subsidies include premium tax credits for coverage obtained through the marketplaces, outlays for the Basic Health Program, and collections and payments for risk adjustment and reinsurance. The average real subsidy per subsidized beneficiary excludes collections and payments for risk adjustment and reinsurance.

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of its health insurance simulation model, HISIM2 (see Box 1-1).

Fourth, after the coverage projections are completed, CBO analysts estimate total spending for Medicaid, CHIP, and the Basic Health Program using program-specific models. Fifth, JCT uses its tax models to estimate the net costs of federal subsidies for work-related coverage and coverage through the nongroup market, as well as taxes and penalties related to coverage.[2]

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. In CBO and JCT's estimates, a monthly average of about 159 million people (or about 58 percent of the population under age 65) have employment-based coverage in 2019—a decrease from 2018, when an estimated 160 million people had employment-based coverage. The agencies estimate that the decline largely stems from the elimination of the penalty associated with the individual mandate.[3] (For a discussion of the various ways in which repealing the individual mandate penalty affects health insurance coverage, see Box 1-2.)

According to CBO's estimates, access to an offer of employment-based insurance varies notably by income: About 36 percent of people with income below 150 percent of the FPL are estimated to have access to such coverage in 2019, while about 90 percent of people with income above 400 percent of the FPL do (see Figure 1-3 on page 12). People's decision to take up an offer of employment-based coverage also varies notably with income. In CBO's projections, about 21 percent of people with income below 150 percent of the FPL enroll in employment-based coverage, while about 88 percent of people with income above 400 percent of the FPL do.

CBO and JCT estimate that the number of people enrolled in employment-based coverage over the next decade will not change significantly. By the agencies' projections, continued growth in employment and wages tends to boost the number of people with employment-based coverage in part because more workers have access to such coverage. Also, higher wages mean workers are less likely to be eligible for subsidies in the marketplaces established under the Affordable Care Act (ACA) and thus have a greater preference for employment-based coverage. But those factors that would increase enrollment are expected to be generally offset over the decade, because health insurance premiums are projected to grow faster than wages, which tends to decrease the number of employers that offer health insurance and the number of people who enroll in it.

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In CBO and JCT's estimates, a monthly average of 62 million noninstitutionalized people receive full Medicaid benefits in 2019.[4] That number is unchanged from the number in 2018.

By 2029, the number of people under age 65 receiving full Medicaid benefits is projected to grow to a monthly average of 64 million people, comprising:

- 7 million people with disabilities,
- 30 million children,
- 14 million adults made eligible for Medicaid through the ACA's expansion of Medicaid coverage at states' option, and
- 13 million adults otherwise eligible for Medicaid.

2. For more information on how CBO prepares its baseline, see Congressional Budget Office, *How CBO Prepares Baseline Budget Projections* (February 2018), www.cbo.gov/publication/53532. For more information on how CBO and JCT analyze major health care proposals, see Congressional Budget Office, *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage* (February 2018), www.cbo.gov/publication/53571. For more information about CBO's new model, see Congressional Budget Office, "CBO Releases Four Products Explaining How Its New Health Insurance Simulation Model Works," *CBO Blog* (April 18, 2019), www.cbo.gov/publication/55116.

3. The individual mandate penalty was eliminated by Public Law 115-97, originally called the Tax Cuts and Jobs Act.

4. Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive assistance from Medicaid only for out-of-pocket payments and premiums for Medicare, people who receive only family planning services, and noncitizens who are not lawfully present who receive only emergency services. Spending for enrollees who receive partial benefits is excluded from the estimates in this report. That spending is accounted for in CBO's baseline projections of total spending for the Medicaid program.

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Box 1-1.

The Model Underlying CBO's Baseline Estimates of Health Insurance Coverage

The Congressional Budget Office uses its health insurance simulation model to help create baseline projections of health insurance coverage and premiums for people under age 65. In collaboration with the staff of the Joint Committee on Taxation (JCT), the agency also uses the model to estimate the effects of proposed legislation on health insurance coverage and premiums.

The model calculates employers' and individuals' probable responses to changes in health insurance rules and subsidies. It also incorporates CBO's best estimates of insurers' likely responses to those same rules and subsidies. It is used in conjunction with other models to develop baseline budget projections (which incorporate the assumption that current laws generally remain the same).

CBO updates its health insurance simulation model at least once a year to incorporate information from the most recent administrative and survey data, CBO's most recent macroeconomic forecast, and relevant judicial decisions, enacted legislation, and administrative actions.

For use beginning in its 2019 baseline, CBO developed a new version of its health insurance simulation model, HISIM2.[1] It includes changes to the base data, incorporating new sources of survey and administrative data.[2] HISIM2 also incorporates reassessments of consumers' and employers' behavior, including the ways that businesses take workers' preferences into account when deciding whether to offer employment-based coverage and how individuals and families choose among coverage options. In addition, the new version of the model incorporates CBO and JCT's estimate of a link between people's income and their preference for employment-based coverage that is stronger this year than last year. (That link, combined with a forecast of continued growth in employment and wages, contributes to a projection of greater enrollment in employment-based coverage than estimated last year.) The revisions allow CBO and JCT to better account for employers' and consumers' selections among different types of insurance plans and to more easily simulate the effects of new insurance products.

Because HISIM2 includes changes to the underlying data and in the relationships among individuals, families, employment, income, and insurance coverage, it yields somewhat different coverage decisions and budgetary costs than the previous version of the model would have. The changes in the baseline stemming from HISIM2 are not large, however, and are similar in magnitude to the changes seen in previous baselines because of the use of more recent data and technical improvements.

CBO expects the new features of HISIM2 to be more apparent when it is used to analyze policy proposals.[3] For that task, results from the new version of the model may differ more substantially from results from the old version because of the changes to data and reassessments of the ways businesses and families make choices. As HISIM2 is used in the coming year, CBO will analyze and evaluate the results and endeavor to explain the major sources of such differences.

1. For details, see Congressional Budget Office, *HISIM2—The Health Insurance Simulation Model Used in Preparing CBO's Spring 2019 Baseline Budget Projections* (April 2019), www.cbo.gov/publication/55097. Material supplementing that document includes segments of computer code underlying the model's simulations of certain decisions about insurance choices.

2. For example, using administrative tax data, CBO and JCT analyzed differences in various businesses' workforces to improve the modeling of employers' offers of health insurance coverage. For details on changes to the base data used for HISIM2, see Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO's Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087.

3. For more information on how CBO and JCT analyze policy proposals related to health insurance coverage, see Congressional Budget Office, *How CBO and JCT Analyze Major Proposals That Would Affect Health Insurance Coverage* (February 2018), www.cbo.gov/publication/53571.

CBO and JCT's estimates of Medicaid enrollment over the next decade reflect the agencies' expectation that, if current federal laws remained in place, additional states would expand eligibility for the program. Under the ACA, states are permitted to expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the FPL. The federal government pays a larger share of the costs for those people than it pays for those who are eligible otherwise. In the agencies' projections, most of the increase in enrollment during the 2019–2029 period stems from additional states' expanding eligibility for the program, rather than from additional enrollment in states that have already expanded eligibility. Currently, about

Box 1-2.

How Repealing the Individual Mandate Penalty Affects Health Insurance Coverage

In projections by the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT), the repeal of the penalty for not having health insurance starting in 2019 results in less insurance coverage. In total, the effects of that repeal that are described here are similar to those that CBO and JCT incorporated in the baseline a year ago.[1]

By 2021, in the current baseline, 7 million more people are uninsured than would have been if the individual mandate penalty had not been repealed; subsequently, that number remains roughly constant to the end of the projection period in 2029.

The effect of the repeal is partially offset by increases in coverage for other reasons. Most important, in the agencies' projections, additional states expand eligibility for Medicaid under the Affordable Care Act, and more people enroll in certain types of health insurance—specifically, those that are exempt from regulations governing the nongroup market but that nonetheless provide major medical coverage.

In the projections, the decline in coverage by 2021 breaks out this way:

- Nongroup coverage declines by about 4 million primarily for two reasons. Some people choose not to be enrolled once they do not face a penalty. Others decide not to enroll when facing higher premiums brought about by lower enrollment by relatively healthy people.
- Coverage through Medicaid and the Children's Health Insurance Program declines by about 2 million, again mainly for two reasons. Some people who would have enrolled to avoid the penalty no longer do so. Others who, induced by the penalty, would have applied for coverage through a marketplace and learned that they were eligible for Medicaid, no longer enroll in the program.
- Employment-based coverage declines by about 1 million, mostly because some employees who would have enrolled to avoid the penalty no longer do so.

CBO and JCT have concluded that some of that effect of eliminating the penalty occurred in 2018 (earlier than they previously expected). By the agencies' estimates, 1 million people were uninsured in that year principally because they thought that the penalty had been repealed for 2018 or that it would not be enforced.[2]

1. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 20–21, www.cbo.gov/publication/53826. The current estimate of the effects of repealing the individual mandate penalty draws upon additional information beyond what was cited in the May 2018 report, including Bradley Heim, Ithai Z. Lurie, and Daniel W. Sacks, *Does the Individual Mandate Affect Insurance Coverage? Evidence From the Population of Tax Returns* (paper presented at the 2019 National Bureau of Economic Research Public Economics Conference, Cambridge, Mass., April 4–5, 2019), papers.nber.org/conf_papers/f120008.pdf (1.3 MB); Paul D. Jacobs, "Mandating Health Insurance Coverage for High-Income Individuals," *National Tax Journal*, vol. 71, no. 4 (December 2018), pp. 807–828, https://tinyurl.com/yyohsd3r; and Matthew Fiedler, *How Did the ACA's Individual Mandate Affect Insurance Coverage? Evidence From Coverage Decisions by Higher Income People* (USC–Brookings Schaeffer Initiative for Health Policy, May 31, 2018), https://tinyurl.com/y26s5nsl.

2. For information about people's understanding of the mandate in 2018, see Ashley Kirzinger and others, *Kaiser Health Tracking Poll—March 2018: Non-Group Enrollees* (April 3, 2018), https://tinyurl.com/y9osz5pm.

65 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO and JCT anticipate that, under current law, the share would increase annually at a rate based on the historical pace of expansion since 2014. By 2029, about three-quarters of the people who would meet the new eligibility criteria are projected to be in states with expanded Medicaid coverage.

CBO and JCT project enrollment in CHIP to be relatively unchanged in the 2019–2029 period, with 7 million people, mostly children but also some pregnant women, enrolled in the program in each year. Together, Medicaid and CHIP are projected to provide insurance coverage for one-quarter of the population under age 65 in 2029.

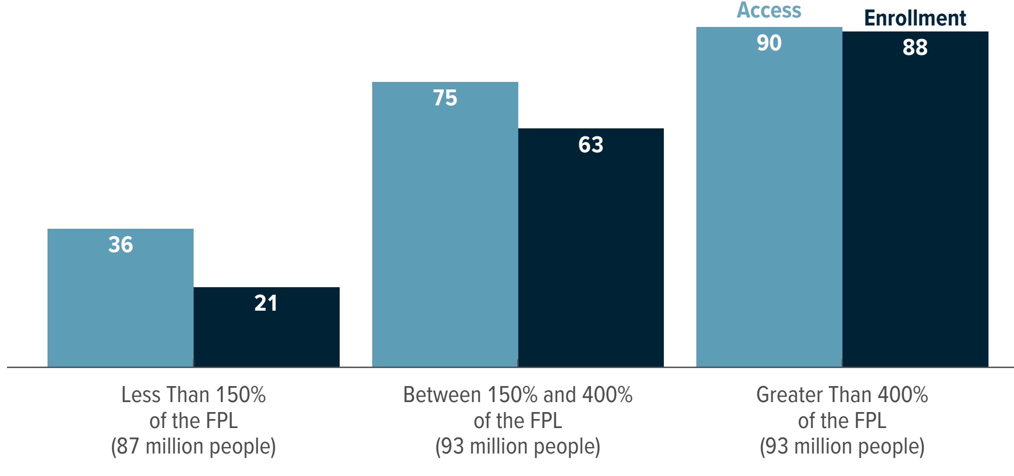
Nongroup Coverage and the Basic Health Program

A small share of the population purchases private health insurance individually through the nongroup market. Whereas employment-based policies and Medicaid currently cover 58 percent and 23 percent of the population under age 65, respectively, nongroup coverage applies to just 5 percent.

Figure 1-3.

Access to and Enrollment in Employment-Based Insurance by Income, 2019

Percent



Access to employment-based insurance tends to grow with income, as higher-income people are more likely to be employed, and their employers are more likely to offer insurance.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows access and enrollment for the noninstitutionalized civilian population under age 65.

FPL = federal poverty level.

Another source of coverage, much smaller still, is the Basic Health Program, which allows states to offer subsidized health coverage to certain low-income people outside the marketplaces established under the ACA.

Nongroup Coverage

In 2019, a monthly average of about 14 million people under age 65 are expected to have nongroup coverage—a decline from 2018, when an estimated monthly average of 15 million people enrolled in such coverage.[5] According to CBO and JCT's analysis, the decline is largely attributable to the repeal of the individual mandate penalty, partially offset by increases in enrollment in nongroup coverage that is exempt from some of the regulations governing the nongroup market but nonetheless provides comprehensive major medical coverage.

Of the 14 million people under age 65 whom CBO and JCT expect to enroll in nongroup coverage in 2019, an estimated 9 million will have purchased it through the marketplaces established under the ACA.[6] (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) The agencies estimate that 8 million of those people will receive subsidies. (The appendix provides information on premiums and stability in the marketplaces.)

5. CBO and JCT's estimates of enrollment in nongroup coverage include people with insurance that covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage includes plans that must comply with all of the regulations governing the nongroup market as well as plans that are exempt from some regulations but continue to provide comprehensive major medical coverage. Examples of nongroup plans that are exempt from some regulations but still meet the agencies' definition of health insurance include ones that were in effect before 2014 (sometimes called grandfathered, grandmothered, or transitional plans), policies purchased by individuals through an association, and some types of short-term, limited-duration plans.

6. A total of 11 million people selected plans through the marketplaces by the close of the open-enrollment period. However, CBO and JCT estimate that the average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year because some people are covered for only part of the year—mostly because they stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources. That decline in coverage is partly offset because people who experience a qualifying life event (such as a change in income, the addition of a dependent, or the loss of employment-based insurance) may be allowed to purchase coverage later in the year.

By 2029, enrollment through the nongroup market is projected to fall to 11 million people, 6 million of them subsidized. That decline is largely the result of two factors:

- Some additional people will forgo health insurance in response to the elimination of the individual mandate penalty, and
- More states are expected to expand eligibility for Medicaid, reducing the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for marketplace coverage.

Basic Health Program

Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.[7] Minnesota and New York have created a Basic Health Program. In CBO and JCT's projections, enrollment in the Basic Health Program is estimated to be about 1 million people in both 2018 and 2019. That number stays about the same each year throughout the 2019–2029 period.

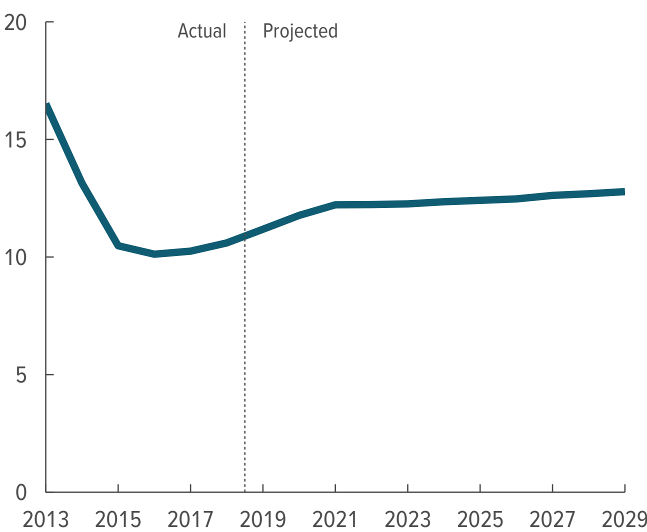
Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Those younger enrollees receive Medicare coverage because they have qualified for benefits from the Social Security Disability Insurance (SSDI) program or have a qualifying diagnosis of end-stage renal disease (ESRD). In general, people become eligible for Medicare two years after they qualify for disability insurance. CBO and JCT estimate enrollment of people under 65 in Medicare to remain unchanged from 2018 to 2019, at 8 million people. The agencies project that number to stay the same in each year throughout the 2020–2029 period. Of those under age 65 and enrolled in Medicare, an estimated 99 percent receive Medicare benefits from the SSDI program and 1 percent because of an ESRD diagnosis.

Other miscellaneous sources of coverage account for about 3 million people each year from 2019 to 2029. Those sources include student health plans, the Indian Health Service, and foreign sources.

Figure 1-4.

Percentage of the Population Who Are Uninsured



Source: Congressional Budget Office, using data from the National Health Interview Survey.

The figure applies to the noninstitutionalized civilian population under age 65.

Actual values are calculated using the number of uninsured people reported by the National Health Interview Survey, adjusted downward to exclude people with coverage provided by the Indian Health Service, which CBO considers to be health insurance coverage. Beginning in 2015, values include an additional slight adjustment as part of a set of integrated estimates of coverage derived from different data sources.

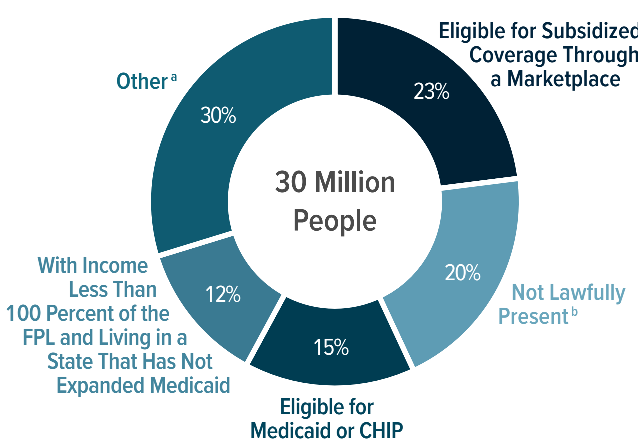
Uninsured

In 2019, 30 million people under age 65, or 11 percent of that population, are projected to be uninsured, an increase from 29 million in 2018 and 28 million in 2017 (see Figure 1-4). Increases in health insurance premiums and the elimination of the individual mandate penalty have contributed to that rise. An additional factor in the increase is people's becoming aware of and enrolling in

7. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed April 22, 2019), www.medicaid.gov/basic-health-program/index.html.

Figure 1-5.

Composition of the Uninsured Population, 2019*



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows information on the noninstitutionalized civilian population under age 65 that is estimated to be uninsured.

CHIP = Children's Health Insurance Program; FPL = federal poverty level.

a. People who have access to health insurance through an employer or directly from insurers but choose not to purchase it.

b. Noncitizens who are not lawfully present in this country are ineligible for marketplace subsidies and for most Medicaid benefits.

coverage (such as short-term, limited-duration plans that do not provide comprehensive major medical coverage) from sources that do not meet CBO and JCT's definition of health insurance.

CBO and JCT consider people uninsured if they are not covered by an insurance plan or are not enrolled in a government program that provides financial protection from major medical risks. Among the uninsured under age 65 in 2019, 23 percent are estimated to be eligible for subsidized coverage through a marketplace but forgo it; 20 percent, to be noncitizens who are not lawfully present in this country; 15 percent, to be eligible for Medicaid or CHIP but to not enroll; 12 percent, to have income below 100 percent of the FPL and to live in states that did not expand Medicaid; and 30 percent, to have access to health insurance through an employer or directly from insurers but to choose to not purchase it (see Figure 1-5).*

By 2029, the number of uninsured people is projected to grow to 35 million, or 13 percent of people under age 65. That estimated growth stems largely from an increase in the number of people expected to forgo health insurance in response to the elimination of the individual mandate penalty. Again, an additional factor is people's increasing enrollment in coverage from sources that do not meet CBO and JCT's definition of health insurance.

Uncertainty Surrounding the Estimates of Coverage

The distribution of health insurance coverage in future years could differ from the projections presented here for a variety of reasons. If national economic trends diverge from CBO's economic forecast, for example, that would alter the number of people offered insurance by their employers, as well as the number of people eligible for Medicaid or coverage through the marketplaces. Additionally, changes in health care laws or regulations would affect health insurance markets. For example, the Administration has recently proposed or finalized several regulations that could substantially affect private health insurance, but their potential effects on insurance coverage and premiums are uncertain. Moreover, such economic, legal, and regulatory factors may interact with one another in a variety of ways to bring about outcomes that differ from the projections presented here. In addition, uncertainty surrounds states' decisions about whether to expand eligibility for Medicaid and how to regulate private health insurance.

[*Values corrected on May 14, 2019]

CHAPTER

2

Projected Subsidies for Health Insurance Coverage

The federal government encourages people to obtain health insurance by making it less expensive than it would be otherwise. For people under age 65, the government subsidizes health insurance coverage in four main ways:

- Giving tax benefits for work-related coverage,
- Providing roughly three-fifths of all funding for Medicaid (and requiring states to provide the remainder),
- Offering tax credits to eligible people who purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive benefits from the Social Security Disability Insurance program or who have been diagnosed with end-stage renal disease.

The costs of those subsidies are partly offset by related taxes and penalties. Those collections include excise taxes on providers of health insurance and penalty payments from large employers that do not offer health insurance that meets certain standards.

The net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—will be $737 billion in 2019, the Congressional Budget Office and the staff of the Joint Committee on Taxation estimate (see Table 2-1). If current laws did not change, that subsidy would total $9.9 trillion over the 2020–2029 period. Those projections are subject to considerable uncertainty; they rely on, among other things, expectations about the choices that people might make about obtaining health insurance.

The total costs of subsidizing health insurance for noninstitutionalized people under age 65 depend on the number of enrollees in each type of coverage and on the average per-person costs of that coverage. Those costs vary substantially depending on the type of coverage—namely, on the expected health care costs of the people who are eligible for or tend to enroll in a particular type of coverage and the extent to which the federal government subsidizes that type of coverage (see Figure 2-1 on page 18). The average cost of federal subsidies for someone under age 65 who is covered by Medicare, for example, is $10,620 in 2019, CBO estimates (see Figure 2-2 on page 19). That number is particularly high because Medicare enrollees under the age of 65 either qualify for SSDI or have ESRD and are therefore costly to treat. By contrast, the average cost of federal subsidies for someone under age 65 with employment-based coverage in 2019 is $1,810, CBO and JCT estimate.[1] That number is much lower because the people who enroll in employment-based insurance tend to be healthier and because the government does not pay directly for that care—but, rather, subsidizes a portion of the costs through the exclusion from income and payroll taxes.[2]

Work-Related Subsidies

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. The projected growth rates for the total amount of such subsidies and

1. The average cost of federal subsidies for employment-based coverage is calculated using the tax exclusion for that coverage.

2. The amounts shown cannot be used to estimate the costs of shifting people from one type of coverage to another because the average per-person costs for each type of coverage depend on the type of people who are eligible for and enroll in that type of coverage. Therefore, values in cost estimates for legislation that would shift some people from one type of coverage to another would differ from the estimates shown here.

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Table 2-1.

Net Federal Subsidies Associated With Health Insurance Coverage, 2019 to 2029

Billions of Dollars, by Fiscal Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total, 2020–2029
Work-Related Coverage												
Tax exclusion for employment-based coverage[a,b]	283	301	320	341	363	387	410	466	502	530	562	4,182
Income tax deduction for self-employment health insurance[c]	4	4	3	3	3	4	4	4	5	5	5	39
Small-employer tax credits[b]	*	*	*	*	*	*	*	*	*	*	*	*
Subtotal	287	304	324	344	367	390	414	470	507	534	567	4,222
Medicaid and CHIP[d]												
Blind and disabled	109	115	121	127	135	143	152	161	172	182	194	1,502
Children	76	80	85	91	96	102	108	114	120	126	133	1,055
Adults made eligible for Medicaid by the ACA	66	66	70	76	83	89	95	102	108	115	121	925
Adults otherwise eligible for Medicaid	46	48	51	54	58	61	65	68	72	76	81	635
CHIP	18	16	14	14	15	16	16	17	18	18	19	164
Subtotal	314	325	341	363	387	411	436	462	490	518	549	4,282
Marketplace-Related Coverage and the Basic Health Program												
Premium tax credit outlays	43	44	43	45	47	49	52	54	55	56	57	503
Premium tax credit revenue reductions	9	10	9	10	10	11	11	12	12	12	12	109
Subtotal	53	53	53	55	58	60	64	66	67	68	70	612
Outlays for the Basic Health Program	6	6	6	7	7	7	8	8	9	9	10	77
Collections for risk adjustment and reinsurance	-6	-5	-6	-6	-6	-6	-7	-7	-7	-8	-8	-66
Payments for risk adjustment and reinsurance	9	5	6	6	6	6	7	7	7	8	8	65
Subtotal	62	59	59	61	65	68	72	74	75	77	79	689
Medicare[e]	86	88	92	96	100	104	109	114	120	127	131	1,082
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	-2	-7	-9	-10	-12	-16	-19	-22	-96
Penalty payments by uninsured people	-3	0	0	0	0	0	0	0	0	0	0	0
Net receipts from tax on health insurance providers[g]	0	-13	-14	-15	-15	-16	-17	-17	-18	-19	-20	-164
Gross collections of employer penalties[f]	-8	-9	-9	-6	-6	-7	-7	-7	-8	-8	-7	-74
Subtotal	-11	-22	-22	-23	-29	-32	-34	-36	-42	-45	-49	-334
Net Subsidies	**737**	**755**	**794**	**842**	**889**	**941**	**997**	**1,085**	**1,149**	**1,211**	**1,277**	**9,940**

Continued

for the amount per recipient are about the same—as is the projected growth rate for private health insurance premiums—because the number of recipients is projected to be stable over the coming decade.

Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships. (Many of those people purchase insurance individually instead of as part of a group; their coverage is categorized as nongroup rather than employment-based even though their subsidies are work-related.) In addition, some small employers that provide health insurance to their employees are eligible

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Table 2-1. Continued

Net Federal Subsidies Associated With Health Insurance Coverage, 2019 to 2029

Billions of Dollars, by Fiscal Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	Total, 2020–2029
Memorandum:												
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	-6	-14	-18	-22	-25	-31	-35	-42	-193

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The table shows subsidies for the noninstitutionalized civilian population under age 65.

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

The table excludes outlays made by the federal government in its capacity as an employer.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between zero and $500 million.

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. The estimates shown, which JCT produced, differ from the agency's estimates of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are not included here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. The estimates shown, which JCT produced, do not include effects stemming from the deduction for people over age 65.

d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $193 billion over the 2020–2029 period, and revenues from penalty payments by employers would total $58 billion over that 10-year period.

g. Net receipts include effects on individual and corporate tax receipts. The tax is suspended in 2019.

to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage for people under age 65 will total about $287 billion in 2019 (or about 1.4 percent of gross domestic product, or GDP).[3] That amount is projected to grow to $567 billion in 2029 and to total $4.2 trillion over the 2020–2029 period. Those sums are large because the number of people with such coverage is large.[4]

Medicaid and CHIP

Medicaid is jointly financed by state governments and the federal government, with the federal government paying for roughly 60 percent of the cost of services, on average. Federal outlays for all noninstitutionalized Medicaid enrollees under age 65 who receive full benefits are estimated to amount to $296 billion in 2019 (see Figure 2-3). For the 2020–2029 period, projected

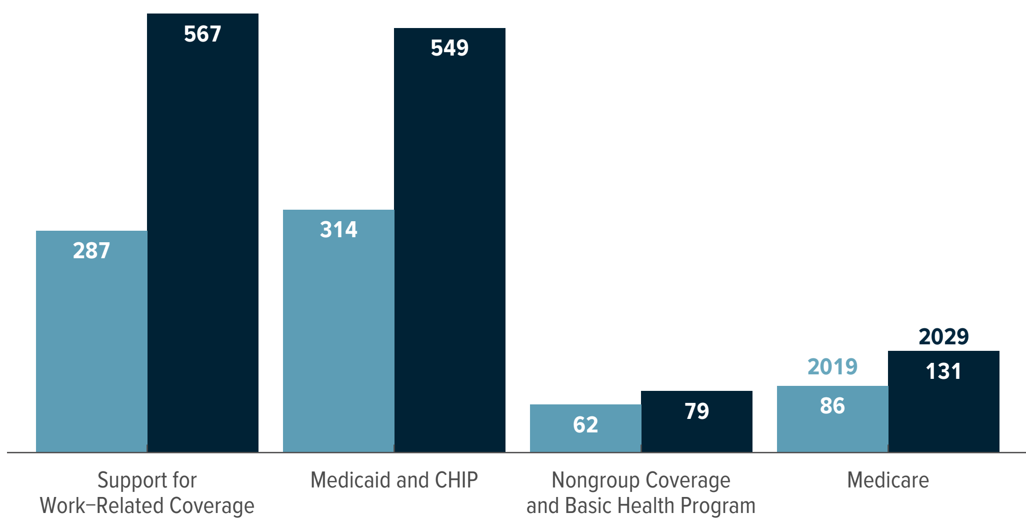
3. That estimate excludes federal spending on medical benefits provided by the Department of Veterans Affairs and on the Defense Department's TRICARE program. For more information about those programs, see Congressional Budget Office, "Military and Veterans' Health Care," www.cbo.gov/topics/health-care/military-and-veterans-health-care.

4. The estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.

Figure 2-1.

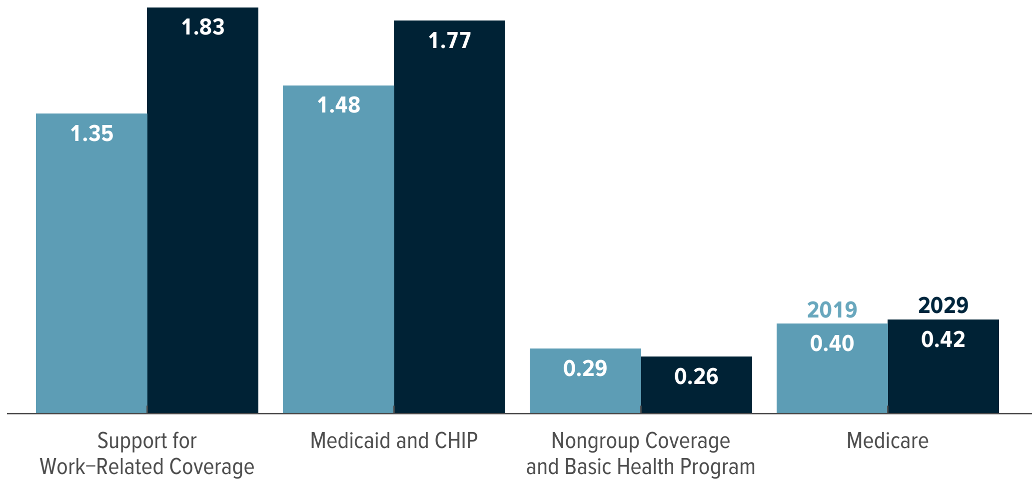
Federal Health Insurance Subsidies

Billions of Dollars



In 2019, the federal government is projected to spend $314 billion for Medicaid and CHIP and $287 billion on support for work-related coverage for people under age 65.

Percentage of Gross Domestic Product



As a share of gross domestic product, total federal subsidies are projected to grow over the coming decade; subsidies for work-related coverage are projected to grow the fastest.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows subsidies for the noninstitutionalized civilian population under age 65.

CHIP = Children's Health Insurance Program.

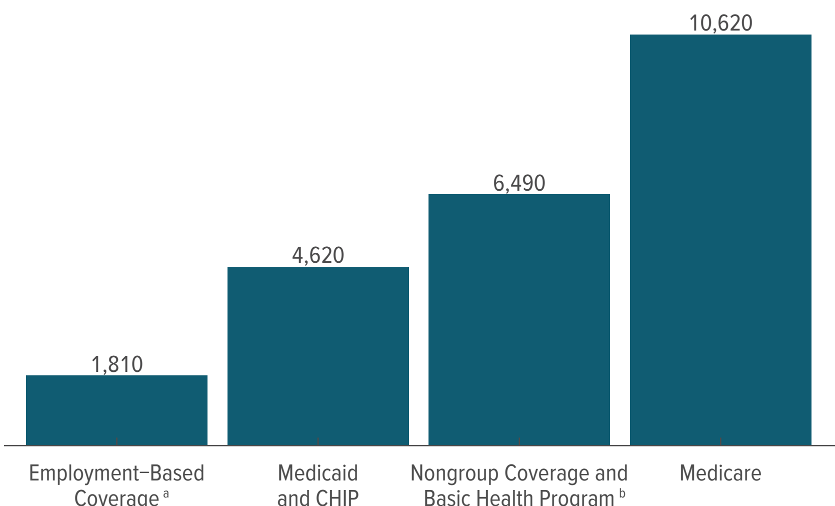
outlays total $4.1 trillion, comprising the following main components:

- $1.5 trillion (or 36 percent of the total) for people with disabilities;
- $1.1 trillion (or 26 percent of the total) for children;
- $925 billion (or 22 percent of the total) for adults made eligible for Medicaid by the Affordable Care Act; and

Figure 2-2.

Average Federal Subsidies for Recipients by Type of Health Insurance, Calendar Year 2019

Dollars



The average federal subsidy for health insurance costs per recipient varies substantially by type of health insurance. The variation occurs because the people who are eligible for each type of insurance differ by age, health status, income, and disability status; because the federal government subsidizes the coverage to different extents; and because the prices paid to providers differ for different types of coverage.

The amounts shown cannot be used to estimate the costs of shifting a group of people from one type of coverage to another because the average cost for each type of coverage depends on the characteristics of the people who are eligible for and enroll in it.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows average federal subsidies for the noninstitutionalized civilian population under age 65.

CHIP = Children's Health Insurance Program.

a. Includes the tax exclusion for employment-based coverage.

b. Includes premium tax credits for coverage through the marketplaces and outlays for the Basic Health Program.

- $635 billion (or 15 percent of the total) for adults otherwise eligible for Medicaid.

Medicaid spending for the noninstitutionalized population under age 65 who receive full Medicaid benefits accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2020–2029 period.

Like Medicaid, the Children's Health Insurance Program is also jointly financed by state governments and the federal government. In 2019, the federal government will pay about 90 percent of the cost of services. In 2020, that share is projected to be roughly 80 percent, and from 2021 to 2029, about 70 percent, as higher matching rates established by the ACA and the HEALTHY KIDS Act (division C of Public Law 115-120) end. Federal outlays for CHIP are estimated to amount to $18 billion in 2019 and $164 billion over the 2020–2029 period.

Marketplace-Related Coverage and the Basic Health Program

In 2019, net subsidies for nongroup coverage obtained through the marketplaces and payments for the Basic Health Program will total $62 billion, CBO and JCT estimate. Over the 2020–2029 period, such costs are projected to total $689 billion and to consist of the following main components:

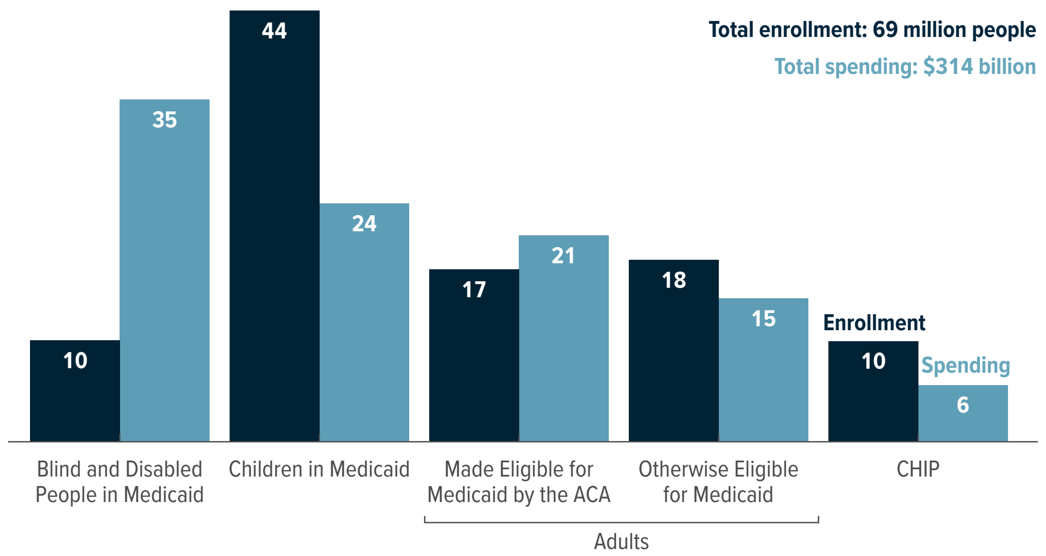
- Outlays of $503 billion and a reduction in revenues of $109 billion for premium tax credits, totaling $612 billion (those tax credits cover a portion of eligible people's health insurance premiums and, because they are refundable, can exceed individuals' tax liability, resulting in outlays in addition to the reduction in revenues);

- Outlays of $77 billion for the Basic Health Program; and

Figure 2-3.

Share of Enrollment in and Spending for Medicaid and CHIP by Eligibility Category, 2019

Percentage of Total



Different eligibility categories for Medicaid and CHIP account for very different shares of enrollment and spending. For example, children in Medicaid are projected to constitute 44 percent of enrollment but only 24 percent of spending in 2019, whereas people with disabilities account for 10 percent of enrollment and 35 percent of spending.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The figure shows enrollment and spending for the noninstitutionalized civilian population under age 65.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

- Outlays of $65 billion and revenues of $66 billion related to payments and collections for risk adjustment.

The third component of those subsidies is projected to have no net costs over time. The risk adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.[5] The programs make payments to insurers with less healthy enrollees; the payments are financed by collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments are recorded in the budget as mandatory outlays, and the collections are recorded as revenues.

Per enrollee, subsidies for insurance obtained through the marketplaces and outlays for the Basic Health Program depend on the premiums for benchmark plans used for determining subsidies and on certain characteristics of enrollees, such as age, family size, and income. Combined, subsidies for coverage through the marketplaces and the Basic Health Program are projected to average $6,490 per subsidized enrollee in calendar year 2019. That amount rises to about $11,670 in 2029, as subsidies grow with premiums and also cover a greater proportion of premiums over time. (That proportion increases mainly because the amounts enrollees pay are limited to certain percentages of their income.) Growth in the total net subsidy amount is smaller than growth in the amounts per subsidized enrollee because the number of enrollees is projected to fall over the next decade.

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be $86 billion in 2019 and to total $1.1 trillion over the 2020–2029 period. That total is about one-eighth of total projected net spending for the Medicare program. By CBO's estimates, in 2019 the average cost for a

5. The risk adjustment and reinsurance programs began in 2014. The reinsurance program was temporary, ending after plan year 2016, and CBO estimates that outlays for it will end in 2020; beginning in 2021, estimated revenues and outlays are only for risk adjustment.

Medicare enrollee under 65 will be $10,620. That cost is projected to rise to $16,320 in 2029. That rate of growth is expected to be slower than the increase in the government's average cost for private health insurance and for Medicaid and CHIP but similar to the growth for the economy overall.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to partially offset the federal subsidies for it. By CBO and JCT's estimates, those taxes and penalties will amount to $11 billion in 2019. Under current law, they would total $334 billion over the 2020–2029 period—mostly from an excise tax on high-premium insurance plans, a tax on health insurance providers, and penalties imposed on some employers for not offering their employees health insurance that meets specified standards.

Excise Tax on High-Premium Insurance Plans

An excise tax on certain high-cost employment-based coverage is scheduled to be collected beginning in 2022. Originally, the tax was scheduled to take effect in 2018, but lawmakers delayed its implementation. In CBO and JCT's projections, collections of that tax total $96 billion over the 2020–2029 period.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to avoid paying it or to reduce their tax liability. Those shifts would generally increase income tax revenues, CBO and JCT estimate, because affected workers would receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT estimates receipts stemming from the imposition of the excise tax to total $193 billion over the coming decade.[6]

Tax on Health Insurance Providers

Health insurers are subject to an excise tax (although legislation eliminated it for calendar year 2019). The ACA specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax. Net revenues from the tax are projected to be $13 billion in 2020 and under current law would increase to about $20 billion by 2029, for a total of $164 billion over the decade, CBO and JCT estimate.

Penalties on Employers

Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace.[7] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $74 billion over the 2020–2029 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by $17 billion, because employers would generally be expected to shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit is $58 billion.

Uncertainty Surrounding the Estimates of Subsidies

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates of federal subsidies for health insurance are uncertain. CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

One reason that the estimates of subsidies are uncertain is that the projections of how many people will enroll in different types of coverage are themselves uncertain. Then, the per-person cost of subsidizing each type of coverage could differ from projections for many reasons, including changes in the mix of people, in terms of their health status or income, who enroll in each type of coverage; changes in how employers and employees value health insurance; and changes in state policies on eligibility for Medicaid and CHIP.

6. If workers' wages were instead held constant, their total compensation would be reduced by the amount of the change in premiums. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

7. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.86 percent in 2019 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

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Many other factors will also affect federal subsidies for health care. One important factor is the extent to which the emergence and adoption of health care technology will raise or lower costs. New and less expensive medical procedures or treatments could prove effective in helping patients, which could lower costs. But other new procedures and treatments might be more expensive and increase costs. Other factors that could affect health care costs include changes in the structure of payment systems, changes in the ownership structure of providers, and innovations in the delivery of health care—say, the expansion of telemedicine. Those changes could encourage providers to supply more cost-effective treatments and reduce costs per enrollee. Other changes could raise costs per enrollee, such as those reaching previously underserved populations.

Comparisons With Previous Estimates and Actual Amounts

As part of the process of updating baseline projections, the Congressional Budget Office and the staff of the Joint Committee on Taxation carefully analyze how the current projections differ from the prior year's projections and how their previous projections compare with actual enrollment and spending outcomes. Such evaluations help guide the agencies' efforts to improve the quality of their projections and help ensure that the current projections accurately reflect any significant changes in economic trends, enrollment and spending patterns, and policy that occurred over the previous year.

Changes in the Estimates of Insurance Coverage and Subsidies Since May 2018

In CBO and JCT's current projections for the 2019–2028 period (the span covered by both last year's projections and the current ones), an average of 3 million more people obtain employment-based insurance and 1 million fewer people are uninsured, compared with the amounts estimated in May 2018. Since last year, the agencies have increased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from $9.3 trillion to $9.4 trillion for that period (see Table 3-1). The changes are primarily driven by updated demographic, economic, enrollment, and spending data.

Changes in the Estimates of Insurance Coverage

Since last year, CBO and JCT's projections of enrollment in Medicaid, nongroup coverage, the Basic Health Program, and Medicare among people under age 65 are largely unchanged, on average, over the 2019–2028 period. The agencies have changed other projections of enrollment (or projections related to it) in the following ways:

- The noninstitutionalized civilian population under the age of 65 is projected to be slightly smaller;
- Enrollment in employment-based coverage is higher;
- Enrollment in the Children's Health Insurance Program is higher;
- Enrollment in other miscellaneous types of coverage is lower; and
- The number of uninsured people is lower.

Total Population. CBO has lowered its projections of the total noninstitutionalized civilian population under age 65 by 1 million in each year of the 2019–2028 period—a change first incorporated in CBO's January 2019 baseline. In the agency's current projections, 276 million noninstitutionalized civilian people under age 65 are expected to reside in the United States in 2028; in the May 2018 projections, that number was 278 million. The revision arises primarily because the agency has reduced its projections of fertility rates and net immigration to better reflect historical trends and has slightly increased its projection of mortality rates.

Employment-Based Coverage. Since last year, CBO and JCT have increased their projections of enrollment in employment-based insurance coverage by an average of 3 million people per year between 2019 and 2028. That increase reflects the agencies' updated assessment of people's preference for employment-based coverage made on the basis of new data and improved analytical methods. Recent data indicate that enrollment in employment-based coverage has increased substantially in the past few years.[1] That increase, a larger reversal of the downward trend that existed before 2014 than the agencies were expecting a year ago, is carried through into the current projections.

Medicaid and CHIP. Relative to the May 2018 estimates, current projections of enrollment in Medicaid

1. See Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

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Table 3-1.

Comparison of Current and Previous Projections of Health Insurance Coverage and Net Federal Subsidies

	2019			2019–2028		
	May 2018 Projection	May 2019 Projection	Difference	May 2018 Projection	May 2019 Projection	Difference
	Insurance Coverage for the Year[a] (Millions of people)			Average Insurance Coverage Over the Period[a] (Millions of people)		
Total Population	273	273	-1	276	274	-1
Employment-Based Coverage	159	159	-1	156	159	3
Medicaid and CHIP[b]						
Adults made eligible for Medicaid by the ACA	12	12	*	13	13	*
People otherwise eligible for Medicaid	48	50	1	49	50	*
CHIP	6	7	1	6	7	1
Total	66	69	2	69	70	1
Nongroup Coverage and the Basic Health Program						
Subsidized nongroup	7	8	1	7	7	*
Unsubsidized nongroup	5	6	1	6	5	*
Total, nongroup coverage	12	14	2	12	12	*
Coverage through the Basic Health Program[c]	1	1	*	1	1	*
Medicare[d]	8	8	*	8	8	*
Other Coverage[e]	5	3	-2	5	3	-2
Uninsured[f]	32	30	-2	35	34	-1
	Effects on the Federal Deficit[g] (Billions of dollars)			Effects on the Cumulative Federal Deficit Over the Period[g] (Billions of dollars)		
Work-Related Coverage						
Tax exclusion for employment-based coverage[h]	276	283	7	3,653	3,903	250
Income tax deduction for self-employment health insurance[i]	5	4	-2	64	38	-26
Small-employer tax credits	1	**	-1	8	**	-7
Subtotal	282	287	4	3,725	3,942	217
Medicaid and CHIP[j]						
Adults made eligible for Medicaid by the ACA	62	66	4	842	870	28
People otherwise eligible for Medicaid	233	230	-3	3,049	3,015	-34
CHIP	16	18	2	143	163	21
Subtotal	310	314	3	4,034	4,047	14
Marketplace-Related Coverage and the Basic Health Program						
Premium tax credits	53	53	**	703	595	-108
Outlays for the Basic Health Program	4	6	2	57	73	16
Net collections and payments for risk adjustment and reinsurance	**	3	3	-1	3	4
Subtotal	57	62	5	760	672	-88
Medicare[k]	84	86	2	1,049	1,037	-13
Taxes and Penalties Related to Coverage						
Gross collections of excise tax on high-premium insurance plans[l]	0	0	0	-47	-75	-27
Penalty payments by uninsured people	-3	-3	**	-3	-3	**
Net receipts from tax on health insurance providers[m]	0	0	0	-161	-144	17
Gross collections of employer penalties[l]	-8	-8	**	-101	-75	26
Subtotal	-11	-11	**	-313	-297	16
Net Subsidies	**723**	**737**	**14**	**9,255**	**9,401**	**146**

Continued

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates of insurance coverage apply to calendar years, and estimates of the effect on the federal deficit apply to fiscal years.

The table applies to the noninstitutionalized civilian population under age 65.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between −500,000 and 500,000; ** = between −$500 million and $500 million.

a. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in every year of the projection period, between 11 million and 12 million people (or about 5 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

b. Includes only noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes noncitizens not lawfully present in this country, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid or CHIP who do not enroll; people who purchase nongroup insurance policies that do not meet the agencies' definition of comprehensive health insurance; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

g. Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

h. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. The estimates shown, which JCT produced, differ from the agency's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are not included here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

i. The estimates shown, which JCT produced, do not include effects stemming from the deduction for people over age 65.

j. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

k. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized beneficiaries under age 65.

l. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.

m. Net receipts include the effects on individual and corporate tax receipts. The tax is suspended in 2019.

and CHIP are 1 million higher, on average, over the 2019–2028 period. Estimates of enrollment in Medicaid are not significantly different from last spring's projections, but estimates of enrollment in CHIP are now higher because recent enrollment has exceeded previous estimates.

CBO and JCT have also increased their estimates of the fraction of people meeting the eligibility criteria established under the Affordable Care Act who live in states that expanded Medicaid. The increase results from improved data underlying CBO's models rather than modifications made to the agency's projections of the rate of states' expansions of Medicaid in the future. On net, however, CBO and JCT's projections of enrollment by people made eligible for Medicaid by the ACA are largely unchanged from the May 2018 estimates.

Nongroup Coverage and the Basic Health Program. Average monthly enrollment in the nongroup market is now projected to be 2 million higher in 2019, 1 million lower in 2028, and less than 500,000 different, on average, over the 2019–2028 period. Projections of enrollment in the Basic Health Program are not noticeably different.

The boost of 2 million in nongroup enrollment for 2019 relative to the May 2018 projection is roughly evenly split between an increase in subsidized coverage and an increase in unsubsidized coverage. Projections

of subsidized coverage in 2019 are higher because the number of people who signed up for it through the marketplaces during the most recent open-enrollment period was higher than the agencies previously expected. Projections of unsubsidized coverage in 2019 are higher largely because of lower-than-expected premiums this year.

On average over the 2019–2028 period, however, CBO and JCT's current projections of both subsidized and unsubsidized enrollment through the nongroup market are not noticeably different from last year's projections. Over that 10-year period, factors that have increased projections of nongroup enrollment are offset by other factors that have reduced projections of enrollment. In particular, lower estimates for premiums in each year of the span, which would tend to increase projected enrollment in nongroup coverage, are offset by higher estimates of the number of businesses that will offer employment-based coverage. That increase in employment-based coverage is associated with a reduction in the number of people who would otherwise enroll in coverage through the nongroup market.

Other Coverage. Compared with what they estimated last year, CBO and JCT currently project that, if current laws remained unchanged, 2 million fewer people would be enrolled in other miscellaneous types of health care coverage, on average, over the 2019–2028 period. Those sources of coverage include student health plans, the Indian Health Service, and foreign sources. The projections for those types of coverage are lower primarily because the agencies now use improved data to estimate the number of people with those kinds of insurance.

Uninsured. In CBO and JCT's current projections, an average of 1 million fewer people are uninsured between 2019 and 2028 than the agencies estimated last May. That difference stems mostly from net changes in projections for other health insurance categories. For example, CBO and JCT lowered their projection of the number of uninsured people in 2019 by 2 million primarily because their current estimates of enrollment in nongroup coverage, Medicaid, and CHIP for the year are higher than last year's.

Changes in the Estimates of Subsidies, Penalties, and Taxes

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is $14 billion higher for 2019 and $146 billion (or about 2 percent) higher for the 2019–2028 period than it was in the agencies' May 2018 projections. That increase is mainly the result of higher estimates of the net cost of the tax exclusion for employment-based coverage, partially offset by lower estimates of nongroup subsidies.

Work-Related Coverage. CBO and JCT have increased their estimate of federal subsidies for work-related coverage. The largest component of those subsidies, by far, is the tax exclusion for employment-based coverage. The agencies have increased their estimates of the net cost of the exclusion by $7 billion (or 2 percent) for 2019 and by $250 billion (or 7 percent) for the 2019–2028 period. The cost of the exclusion depends on the number of people with employment-based coverage, the marginal tax rates of people enrolled in that coverage, and premiums for that coverage. The increase results in part from higher projected enrollment in employment-based insurance.

That increase is offset, in part, by slower growth of premiums. In 2018, CBO and JCT projected spending by private health insurers per beneficiary, which is the basis for premiums, to increase by an average of 5.8 percent per year over the 2019–2028 period.[2] The agencies now estimate that rate to be 5.4 percent. (CBO and JCT project spending by private health insurers on health care and administration on the basis of trends in premium growth and of projected growth in personal income, which affects people's ability to buy health insurance.) The change results mainly from new data from the Centers for Medicare & Medicaid Services indicating a lower rate of spending growth than previously reported.

Medicaid and CHIP. CBO has increased its projections of outlays for Medicaid and CHIP by $3 billion for 2019 and by $14 billion for the 2019–2028 period. Outlays for CHIP are projected to be $21 billion higher over that period because of recent higher-than-expected enrollment in the program. That increase is partially offset by a $7 billion reduction in projected Medicaid spending for the period.

2. CBO and JCT's projection of the underlying growth in spending by private health insurers per enrollee differs somewhat from their projection of growth in premiums for employment-based coverage because the latter also incorporates changes under current law that affect employers' willingness to offer insurance and employees' taking up an offer (for example, the imposition of the excise tax on high-premium health insurance plans beginning in 2022).

Marketplace-Related Coverage and the Basic Health Program. CBO and JCT reduced their projections of spending for subsidies for health insurance purchased through the marketplaces by $108 billion (or 15 percent), on net, over the 2019–2028 period. That reduction largely reflects the fact that insurers, overall, requested smaller increases in premiums for 2019 than the agencies expected last spring. In CBO and JCT's current projections, gross premiums for benchmark plans used to determine subsidies are 11 percent lower in 2019 and 16 percent lower in 2028 than in the agencies' May 2018 projections. The reduction over the period is partially offset by spending on the Basic Health Program that is now estimated to be $16 billion higher.

In total, CBO and JCT's estimates of the net cost of subsidies for nongroup coverage and the Basic Health Program are now $88 billion lower for the 2019–2028 period.

Taxes and Penalties Related to Coverage. CBO and JCT have reduced their estimate of collections of penalty payments from employers that do not offer coverage meeting the ACA's standards by $26 billion for the 2019–2028 period as a result of new data from the Department of the Treasury showing less reported penalty liability than previously projected.

CBO and JCT have increased their estimate of the gross revenues resulting from the excise tax on high-premium employment-based insurance by $27 billion for the 2019–2028 period. The tax, which is currently scheduled to take effect in 2022, will impose a 40 percent fee on the contributions that firms and employees make toward their employment-based insurance when those contributions exceed statutory thresholds. By the agencies' expectations, some firms will choose to pay the tax, and others will offer insurance plans with lower premiums in order to avoid it.

The increase in revenues stems from an increase in projected total enrollment in employment-based insurance and from technical improvements to modeling. On the basis of new data, CBO and JCT now estimate that a greater percentage of firms will choose to pay the excise tax rather than alter the types of insurance plans they offer to their employees. The increase in projected revenues is partially offset by the agencies' lower projections of private health insurance spending per enrollee.

Comparisons With Actual Amounts

In order to improve their baseline projections, CBO and JCT compare their projections of health insurance coverage and federal subsidies for people under age 65 with actual enrollment and costs reported by the Administration, state governments, and surveys whenever possible. This report compares projections for 2018 published in September 2017 and May 2018 with actual amounts for 2018 (see Table 3-2).[3]

Coverage

Differences in health insurance coverage between those two sets of projections and actual amounts were 1 million or less for most categories of coverage. In two cases, for CHIP and employment-based coverage, the actual amounts differed by 3 million from the 2017 projections. When the projection for CHIP was made, funding for the program was scheduled to expire at the end of fiscal year 2017, but in 2018, funding was extended. As for employment-based coverage, recent growth turned out to be stronger than CBO and JCT previously forecast, perhaps because of improving labor market conditions.

Subsidies

The largest errors in the subsidy estimates that could be examined (because sufficient preliminary data were available to estimate the actual 2018 amounts) occurred in projections of Medicaid spending and risk adjustment outlays (amounts paid to insurance plans that attract less healthy enrollees).

Medicaid. Among the various estimates for 2018, the largest error occurred in CBO's September 2017 projection of federal spending on Medicaid. The agency estimated that Medicaid spending for noninstitutionalized enrollees under age 65 who have full Medicaid benefits would total $302 billion in 2018—about $15 billion (or 5 percent) more than the actual amount currently estimated for that year. When CBO made its September 2017 estimate, available data showed that outlays had been growing strongly because of continued increases in the number of enrollees made eligible by the ACA.

3. For comparisons of CBO and JCT's projections with actual outcomes for 2017, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 25–27, www.cbo.gov/publication/53826; for 2014 to 2016, see Congressional Budget Office, *CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016* (December 2017), www.cbo.gov/publication/53094.

Table 3-2.

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies in CBO's September 2017 and May 2018 Projections Compared With Actual Coverage and Subsidies in 2018

	September 2017 Projection	May 2018 Projection	Actual Amounts	Difference, September 2017	Difference, May 2018
	Selected Categories of Health Insurance Coverage for People Under Age 65 (Millions of people, calendar year 2018)				
Employment-Based Coverage	157	158	160	-3	-1
Medicaid and CHIP					
Adults made eligible for Medicaid by the ACA	13	12	12	1	*
People otherwise eligible for Medicaid	51	49	50	1	-2
CHIP	5	6	7	-3	-1
Total	68	67	69	-1	-2
Nongroup Coverage and the Basic Health Program					
Nongroup coverage purchased through marketplaces					
Subsidized	9	8	8	1	-1
Unsubsidized	2	2	1	*	*
Subtotal	11	9	10	1	*
Nongroup coverage purchased outside marketplaces	5	5	5	*	1
Total, nongroup coverage	16	15	15	1	*
Coverage through the Basic Health Program	1	1	1	*	*
Medicare	8	8	8	*	*
Other Coverage	5	5	3	2	2
Uninsured	30	29	29	1	*

Continued

However, that growth unexpectedly slowed in the second half of 2017 and the first half of 2018, as did the growth in spending for people otherwise eligible for Medicaid.

For its May 2018 projections, CBO lowered its estimate of Medicaid spending for the year on the basis of newer data through March 2018, which showed relatively slow growth in outlays for the program to that point in the year. Later in 2018, spending for Medicaid grew more quickly than it had in 2017 and early 2018. As a result, CBO's May 2018 estimate of Medicaid spending for the year was $7 billion (or 2 percent) lower than actual spending turned out to be.

Risk Adjustment. The second-largest error occurred in CBO's May 2018 projection of risk adjustment outlays. The agency estimated that those payments would total $7 billion in 2018—about double the actual amount reported by the Administration for 2018. The over-estimate was the result of a temporary halt in payments to insurers in July 2018 in response to a federal court decision. Later in the summer of 2018, the Department of Health and Human Services reissued regulations that allowed the risk adjustment payments and collections to resume. Typically, risk adjustment outlays occur in September—and under that schedule, they would have been made in fiscal year 2018. Instead, most of those delayed payments were made in the first quarter of fiscal year 2019. CBO expects that payments and collections for 2019 and later years will occur on the same schedule as they did in prior years, unlike the pattern in 2018.

Table 3-2. Continued

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies in CBO's September 2017 and May 2018 Projections Compared With Actual Coverage and Subsidies in 2018

	September 2017 Projection	May 2018 Projection	Actual Amounts	Difference, September 2017	Difference, May 2018
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2018)				
Medicaid and CHIP[a]					
Medicaid[b]	302	280	287	15	-7
CHIP	13	16	17	-4	-2
Total	315	296	304	10	-8
Nongroup Coverage and the Basic Health Program					
Premium tax credits[c]	47	49	49	-2	**
Payments for cost-sharing reductions[d]	9	0	0	9	0
Outlays for the Basic Health Program[c]	5	4	5	1	-1
Collections for risk adjustment and reinsurance[e]	-5	-5	-5	**	**
Payments for risk adjustment and reinsurance[e]	5	7	3	2	4
Total	62	55	52	10	3
Medicare[a,f]	81	82	83	-2	-1
Penalty Payments by Uninsured People[g]	-4	-4	-3	-1	**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation; and additional sources listed below.

Comparisons are shown only for categories of net federal subsidies associated with health insurance coverage for people under age 65 for which sufficient preliminary data were available to estimate the actual 2018 amounts. Estimates of actual enrollment reflect data from different sources that CBO then adjusts slightly to develop integrated estimates that are consistent with one another and that sum accurately to depict the total population. For more information on the individual data sources and how CBO develops its integrated estimates, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

CHIP = Children's Health Insurance Program; * = between −500,000 and 500,000; ** = between −$500 million and $500 million.

a. See Department of the Treasury, "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2018 Through September 30, 2018, and Other Periods" (October 2018), https://go.usa.gov/xmKQk (PDF, 1.8 MB).

b. Actual value reported by the Department of the Treasury adjusted to reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

c. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (March 2019), pp. 958–959, https://go.usa.gov/xmKQf (PDF, 13.9 MB).

d. On October 12, 2017, the Administration announced that, without an appropriation, it would no longer make payments to insurers for cost-sharing reductions.

e. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of Health and Human Services" (March 2019), pp. 451–452, https://go.usa.gov/xmKQf (PDF, 13.9 MB).

f. Actual value reported by the Department of the Treasury, adjusted to reflect benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

g. Actual value based on preliminary data from the Internal Revenue Service. See Internal Revenue Service, "SOI Tax Stats–Individual Income Tax Returns" (accessed April 11, 2019), https://go.usa.gov/xm5ju.

Appendix: Premiums and Stability in the Marketplaces

In 2019, a monthly average of about 9 million people are projected to buy nongroup policies through the health insurance marketplaces established under the Affordable Care Act (ACA). That coverage can be purchased with or without government subsidies, depending on an enrollee's income relative to the federal poverty guidelines (known as the federal poverty level, or FPL). Gross premiums—that is, the amounts without subsidies—for nongroup coverage that is subject to all rules governing that market may vary only on the basis of age, tobacco use, geographic location, and family size.

People in families with income generally between 100 percent and 400 percent of the FPL are eligible for tax credits to help cover a portion of their premiums. The size of those tax credits varies with income and premiums. Net premiums that enrollees pay after accounting for the tax credits are often substantially lower than the gross premiums. Among most people receiving such credits, net premiums for a given plan vary only by income and family size.

In 2019, the average gross premium for subsidized enrollees in all states that use the federally facilitated marketplace platform healthcare.gov is about $7,510 per year. The average net premium paid after subsidies is about $1,040. People not receiving subsidies pay the gross amount.[1]

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The second-lowest-cost silver plan available in the marketplaces in any given area is known as the benchmark plan and is the basis for determining the size of the subsidy that enrollees are eligible for.

1. CBO's calculations are based on data on plans selected during the open-enrollment period for 2019. See Centers for Medicare & Medicaid Services, "2019 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xmTZD.

The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide cost-sharing reductions (CSRs) to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is about 70 percent. People who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are about 60 percent and 80 percent, respectively.

The nongroup health insurance market is driven in large part by individual decisions to purchase insurance, which are affected by the stability of the market. If premiums are priced too low or too high, the mix of healthy and unhealthy people who want to purchase health insurance may change, potentially causing some insurers to be unprofitable. In recent years, the nongroup insurance market has stabilized, as insurers are generally profitable, and in 2019, more insurers have entered the market than left. Although the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate declines in enrollment in nongroup policies in the marketplaces over the next decade, the agencies expect that market to remain stable because of the amount of the tax credits for premiums, the structure of the credits in insulating subsidized enrollees from large increases in gross premiums, and enrollment that is sufficient to sustain profits for insurers.

Premiums for Benchmark Plans in the Marketplaces

Between 2015 and 2018, gross premiums for the benchmark silver plans in the marketplaces for a person of a given age increased substantially; they grew by 7 percent to 8 percent in 2015 and 2016 and by 22 percent in 2017. Then, in 2018, gross benchmark premiums rose by

32 percent; a significant contributor to that increase was the incorporation of the cost of CSRs in those premiums (discussed more shortly, under the heading "Premiums by Metal Tier").

This year, those premiums have remained about the same as they were last year (see Figure A-1). That steadiness is the net result of several factors. Factors that put downward pressure on gross premiums in 2019 include these:

- **Increased competition.** One way insurers compete for enrollees is through lower premiums. The increase in the number of insurers in the marketplaces and a decrease in the share of the population living in a county with only one insurer in the marketplace between 2018 and 2019 reduced the number of people living in areas with a low level of competition among insurers (see Figure A-2). That increased competition among insurers tended to drive down premiums.

- **Insurers' profitability.** Data through the first half of 2018 suggest that, on average, for the second consecutive year, insurers in the marketplaces were profitable in 2018.[2] That profitability indicates that they have set premiums high enough to cover the expected costs for the people purchasing health insurance in the nongroup market.

Factors that put upward pressure on gross premiums include these:

- **Elimination of the individual mandate penalty.** The elimination of the individual mandate penalty, which took effect in 2019, is projected to result in a less healthy mix of people enrolling in coverage through the nongroup market, as some healthier enrollees choose to go without coverage. However, insurers appear to have accounted for at least part of that effect when setting premiums for 2018, given the general uncertainty about whether the individual mandate would be enforced.

- **Expanded availability of products exempt from rules governing the nongroup market.** Rules issued by the Administration that were designed to increase enrollment in certain types of products that are exempt from rules governing the nongroup market took effect beginning in 2019.[3] People newly enrolling in those types of coverage are expected to be healthier than those enrolled in nongroup coverage that is subject to all regulations governing the nongroup market (which includes coverage offered through the marketplaces). Their departure exerts upward pressure on premiums for the benchmark plans. However, in CBO and JCT's estimation, the increase is small in 2019.

Between 2018 and 2029, insurers are projected to increase gross premiums for the benchmark plans for a person of a given age by an average of roughly 5.3 percent per year. That premium growth is mostly attributable to projected growth in health care spending per person. As that spending increases, insurers will be required to cover the same proportion of costs as they do currently—and they are expected to pass a portion of those costs along to enrollees by increasing premiums.[4] A small portion of the premium growth stems from a shift in the health status of enrollees. Some healthier people are expected to depart the market, and some sicker people are expected to newly enroll in coverage—as more people respond over time to the elimination of the individual mandate penalty and as more products exempt from some of the regulations governing the nongroup market become available.

Between 2018 and 2029, gross premiums for a benchmark silver plan for people with income between 150 percent and 400 percent of the FPL (with changes in the age mix of that population accounted for) are projected to grow by an average of 5.5 percent per year in nominal terms and 3.4 percent per year in real terms (that is, after the effects of inflation are removed). Growth in net premiums for those people—which is projected to average 2.8 percent per year in real terms over the same time period—is largely independent of the growth in gross premiums for a benchmark plan. Because subsidized enrollees' net premiums are primarily based

2. See Rachel Fehr, Cynthia Cox, and Larry Levitt, *Individual Insurance Market Performance in Mid-2018* (Kaiser Family Foundation, October 5, 2018), https://tinyurl.com/yyhjvgch.

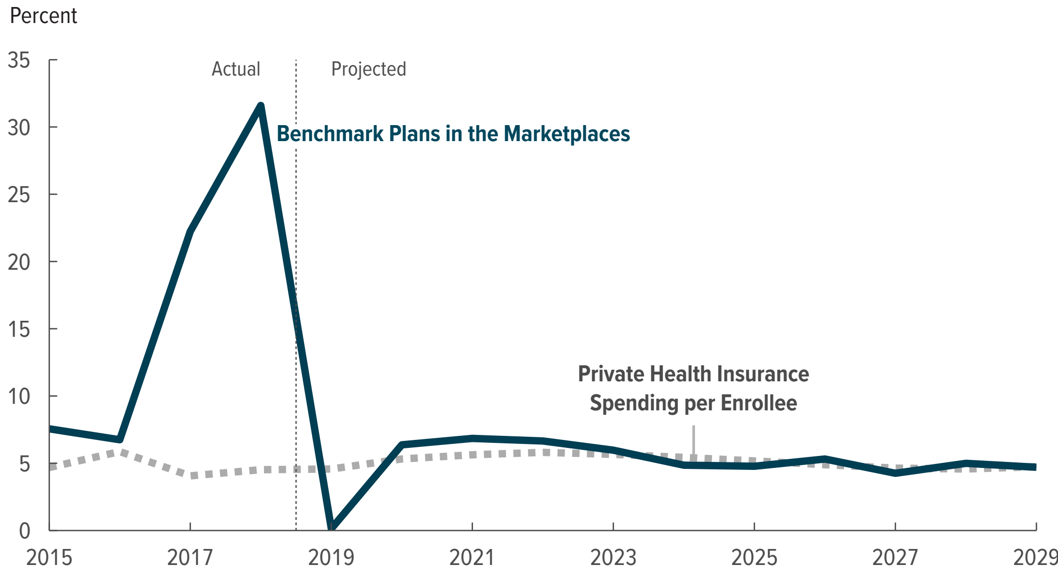
3. See Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (January 2019), www.cbo.gov/publication/54915.

4. For a discussion of how CBO and JCT project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

CBO

Figure A-1.

Annual Percentage Change in Gross Premiums for Benchmark Plans in the Marketplaces



In 2017 and 2018, premiums for benchmark silver plans purchased through the marketplaces established under the ACA grew much more quickly than did those for private health insurance overall. In 2019, they were about the same as they were the year before. Over the 2020–2029 period, they are projected to grow at a rate similar to that for private health insurance premiums overall.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

A benchmark plan is the second-lowest-cost silver plan available in the marketplace in any given area.

CBO and JCT project future spending by private insurers on health care and administration on the basis of trends in the growth of premiums and of projected growth in personal income, which affects people's ability to buy health insurance. Calculations of the growth of premiums include adjustments to remove the effects of changes in the composition of the population in terms of age and sex.

ACA = Affordable Care Act; JCT = Joint Committee on Taxation.

on a percentage of their income, growth in such premiums over time is determined by changes in their income relative to the FPL and by the percentage of income that they pay. That percentage of income increases over time depending on the extent to which growth in private health insurance premiums—including those for employment-based plans and, beginning in 2020, nongroup plans—exceeds income growth.

Premiums by Age and Income

For any given income relative to the FPL, people of different ages pay different gross premiums but the same net premiums; the size of their subsidy varies (see Figure A-3 on page 35). In 2019, the average benchmark premium for a 21-year-old, for example, is estimated to be $4,560 for coverage for the year. If that was the gross premium in one's local area, a person of that age with income at 150 percent of the FPL would pay about $760 for that plan; with income at 225 percent of the FPL, about $2,030; with income at 325 percent of the FPL, about $3,450; and with income at 425 percent of the FPL, the full gross premium of $4,560.

Gross premiums in almost all states are rated by age, and for coverage in the nongroup market, most states require insurers to charge 64-year-olds premiums that are three times those for a 21-year-old. If that was the case in the area used for the example just given, the average benchmark premium for a 64-year-old would be $13,690 for the year. Even so, at the different levels of income eligible for subsidies, the 64-year-old's net premiums would be the same as those for a 21-year-old because the subsidies, based primarily on income, are much larger. But if the 64-year-old had income at 425 percent of the FPL, he or she would pay the full gross premium. That amount is about four times greater than it would be if that person's income was at 325 percent of the FPL, for instance.

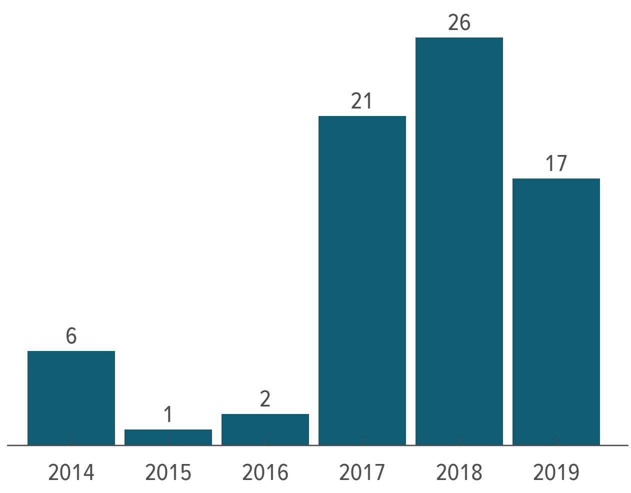
Premiums by Metal Tier

Before 2018, gross premiums corresponded with the actuarial value of the plans—with bronze plans being the least expensive, followed by silver plans, and then gold plans. Premiums during that period were set with the expectation that the federal government would reimburse insurers for the cost of CSRs through direct payments.

Figure A-2.

Share of Enrollees Living in a County With Only One Insurer in the Marketplace

Percent



Source: Kaiser Family Foundation.

On October 12, 2017, the Administration announced that, without an appropriation from the Congress for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs for enrollees with certain incomes who enroll in silver plans and to bear the costs even without a direct payment from the government, almost all insurers covered those costs by explicitly increasing premiums for silver plans offered through the marketplaces between 2017 and 2018.

As a result of the structure of the subsidies for coverage purchased through the marketplaces, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. CBO and JCT's projections reflect the agencies' expectations that, in the absence of the direct payments, CSRs will continue to be funded through premium tax credits in future years.[5]

For plans besides silver ones, insurers in most states did not increase gross premiums between 2017 and 2018 much, if at all, to cover the costs of CSRs. Because tax credits are primarily based on the income of enrollees and can be used to enroll in any plan sold through the marketplaces, enrollees can use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people were able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket payments for premiums in 2018 than in 2017. Also, some people purchased gold plans in 2018 and paid net premiums that were similar to or lower than those they would have paid if they had purchased silver plans covering a smaller share of costs.

Higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have the option of purchasing other plans to avoid paying the premium increases resulting from the October 2017 policy change regarding the government's payments for CSRs. Just as insurers in most states have not appreciably increased premiums for plans other than silver ones to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies have been able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases stemming from the lack of a direct appropriation for CSRs.

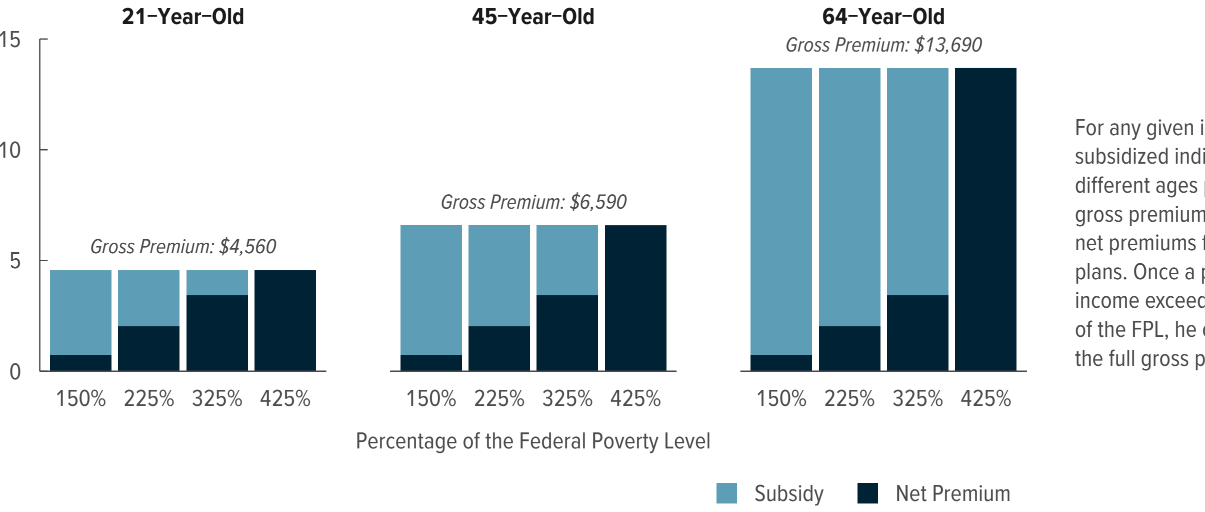
CBO and JCT estimate that, in 2017, when the government reimbursed insurers for the cost of CSRs through direct payments, the average premium for the

5. CBO has determined that the requirement that the federal government compensate insurers for CSRs should continue to be viewed as a form of entitlement authority and, as a result, that the agency's baseline should project funding that is adequate to make all required payments, as specified by the Balanced Budget and Emergency Deficit Control Act. For additional background, see Congressional Budget Office, "Cost-Sharing Reductions in CBO's Spring 2018 Baseline," *CBO Blog* (May 3, 2018), www.cbo.gov/publication/53799. CBO has observed how the government's operations and insurance markets adapted to the termination of direct payments and how CSRs have been funded through premium tax credits. The agency has aligned its current baseline projections to actual premiums in the marketplaces and does not project direct payments for CSRs. That approach reflects what is actually happening—namely, that almost all insurers have covered the costs of CSRs by increasing premiums for silver plans offered through the marketplaces. In 2019, insurance regulators in all states have allowed insurers to explicitly increase premiums for silver plans in the marketplaces to account for CSRs. Although regulators in the District of Columbia have not allowed that increase, premiums in that area are, by CBO's estimates, sufficient to cover the cost of CSRs.

Figure A-3.

Illustrative Examples, for Single Individuals, of Net Premiums and Subsidies for Health Insurance Purchased Through the Marketplaces, 2019

Thousands of Dollars



For any given income, subsidized individuals of different ages pay different gross premiums but the same net premiums for benchmark plans. Once a person's income exceeds 400 percent of the FPL, he or she faces the full gross premiums.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Net premiums equal gross premiums minus the projected premium tax credits for which a person is eligible. Premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage generally grows over time. For the purpose of determining the premium tax credits, eligibility is based on the most recently published FPL as of the first day of the annual open-enrollment period for coverage for the year. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides.

The examples incorporate the federal default age-rating methodology, which most states use. Specifically, compared with premiums for a 21-year-old, premiums for a 64-year-old are three times higher and for a 45-year-old, 1.444 times higher.

For coverage in 2019, the modified adjusted gross income for a single person in most states at 150 percent of the FPL is $18,210; at 225 percent of the FPL, $27,315; at 325 percent of the FPL, $39,455; and at 425 percent of the FPL, $51,595.

FPL = federal poverty level.

second-lowest-cost silver plan (the benchmark plan) was about 24 percent more expensive than that for the lowest-cost bronze plan and about 19 percent cheaper than that for the lowest-cost gold plan. By CBO and JCT's estimates, in 2018, after the government stopped those direct payments to insurers, the average premium for the benchmark silver plan was 39 percent more expensive than it was for the lowest-cost bronze plan and 9 percent cheaper than it was for the lowest-cost gold plan. Those figures reflect the faster premium growth for silver plans relative to that for plans in other tiers in 2018.

Stability in the Marketplaces

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on individual enrollees' health status, the market for insurance would be unstable if, for example, the people who wanted to buy coverage at any offered price had average health care expenditures so high that offering the insurance would be unprofitable for insurers.

CBO and JCT project an overall decline in nongroup coverage over the 2020–2029 period. In 2019, those enrolled in nongroup coverage are estimated to represent 8 percent of the private health insurance market for people under age 65, and in 2029, 7 percent. Despite the decline in nongroup coverage, the marketplaces are

projected to be stable in most areas in large part because most enrollees purchasing subsidized health insurance are insulated from large increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other rules governing the nongroup insurance market—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.

Data about the number of insurers selling insurance in the marketplaces and the profitability of insurers in the past two years suggest that the risk that markets will become unstable in the next few years has lessened. In 2019, for the first time since 2015, more insurers entered the nongroup market than left. On net, insurers participating in the marketplaces entered into 608 counties and exited from 5.[6] The portion of enrollees living in a county with only one insurer decreased to 17 percent in 2019 from 26 percent the year before.

Data on insurers' profitability in the first half of 2018—as measured by the share of premiums that goes toward their administrative costs and profits rather than payments of claims—show that insurers were profitable, on average, for the second consecutive year and that profitability increased from 2017 to 2018. Therefore, the premium increases from 2017 to 2018 were probably sufficient to account for changes in the underlying health risk of the population and the additional costs to insurers of providing CSRs in most areas.

6. See Rachel Fehr, Cynthia Cox, and Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014–2019* (Kaiser Family Foundation, November 14, 2018), https://tinyurl.com/yycm26dp.

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About This Document

Each year, the Congressional Budget Office issues a series of publications describing its projections of the federal budget. This report provides background information that helps explain some of the projections in the most recent of those publications and also provides updated estimates. In keeping with CBO's mandate to provide objective, impartial analysis, the document makes no recommendations.

Kate Fritzsche, Kevin McNellis, and Emily Vreeland prepared the report. Susan Yeh Beyer, Alice Burns, Zhuang Hao, Philippa Haven, Keren Hendel, Lori Housman, Ben Hopkins, Geena Kim, Sean Lyons, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, Colin Yee (formerly of CBO), Rebecca Yip, Chris Zogby, and the staff of the Joint Committee on Taxation contributed to the analysis. Jessica Banthin, Chad Chirico, Theresa Gullo, Leo Lex, Sarah Masi, Alexandra Minicozzi, and David Weaver provided guidance and helpful comments.

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CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

Keith Hall
Director
May 2019

U.S. Bureau of Labor Statistics
May 8, 2020

Frequently asked questions: The impact of the coronavirus (COVID-19) pandemic on The Employment Situation for April 2020

(NOTE: On May 11, 2020, BLS corrected data in the response to item 4 and table A in this document. The corrected change in total nonfarm employment for April is 37,000 lower than initially reported. Professional and business services and total private employment were also affected.)

The labor market data from the establishment and household surveys for April clearly reflect the impact of the coronavirus (COVID-19) pandemic. The material below addresses some questions about the effect of the pandemic on The Employment Situation for April 2020, which presents national-level estimates from the establishment (Current Employment Statistics, or CES) and household (Current Population Survey, or CPS) surveys. (See the assessment of the impact on the Employment Situation for March 2020.)

Additional detail at the state and local area level will be available in forthcoming releases with data from the CES State and Metro Area and the Local Area Unemployment Statistics (LAUS) programs.

1. Household and establishment surveys: What is the reference period for the two surveys?

The household survey reference period is generally the calendar week that contains the 12th day of the month, in this case April 12th through April 18th. In the household survey, individuals are classified as employed, unemployed, or not in the labor force based on their answers to a series of questions about their activities during the survey reference week.

In the establishment survey, workers who are paid by their employer for all or any part of the pay period including the 12th of the month are counted as employed, even if they were not actually at their jobs. Workers who are temporarily or permanently absent from their jobs and who are not being paid are not counted as employed, even if they continue to receive benefits. The length of the reference period does vary across businesses in the establishment survey; one-third of businesses have a weekly pay period, slightly over 40 percent a bi-weekly, about 20 percent semi-monthly, and a small amount monthly.

2. Establishment survey: Was there an impact on data collection in the establishment survey?

Yes. Data collection for the establishment survey was impacted by the coronavirus. Approximately one-fifth of the data is collected at four regional data collection centers. Although these centers were closed during the collection period, about half of the interviewers at these centers worked remotely to collect data by telephone. Additionally, BLS encouraged businesses to report electronically. Approximately half of the data that are typically collected by telephone were instead collected by web.

The collection rate for the establishment survey in April was 75 percent. This is unchanged from the average for the 12 months ending in February 2020, before data collection was impacted by the

coronavirus, and higher than March (66 percent). This rate was also higher than that for April 2019 (72 percent). The survey benefitted from a longer than average collection period in April (16 business days). The typical collection period for this survey ranges from 10-16 days.

The collection rates for construction, manufacturing, wholesale trade, and other services declined between 10 and 20 percentage points in April from the average for the 12 months ending in February 2020. Conversely, the collection rates for leisure and hospitality and for federal government increased by 10 to 20 percentage points from the average for the 12 months ending in February 2020. The collection rates for all other major industries were within 10 percentage points of the average of the 12 months ending in February 2020.

Although the collection rates were adversely affected by pandemic-related issues, BLS was still able to obtain estimates that met our standards for accuracy and reliability.

3. Establishment survey: Were there methodological changes to the establishment survey estimates?

Yes. BLS changed the estimation method used in the establishment survey for April. Business births and deaths cannot be adequately captured by the establishment survey as they occur. Therefore, the establishment survey estimates use a model to account for the relatively stable net employment change generated by business births and deaths. Due to the impact of the COVID-19 pandemic, the relationship between the two was no longer stable in April. Therefore, the establishment survey made changes to the birth-death model.

These changes include using a portion of business deaths reported by establishments in the estimation process. These business deaths are normally excluded from the estimation process. BLS also added a regression variable to the model for forecasting net business births and deaths. The regression variable added more recent information to the model, which typically relies on inputs only available on a lag of several months. See additional information about changes to the net birth-death model.

The establishment survey also uses outlier detection as a usual part of the seasonal adjustment process. All outliers for seasonal adjustment are identified on a monthly basis in the establishment survey seasonal adjustment documentation.

4. Establishment survey: How did the pandemic response impact April employment, hours, and earnings estimates?

As highlighted in The Employment Situation news release, total nonfarm payroll employment fell by 20.5 million in April, after declining by 881,000 in March. Over the two months, payroll employment fell by 14 percent, reflecting the effects of the coronavirus and efforts to contain it. The April over-the-month decline is the largest in the history of the series and brought employment to its lowest level since January 2011 (the series dates back to 1939). Job losses were widespread in April. The largest employment decline occurred in leisure and hospitality, where employment plummeted by 7.7 million over the month, or 47 percent. (See table A.)

Table A. Employment by industry, April 2020 compared with historical levels and changes
(Numbers in thousands)

Industry	April 2020			Last time employment level was lower		Last time monthly loss was larger (or next largest loss)		Last time monthly percent loss was larger (or next largest loss)	
	Employ-ment level	Monthly change	Monthly percent change	Date	Employ-ment level	Date	Monthly change	Date	Monthly percent change
Total nonfarm	131,045 (c)	-20,537 (c)	-13.5	Jan 2011 (c)	130,841 (c)	Sep 1945	-1,959	Sep 1945	-4.8
Total private	109,308 (c)	-19,557 (c)	-15.2 (c)	Mar 2011	109,096	Sep 1945	-1,766	Sep 1945	-5.1
Mining and logging	657	-50	-7.1	Feb 2017	655	Apr 1981	-134	Apr 1981	-11.6
Construction	6,631	-975	-12.8	Jan 2016	6,620	Mar 1960	-172	Jul 1943	-7.5
Manufacturing	11,488	-1,330	-10.4	Mar 2010	11,453	Sep 1945	-1,715	Sep 1945	-12.1
Wholesale trade	5,569	-363	-6.1	Feb 2012	5,562	Feb 2009	-48	Jun 1942	-1.3
Retail trade	13,520	-2,107	-13.5	Jul 1994	13,516	Apr 1951	-123	Apr 1951	-2.6
Transportation and warehousing	5,087	-584	-10.3	Jan 2017	5,078	Aug 1997	-148	Aug 1997	-3.7
Utilities	543	-3	-0.6	Aug 1971	542	Jul 2018	-4	Jul 2012	-1.3
Information	2,636	-254	-8.8	Aug 2011	2,634	Aug 1983	-586	Aug 1983	-25.4
Financial activities	8,580	-262	-3.0	May 2018	8,567	Apr 2009	-57	Jan 1947	-1.2
Professional and business services	19,305 (c)	-2,165 (c)	-10.1 (c)	Oct 2014	19,285	Feb 2009	-196	Sep 1945	-2.4
Education and health services	21,941	-2,544	-10.4	Apr 2015	21,906	Nov 2008	-101	Jan 1949	-0.8
Leisure and hospitality	8,715	-7,653	-46.8	Aug 1988	8,663	Mar 2020	-499	Mar 2020	-3.0
Other services	4,636	-1,267	-21.5	Jan 1996	4,625	Nov 2008	-40	Nov 2008	-0.7
Government	21,737	-980	-4.3	Jan 2005	21,735	Jun 2000	-260	Sep 1945	-3.1

(c) Corrected May 11, 2020

Average weekly hours for all private-sector workers showed an increase of 0.1 hour in April, after declining by 0.3 hour in March. However, in April, there were notable declines in the average workweek for manufacturing (-2.1 hours), construction (-1.3 hours), and wholesale trade (-1.2 hours).

Given the large employment decline in March and the extreme job cuts in April, one must be cautious when interpreting the changes in average weekly hours for all private-sector workers. While it is

certainly true some employees worked additional hours in April, the majority of the increase in average weekly hours reflects the disproportionate number of workers with shorter workweeks who went off payrolls; their removal put upward pressure on the average hours estimate.

Similarly, estimates of average hourly earnings for April also must be interpreted with extra caution. Average hourly earnings of all employees on private nonfarm payrolls rose by $1.34 in April to $30.01, following a gain of 15 cents in March. While some workers experienced an increase in pay in April, the increase in average hourly earnings reflects the disproportionate number of lower-paid workers who went off payrolls; their removal put upward pressure on the average hourly earnings estimate.

In the establishment survey, workers who are paid by their employer for all or any part of the pay period including the 12th of the month are counted as employed, even if they were not actually at their jobs. Workers who are temporarily or permanently absent from their jobs and who are not being paid are not counted as employed, even if they continue to receive benefits. The length of the reference period does vary across businesses in the establishment survey; one-third of business have a weekly pay period, slightly over 40 percent a bi-weekly, about 20 percent semi-monthly, and a small amount monthly.

5. Household survey: What was the impact on data collection in the household survey?

The household survey is conducted by the U.S. Census Bureau and normally includes both in-person and telephone interviews, with the majority of interviews collected by telephone. Interviewing for the household survey began on April 19, 2020.

Households are in the survey's sample for a total of 8 months, meaning that interviewers attempt to interview someone in the household each of those 8 months. Generally, households entering the sample for their first month are interviewed through a personal visit, and households in their fifth month also often receive a personal visit. Interviews for other months are generally conducted by telephone.

For the safety of both interviewers and respondents, the Census Bureau did not conduct in-person interviews in April. Additionally, the two Census Bureau call centers that assist with telephone interviewing were closed. The Census Bureau continued to conduct the household survey by telephone and made efforts to collect telephone interviews for households that would normally have been interviewed in person.

The response rate for the household survey was 70 percent in April 2020, following a response rate of 73 percent in March. For comparison, the response rate for April 2019 was 83 percent, and the average response rate for the 12 months ending in February 2020 was also 83 percent.

The response rate for households entering the sample for their first month was particularly low. The response rate for these households, which would normally have been interviewed in person, was over 30 percentage points lower than the average for the 12 months ending in February 2020. In addition, households in the sample for their second month—which entered the sample for the first time last month and had low response rates in March—were down about 20 percentage points compared with the average for the 12 months ending in February. The rate for those in their fifth month was over 10 percentage points lower.

Although the response rate was adversely affected by pandemic-related issues, BLS was still able to obtain estimates that met our standards for accuracy and reliability.

6. Household survey: Were there modifications to the seasonal adjustment methodology for the household survey?

During their review of household survey data for April, BLS staff tested for outliers to determine whether any changes were needed to the seasonal adjustment models. BLS staff determined that the vast majority of household survey data series had significant outliers in April and manually added outlier terms to the seasonal adjustment models.

Seasonal adjustment factors can be either multiplicative or additive. A multiplicative seasonal effect is assumed to be proportional to the level of the series. A sudden large increase in the level of the series will be accompanied by a proportionally large seasonal effect. In contrast, an additive seasonal effect is assumed to be unaffected by the level of the series. In times of relative economic stability, the multiplicative option is generally preferred over the additive option. However, in the presence of a large level shift in a time series, multiplicative seasonal adjustment factors can result in systematic over- or under-adjustment of the series; in such cases, additive seasonal adjustment factors are preferred since they tend to more accurately track seasonal fluctuations in the series and have smaller revisions.

Most household data series that had outliers in April used multiplicative seasonal adjustment factors. Therefore, BLS staff decided to specify all series with significant April outliers as additive. In accordance with the household survey's usual practice, the seasonal adjustment models and factors will be reviewed at the end of the calendar year, when five years of seasonally adjusted estimates will be subject to revision.

More information about seasonal adjustment is available in the household survey documentation.

7. Household survey: Were there any changes to measures of error for household survey estimates?

As with all survey-based estimates, household survey estimates are subject to sampling error. When a sample is surveyed, there is a chance that the sample estimates may differ from the true population values they represent. The component of this difference that occurs because samples differ by chance is known as sampling error, and its variability is measured by the standard error of the estimate. There is about a 90-percent chance, or level of confidence, that an estimate based on a sample will differ by no more than 1.6 standard errors from the true population value because of sampling error. BLS analyses are generally conducted at the 90-percent level of confidence.

In general, estimates based on a large number of observations have lower standard errors (relative to the size of the estimate) than estimates based on a small number of observations. Also, estimates of higher magnitude tend to have higher standard errors than estimates of lower magnitude.

The relatively low April response rate—meaning that household survey estimates were based on fewer observations in April than in prior months—increased standard errors for most measures. However, many estimates had substantially different magnitudes than in prior months, which also had an effect on standard errors. For example, the 90-percent confidence interval for the over-the-month change in the unemployment rate was +/- 0.3 percentage point in April, compared with about +/- 0.2 percentage point in April of last year. The increase in the size of the confidence interval is largely due to the increase in the magnitude of the unemployment rate (14.7 percent in April 2020 versus 3.6 percent in April 2019) rather than to the lower response rate. See information about the reliability of estimates in the household survey.

8. Household survey: Were interviewers provided with any special guidance?

Due to the unusual circumstances related to the pandemic, additional guidance was provided to Census Bureau interviewers prior to collecting data in April. This was similar to the guidance that had been provided in March. In both months, guidance was provided only for the three items discussed below. Information was not provided for other survey questions.

If someone who usually works full time (35 hours or more per week) reports working 1 to 34 hours during the survey reference week, there is a question that asks the main reason they worked less than 35 hours. For this question, if a person indicated they were under quarantine or self-isolating due to health concerns the interviewer should select "own illness, injury, or medical problem." For people who were not ill or quarantined but said that their hours were reduced "because of the coronavirus," the interviewer should select "slack work or business conditions." An example would be "the store cut back hours during the coronavirus."

For those who did not work at all during the survey reference week of April 12–18, if a person indicated they were under quarantine or self-isolating due to health concerns, the interviewer should select "own illness, injury, or medical problem." For people who were not ill or quarantined but said that they did not work last week "because of the coronavirus," the interviewer should select "on layoff (temporary or indefinite)." This scenario would include people who reported "I work at a sports arena and everything is postponed" or "the restaurant closed for now because of the coronavirus."

To be classified as unemployed on temporary layoff, a person has either been given a date to return to work by their employer or expects to be recalled to their job within 6 months. Additional guidance was also provided to household survey interviewers regarding the question "Have you been given any indication that you will be recalled to work within the next 6 months?" If, because of the coronavirus, a person was uncertain of when they would be able to return to work and thus was unsure of how to answer the question, the interviewer was instructed to enter a response of "yes," rather than "don't know." This would allow the individual to be included among the unemployed on temporary layoff. In light of the uncertainty of circumstances related to the pandemic, this unusual step was taken as part of an attempt to classify people who were effectively laid off due to pandemic-related closures among the unemployed on temporary layoff.

9. Household survey: How did the pandemic response impact April estimates?

Household survey total employment fell precipitously, and unemployment rose sharply in April. These changes were widespread, as the labor market reacted to efforts to contain the spread of the coronavirus. (See details in item 10 below.)

The household survey can identify people who were not at work during the survey reference week for reasons such as their own illness, vacation, or taking care of a family member. Under the guidance provided to the household survey interviewers, workers who indicate that they were not working during the entire reference week due to efforts to contain the spread of the coronavirus should be classified as unemployed on temporary layoff, whether or not they are paid for the time they were off work. (See details in item 8 above.)

Among the unemployed, a large increase occurred among people on temporary layoff in April. However, as happened in March, some workers who were not at work during the entire reference week were not classified as unemployed on temporary layoff in April 2020. Rather, they were classified as employed but absent from work. BLS analysis of the underlying data suggests that most of these workers were misclassified; they should have been classified as unemployed on temporary layoff. (See details in item 13 below.)

The number of hours some people worked were affected by efforts to contain the pandemic. Employed people who usually work full time (35 hours or more per week) but indicate that they had worked fewer than 35 hours in the reference week because of slack work or business conditions, including those due to pandemic-related closures, are classified as employed part time for economic reasons. (See details in item 15 below.) Other effects can be seen in the number of people at work part time for noneconomic reasons. (See details in item 16 below.)

The number of people not in the labor force who currently want a job nearly doubled in April, as the impact of the pandemic kept many individuals from engaging in labor market activity. (See details in item 18 below.)

10. Household survey: How did the pandemic response impact unemployment and employment measures from the household survey?

As highlighted in The Employment Situation news release, the unemployment rate increased by 10.3 percentage points to 14.7 percent in April. This is the highest rate and the largest over-the-month increase in the history of the series (seasonally adjusted data are available back to January 1948). The number of unemployed people rose by 15.9 million to 23.1 million in April. Jobless rates rose sharply among all major worker groups. The stark increases in unemployment reflect the effects of the coronavirus and efforts to contain it. (Note that measures from the household survey pertain to the week of April 12–18.)

The number of unemployed people who reported being on temporary layoff increased by 16.2 million in April to 18.1 million. The number of permanent job losers increased by 544,000 to 2.0 million.

The number of unemployed people who were jobless less than 5 weeks increased sharply by 10.7 million in April to 14.3 million, accounting for 61.9 percent of the unemployed.

Employment, as measured by the household survey, fell sharply in April, declining by 22.4 million to 133.4 million. The employment-population ratio, at 51.3 percent, dropped by 8.7 percentage points over the month. This is the lowest rate and largest over-the-month decline in the history of the series, which dates back to 1948. Employment declines were widespread among the major worker groups. People who usually work part time were particularly affected; part-time workers accounted for one-third of the over-the-month employment decline.

11. Household survey: How are people who are absent from their jobs counted in the household survey?

The monthly household survey has two measures that show the number of people who missed work. One addresses people who did not work at all in the survey reference week, and the other addresses people who usually work full time but were at work part time (1 to 34 hours) during the reference week.

First, the survey collects data on the number of people who had a job but were not at work for the entire reference week due to reasons like vacation or their own illness. These people are counted as employed regardless of whether they were paid for the time off. People who have a job but were not at work for other reasons may be classified as employed or unemployed depending on the reason they missed work. For example, people who missed work due to vacation, parental leave, or bad weather are classified as employed. People who were temporarily laid off and expecting recall are classified among the unemployed on temporary layoff. (See details in item 12 below.)

Second, the household survey provides a measure of the number of people who usually work full time (35 hours or more per week) but were at work part time (1 to 34 hours) during the survey reference week. Depending on the reason provided, these workers are then grouped into those at work part time for economic or noneconomic reasons. Economic reasons include working reduced hours due to slack work or business conditions, seasonal work, or starting or ending a job during the week. Noneconomic reasons include illness, vacation, holidays, schooling, childcare problems, labor dispute, bad weather, and other reasons. (See details in items 15 and 16 below.)

People who report in the survey that they do not have a job, including those who permanently lost their job, are classified as unemployed if they are both available for work and actively looking for employment. (People on temporary layoff do not need to look for work to be unemployed.) People who do not meet the criteria to be unemployed (for example, they are not available to work for reasons other than their own temporary illness or they do not expect to be recalled from their layoff) are classified as not in the labor force. (See further explanation in item 18 below.)

(Continues on next page.)

12. Household survey: How many employed people were not at work during the reference week?

In April, 11.5 million workers were classified as employed with a job but not at work during the survey reference week (not seasonally adjusted). This is much larger than the number of employed people with a job not at work typical at this time of the year and reflects the impact of the coronavirus pandemic.

Table B. Employed people with a job but not at work, March and April, selected years, not seasonally adjusted
(Numbers in thousands)

Year	March		April		Difference* (April - March)	
	Total employed	With a job not at work	Total employed	With a job not at work	Total employed	With a job not at work
2016	150,738	4,496	151,075	4,022	337	-474
2017	152,628	5,573	153,262	5,625	634	52
2018	154,877	5,612	155,348	4,083	471	-1,529
2019	156,441	5,108	156,710	4,078	269	-1,030
2020	155,167	6,439	133,326	11,524	-21,841	5,085

* Users are generally cautioned against over-the-month comparisons of not seasonally adjusted data, as the change could be affected by some seasonal component.

There were many reasons why employed people were not at work for the entire survey reference week. BLS tabulates data on employed people not at work whose main reason for being absent was vacation, own illness, childcare problems, other family or personal obligations, labor dispute, bad weather, maternity or paternity leave, school or training, civic or military duty, and other reasons. Vacation and a person's own illness are typically the most common reasons people are not at work. (See table C below.)

Of the 11.5 million employed people not at work during the survey reference week in April 2020, 2.0 million people were included in the "own illness, injury, or medical problems" category (not seasonally adjusted). This was twice as large as the 1.0 million that is typical for April in recent years. People who were not at work to care for a sick family member should be counted in the "other family or personal obligations" category. This measure was within the usual range for April in recent years.

In April 2020, 8.1 million people were included in the "other reasons" category—more than two-thirds of the 11.5 million employed people not at work during the survey reference week (not seasonally adjusted). This is the highest value in the "other reasons" series, which dates back to 1994, and is much higher than the average of 620,000 for April 2016–2019. BLS analysis of the underlying data suggests that this group included workers affected by the pandemic response who should have been classified as unemployed on temporary layoff. Such a misclassification is an example of nonsampling error and can occur when respondents misunderstand questions or interviewers record answers incorrectly.

(Continues on next page.)

Table C. Employed people with a job but not at work, April, selected years, not seasonally adjusted (Numbers in thousands)

April	Total not at work	Vacation	Own illness, injury, or medical problems	Childcare problems	Other family or personal obligations	Labor dispute	Bad weather	Maternity or paternity leave	School or training	Civic or military duty	Other reasons
2016	4,022	1,620	1,045	16	267	7	65	288	133	4	576
2017	5,625	2,981	1,065	28	293	10	117	295	116	2	718
2018	4,083	1,618	981	22	236	11	142	313	125	4	630
2019	4,078	1,835	912	24	235	8	98	312	99	1	554
2020	11,524	622	2,010	81	232	4	51	370	58	11	8,085

13. Household survey: How many more workers should have been classified as unemployed on temporary layoff in April?

Other than those who were themselves ill, under quarantine, or self-isolating due to health concerns, people who did not work during the survey reference week (April 12–18) due to efforts to contain the spread of the coronavirus should have been classified as "unemployed on temporary layoff." However, as happened in March, some people who were not at work during the entire reference week were not included in this category. Instead, they were misclassified as employed but not at work.

Of the 11.5 million employed people not at work during the survey reference week in April 2020, 8.1 million people were included in the "other reasons" category, much higher than the average of 620,000 for April 2016–2019 (not seasonally adjusted). BLS analysis of the underlying data suggests that this group included workers affected by the pandemic response who should have been classified as unemployed on temporary layoff. Such a misclassification is an example of nonsampling error and can occur when respondents misunderstand questions or interviewers record answers incorrectly.

According to usual practice, the data from the household survey are accepted as recorded. To maintain data integrity, no ad hoc actions are taken to reassign survey responses.

14. Household survey: What would the unemployment rate be if these misclassified workers were included among the unemployed?

If the workers who were recorded as employed but not at work the entire survey reference week had been classified as "unemployed on temporary layoff," the overall unemployment rate would have been higher than reported. This kind of exercise requires some assumptions. For example, first one needs to determine how many workers might be misclassified. The 8.1 million workers with a job but not at work who were included in the "other reasons" category is about 7.5 million higher than the average of recent April estimates. (While this category contains misclassified workers, not every person in this category was necessarily misclassified. The average for 2016–2019 was 620,000 employed people with a job not at work for "other reasons.")

One assumption might be that these additional 7.5 million workers who were included in the "other reasons" category should have been classified as unemployed on temporary layoff. If these 7.5 million people were to be considered unemployed on temporary layoff, the number of unemployed people in April (on a not seasonally adjusted basis) would increase by 7.5 million from 22.5 million to 30.0 million. The number of people in the labor force would remain at 155.8 million in April (not seasonally adjusted) as people move from employed to unemployed but stay in the labor force. The resulting unemployment rate for April would be 19.2 percent (not seasonally adjusted), compared with the official estimate of 14.4 percent (not seasonally adjusted). Estimates of people with a job but not at work are not available on a seasonally adjusted basis, so seasonally adjusted data, such as the unemployment rate mentioned in The Employment Situation news release, are not used in this exercise. (Repeating this exercise, but combining the not adjusted data on people with a job but not at work with the seasonally adjusted estimates reported in The Employment Situation news release yields a similar 4.8 percentage point increase in the unemployment rate for April—or 19.5 percent, compared with the official seasonally adjusted rate of 14.7 percent.)

15. Household survey: How many people were at work part time for economic reasons in April?

The pandemic may have affected the number of hours some people worked during the survey reference week (April 12-18). For example, some people may have worked for some part of the reference week, but not as many hours as they usually work. Some people may have worked more hours than usual.

In April 2020, there were 10.9 million workers who worked part time for economic reasons (seasonally adjusted). These individuals, who would have preferred full-time employment, were working part time because their hours had been reduced or they were unable to find full-time jobs. This was 5.1 million more than the previous month and 6.6 million more than in February, clearly reflecting slack work or business conditions due to the pandemic response.

The over-the-month increase in the number of people working part time for economic reasons was particularly large in both educational services and in health care.

16. Household survey: What else do we know about why people were at work part time in April?

Employed people who usually work full time (35 hours or more per week) but indicated that they had worked fewer than 35 hours in the survey reference week are asked the reason they worked part time that week. Depending on the reason provided, these workers are then grouped into those at work part time for economic or noneconomic reasons. Economic reasons include working reduced hours due to slack work or business conditions, seasonal work, or starting or ending a job during the week. (See item 15 for a discussion of people at work part time for economic reasons.) Noneconomic reasons include illness, vacation, holidays, schooling, childcare problems, labor dispute, bad weather, and other reasons.

The number of people who usually work full time but were at work part time for noneconomic reasons fell in April, reflecting the overall decline in employment. In addition, the change in the number of full-time workers who reported being at work part time for "other reasons" likely reflects the pandemic. There were 3.5 million workers who usually work full time but worked less than 35 hours in April due

to "other reasons" (not seasonally adjusted). Prior to 2020, this category typically has had about half a million people in March and April.

It is important to note that the household survey data do not reflect all cases of people who worked fewer hours during the month. They refer to work missed only during the survey reference week. They are restricted to cases where people who usually work full time (35 hours or more per week) worked 1 to 34 hours. Thus, a person who usually works 50 hours per week but missed 8 hours would not be included in this measure since they still worked more than 35 hours. Also, the data do not reflect how many people who usually work part time miss work.

17. Household survey: What were the effects of the coronavirus on occupational employment and unemployment?

In April, the household survey estimate of total employment fell by 21.8 million, or 14 percent, on a not seasonally adjusted basis. Declines occurred across all the major occupation groups, but service workers were especially affected. Employment in service occupations fell by 7.3 million over the month, nearly 30 percent. In particular, both food preparation and serving related occupations (-3.5 million, or 45 percent) and personal care and service occupations (-1.8 million, or 43 percent) were severely affected.

Unemployment rates increased for all occupation groups. The highest rates were experienced by workers in service occupations, where the unemployment rate tripled to 27.1 percent in April. The unemployment rate for food preparation and serving related occupations increased to 41.8 percent, and the jobless rate for personal care and service occupations increased to 39.3 percent (not seasonally adjusted).

Online monthly tables show additional information on employment and unemployment by occupation. Time series estimates of employment and unemployment by occupation from the household survey are also available in our online database. (These data are not seasonally adjusted. Users are generally cautioned against over-the-month comparisons of not seasonally adjusted data, as the change could be affected by some seasonal component. Additionally, changes in the classification of occupations complicate comparisons over time.)

18. Household survey: How many people want a job, but are not classified as unemployed?

People are categorized as either employed, unemployed, or not in the labor force based on how they respond to survey questions about their recent activities. People who have a job are employed, including those who may be temporarily absent (whether or not they are paid). People who do not have a job and are actively looking for and available for work are unemployed. People who do not have a job and are on layoff and expecting to be recalled to their job do not need to look for work to be counted as unemployed, but they do need to be available for work. Those who do not meet the criteria to be classified as either employed or unemployed are not in the labor force.

Among those not in the labor force, the survey does identify people who want a job. There were 9.9 million people not in the labor force who wanted a job in April, nearly twice as many as in March (5.5

million) and a high for the monthly series that dates back to 1994. In April, people who wanted a job represented 1 in 10 of those not in the labor force, much higher than in recent months. Among people ages 25 to 54, those who wanted a job represented nearly 1 in 5 people not in the labor force.

The large increase in the want a job category reflects the impact of the pandemic on the job market, as mandatory business closures, stay-at-home orders, and concerns about the coronavirus kept many individuals from engaging in labor market activity in April. Most people who wanted a job in April had not looked for work recently. If they had actively looked for work in the prior 4 weeks and were available to take a job, they would have been counted among the unemployed.

If the entire 9.9 million people who want a job but were not in the labor force were added to the total 23.1 million people unemployed in April, the resulting 33.0 million people would represent 19.8 percent of the labor force plus those who want a job. A similar calculation for March results in 7.5 percent.

19. Household survey: What's the difference between a furlough and a layoff?

Some people use the terms furlough and layoff interchangeably, and others find them to be distinct. The household survey does not have a formal measure or definition of furlough.

The survey identifies different reasons people are unemployed, including being on temporary layoff. This measure includes people who were "furloughed", although that is not a term used in the survey questionnaire. (The manual provided to survey interviewers does discuss how to code responses from people who report that they are furloughed. This guidance was prepared several year ago and was tailored to the use of "furlough" as a term describing budget-related layoffs, typically among government entities.)

Unemployed people on temporary layoff are those who said they were laid off or were not at work during the survey reference week because of layoff (temporary or indefinite) or slack work/business conditions, and who have been given a date to return (or expect to be recalled within the next 6 months), and who could have returned to work if they had been recalled (except for temporary illness). Unlike other unemployed people, those on temporary layoff do not need to look for work to be classified as unemployed. Pay status is not a criteria to be unemployed on temporary layoff. People absent from work due to temporary layoff can be classified as unemployed on temporary layoff, whether or not they are paid for the time they were off work.

Recent information about unemployed people on temporary layoff is available in an online table; additional information is available from our online database.

The household survey does not include any information on whether people on temporary layoff return to their employers. The monthly survey is a snapshot of the labor market and is not designed to track people's work experience over time.

20. How many working people had to take care of children that could not go to school?

BLS does not have monthly estimates of employed parents, nor do we have data that reflect school closures.

21. Do the household and establishment surveys measure telework?

No, the surveys do not regularly measure telework or work from home. However, BLS is adding new questions related to the coronavirus pandemic to the household survey, including one on telework. (See item 22 below.)

22. Are there plans to learn more about people affected by the pandemic?

Yes, the household survey will begin collecting information from 5 new questions related to the pandemic in May. Information from these new questions will not be available with the release of the regular May estimates from the household survey.

23. How are these data different from the unemployment insurance (UI) claims data?

For the household and establishment surveys, the data for a given month relate to a particular week or pay period. In the household survey, the reference period is generally the calendar week that contains the 12th day of the month, in this case April 12–18. In the establishment survey, the reference period is the pay period that includes the 12th of the month, regardless of the length of the pay period. (The length of the reference period does vary across businesses in the establishment survey; one-third of businesses have a weekly pay period, slightly over 40 percent a bi-weekly, about 20 percent semi-monthly, and a small amount monthly.)

Every week, the Department of Labor's Employment and Training Administration (ETA) reports the number of people filing initial and continuing claims for UI benefits. Because the UI claims data are a weekly series, they can capture the impact of shocks more quickly than the BLS monthly household and establishment surveys, particularly when these shocks hit between survey reference periods.

Data users must be cautious about trying to compare or reconcile the UI claims data with the official unemployment figures gathered through the household survey. The unemployment data derived from the household survey in no way depend upon the eligibility for or receipt of unemployment insurance benefits. Learn more about how the government measures unemployment.

ECONOMY & JOBS

April's Job Losses Show Many Workers Are Still Connected to Their Employers

May 8, 2020 | 5 minute read

Council of Economic Advisers

Over the past weeks, Americans' efforts to slow COVID-19's spread have helped flatten the curve. As a result of this action, the Bureau of Labor Statistics' (BLS) April Employment Situation report shows that nonfarm payroll employment fell by 20.5 million and the unemployment rate (U-3) jumped 10.3 percentage points to 14.7 percent. Both of these monthly changes are the largest in the series' histories, as never before has the United States halted large portions of its economic activity.

While April's jobs numbers may astound Americans, the economy's strength earlier this year put the Nation in a better position to make temporary economic sacrifices to slow COVID-19's spread. After all, the unemployment rate stood at a 50-year low of 3.5 percent only two months ago.

Aided by Federal policy, the connection between many unemployed individuals and their previous employers remains strong—as temporary layoffs account for many of April's job losses and all of the month's unemployment increase. But these connections deteriorate the longer that States continue limiting economic activity. As States start or consider reopening their economies in a responsible way, it is

critical that policymakers’ focus expands to reviving the health of the United States labor force.

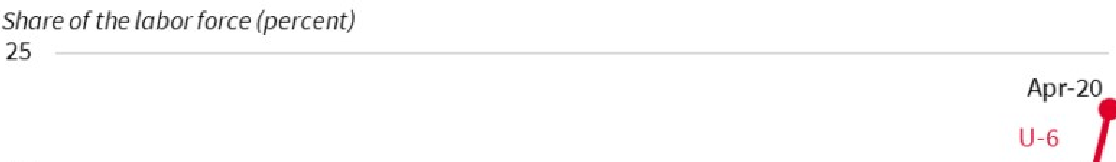
The April report also shows that the African American unemployment rate rose 10.0 percentage points to 16.7 percent, and that the Hispanic American unemployment rate rose 12.9 percentage points to 18.9 percent. These substantial increases come after unemployment rates for both demographics reached historic lows in 2019. Furthermore, those with lower education levels are experiencing the largest job losses. The unemployment rate for those without a high school diploma rose 14.4 percentage points to 21.2 percent in April, and the unemployment rate for those with only a high school degree rose 12.9 percentage points to 17.3 percent.

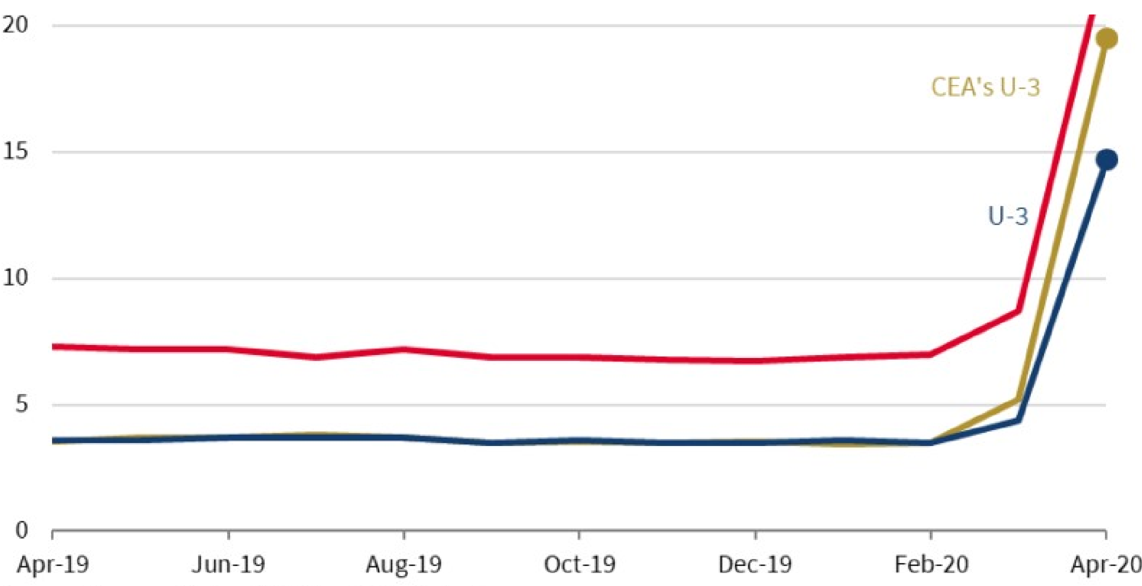
Even though April’s unemployment rate reached the highest level on record, COVID-19’s sudden shock to the labor market has put more people out of work than the top-line number suggests. Those who lost their jobs and are not looking for work do not count as unemployed unless they are temporarily laid off; instead, they count as not in the labor force. Since the U-3 rate is calculated by dividing the number of the unemployed by the size of the labor force, the prevalence of this category of workers substantially changes the unemployment rate calculation. Flows from employment to not in the labor force totaled 9.5 million from March to April, compared with 17.5 million people who moved from employment to unemployment. Adding the increase in the number of Americans who were classified as not in the labor force because they are not searching for work further increases April’s unemployment rate.

With the right policies, there is reason to expect a faster labor market recovery than the unemployment rate suggests. The April report shows that temporary layoffs explain the entire increase in the number of unemployed from March to April, meaning these workers could return to their previous jobs as economic activity picks up. Additionally, the number of temporarily laid off workers is likely higher than BLS reports. Compared to the average April value over the previous four years, 7.5 million more workers were classified as employed but not at work for “other

reasons" last month. Reclassifying these workers, who may be on temporary layoff and not getting paid, as unemployed would raise April's U-3 rate to 19.5 percent. Figure 1 shows the distribution of types of job loss in April, including the excess workers who claim to be employed but not at work for "other reasons."

BLS has other unemployment metrics to help capture this unprecedented labor market situation. While not the same as CEA's modified U-3 rate of 19.5 percent shown in Figure 2, the more comprehensive U-6 rate captures workers who are part-time for economic reasons, as well as discouraged or marginally attached workers who were unemployed prior to the crisis and stopped searching for work. After hitting a series low of 6.7 percent in December 2019, the U-6 rate increased to 22.8 percent in April.





Sources: Bureau of Labor Statistics; CEA calculations.
Note: CEA's U-3 was calculated by adding the excess employed but not at work for other reasons to the number of unemployed, and then dividing the result by the number in the labor force.

The April jobs report shows that the key to the labor market's rebound—bonds between employers and employees—remains even while many Americans are not working. Looking ahead to next month, with many States reopening their economies, the May report may show early signs of the economic comeback. However, given the 7 million initial unemployment insurance claims filed since the April report's reference period, and that the May report's household survey covers next week, further indications of recovery may not be shown until the June report—even if they are already underway.

Workers' economic sacrifices allowed the United States to keep healthcare capacity from being exceeded in most of the Nation. But temporarily shutting down large portions of the economy to ensure adequate healthcare capacity and create systems to protect the most vulnerable came at a high cost—especially for minority and lower-income workers. While Federal responses have enabled more workers to remain attached to their jobs for now, these critical attachments will weaken the longer that State-imposed shutdowns are in effect. As April's jobs report shows, the declining health of America's labor force needs to be considered as the Nation continues responding to COVID-19.

NEWS RELEASE
BUREAU OF LABOR STATISTICS
U. S. DEPARTMENT OF LABOR

Transmission of material in this news release is embargoed until 8:30 a.m. (EDT) Friday, June 5, 2020

USDL-20-1140

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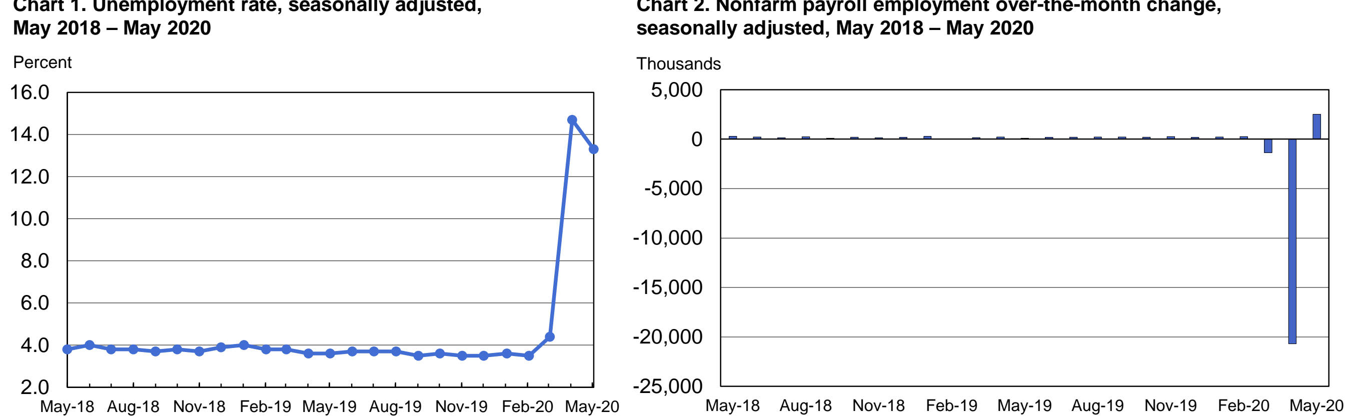
THE EMPLOYMENT SITUATION — MAY 2020

Total **nonfarm payroll employment** rose by 2.5 million in May, and the **unemployment rate** declined to 13.3 percent, the U.S. Bureau of Labor Statistics reported today. These improvements in the labor market reflected a limited resumption of economic activity that had been curtailed in March and April due to the coronavirus (COVID-19) pandemic and efforts to contain it. In May, employment rose sharply in leisure and hospitality, construction, education and health services, and retail trade. By contrast, employment in government continued to decline sharply.



This news release presents statistics from two monthly surveys. The household survey measures labor force status, including unemployment, by demographic characteristics. The establishment survey measures nonfarm employment, hours, and earnings by industry. For more information about the concepts and statistical methodology used in these two surveys, see the Technical Note.

Household Survey Data

The **unemployment rate** declined by 1.4 percentage points to 13.3 percent in May, and the number of **unemployed persons** fell by 2.1 million to 21.0 million. Reflecting the effects of the coronavirus pandemic and efforts to contain it, the unemployment rate and the number of unemployed persons are up

by 9.8 percentage points and 15.2 million, respectively, since February. (See table A-1. For more information about how the household survey and its measures were affected by the coronavirus pandemic, see the box note on page 6.)

Among the **major worker groups**, the unemployment rates declined in May for adult men (11.6 percent), adult women (13.9 percent), Whites (12.4 percent), and Hispanics (17.6 percent). The jobless rates for teenagers (29.9 percent), Blacks (16.8 percent), and Asians (15.0 percent) showed little change over the month. (See tables A-1, A-2, and A-3.)

The number of unemployed persons who were on **temporary layoff** decreased by 2.7 million in May to 15.3 million, following a sharp increase of 16.2 million in April. Among those not on temporary layoff, the number of **permanent job losers** continued to rise, increasing by 295,000 in May to 2.3 million. (See table A-11.)

In May, the number of unemployed persons who were **jobless less than 5 weeks** decreased by 10.4 million to 3.9 million. These individuals made up 18.5 percent of the unemployed. The number of unemployed persons who were **jobless 5 to 14 weeks** rose by 7.8 million to 14.8 million, accounting for about 70.8 percent of the unemployed. The number of **long-term unemployed** (those jobless for 27 weeks or more), at 1.2 million, increased by 225,000 over the month and represented 5.6 percent of the unemployed. (See table A-12.)

The **labor force participation rate** increased by 0.6 percentage point in May to 60.8 percent, following a decrease of 2.5 percentage points in April. Total employment, as measured by the household survey, rose by 3.8 million in May to 137.2 million, following a large decline in April. After an 8.7 percentage-point decline in April, the **employment-population ratio** rose by 1.5 percentage points to 52.8 percent in May. (See table A-1.)

In May, the number of persons who **usually work full time** increased by 2.2 million to 116.5 million, and the number who **usually work part time** rose by 1.6 million to 20.7 million. Part-time workers accounted for about two-fifths of the over-the-month employment growth. (See table A-9.)

The number of persons employed **part time for economic reasons**, at 10.6 million, changed little in May, but is up by 6.3 million since February. These individuals, who would have preferred full-time employment, were working part time because their hours had been reduced or they were unable to find full-time jobs. This group includes persons who usually work full time and persons who usually work part time. (See table A-8.)

The number of persons **not in the labor force who currently want a job**, at 9.0 million, declined by 954,000 in May, after increasing by 4.4 million in April. These individuals were not counted as unemployed because they were not actively looking for work during the last 4 weeks or were unavailable to take a job. (See table A-1.)

Persons **marginally attached to the labor force**—a subset of persons not in the labor force who currently want a job—numbered 2.4 million in May, little different from the prior month. These individuals were not in the labor force, wanted and were available for work, and had looked for a job sometime in the prior 12 months but had not looked for work in the 4 weeks preceding the survey. **Discouraged workers**, a subset of the marginally attached who believed that no jobs were available for them, numbered 662,000 in May, also little changed from the previous month. (See Summary table A.)

Establishment Survey Data

Total **nonfarm payroll employment** increased by 2.5 million in May, reflecting a limited resumption of economic activity that had been curtailed due to the coronavirus pandemic and efforts to contain it. Employment fell by 1.4 million and 20.7 million, respectively, in March and April. Despite the over-the-month increase, nonfarm employment in May was 13 percent below its February level. Large employment increases occurred in May in leisure and hospitality, construction, education and health services, and retail trade. Government employment continued to decline sharply. (See table B-1. For more information about how the establishment survey and its measures were affected by the coronavirus pandemic, see the box note on page 6.)

In May, employment in **leisure and hospitality** increased by 1.2 million, following losses of 7.5 million in April and 743,000 in March. Over the month, employment in food services and drinking places rose by 1.4 million, accounting for about half of the gain in total nonfarm employment. May's gain in food services and drinking places followed steep declines in April and March (-6.1 million combined). In contrast, employment in the accommodation industry fell in May (-148,000) and has declined by 1.1 million since February.

Construction employment increased by 464,000 in May, gaining back almost half of April's decline (-995,000). Much of the gain occurred in specialty trade contractors (+325,000), with growth about equally split between the residential and nonresidential components. Job gains also occurred in construction of buildings (+105,000), largely in residential building.

Employment increased by 424,000 in **education and health services** in May, after a decrease of 2.6 million in April. Health care employment increased by 312,000 over the month, with gains in offices of dentists (+245,000), offices of other health practitioners (+73,000), and offices of physicians (+51,000). Elsewhere in health care, job losses continued in nursing and residential care facilities (-37,000) and hospitals (-27,000). Employment increased in the social assistance industry (+78,000), reflecting increases in child day care services (+44,000) and individual and family services (+29,000). Employment in private education rose by 33,000 over the month.

In May, employment in **retail trade** rose by 368,000, after a loss of 2.3 million in April. Over-the-month job gains occurred in clothing and clothing accessories stores (+95,000), automobile dealers (+85,000), and general merchandise stores (+84,000). By contrast, job losses continued in electronics and appliance stores (-95,000) and in auto parts, accessories, and tire stores (-36,000).

Employment increased in the **other services** industry in May (+272,000), following a decline of 1.3 million in April. About two-thirds of the May increase occurred in personal and laundry services (+182,000).

In May, **manufacturing** employment rose by 225,000, with gains about evenly split between the durable and nondurable goods components. In April, manufacturing employment declined by 1.3 million, with about two-thirds of the loss occurring in the durable goods component. Within durable goods, employment gains in May were led by motor vehicles and parts (+28,000), fabricated metal products (+25,000), and machinery (+23,000). Within nondurable goods, job gains occurred in plastics and rubber products (+30,000) and food manufacturing (+25,000).

Professional and business services added 127,000 jobs in May, after shedding 2.2 million jobs in April. Over the month, employment rose in services to buildings and dwellings (+68,000) and temporary help services (+39,000), while employment declined in management of companies and enterprises (-22,000).

Financial activities added 33,000 jobs over the month, following a loss of 264,000 jobs in April. In May, employment gains occurred in real estate and rental and leasing (+24,000) and in credit intermediation and related activities (+7,000).

Wholesale trade employment was up by 21,000 in May, largely reflecting job gains in its nondurable goods component (+13,000). In April, wholesale trade employment declined by 383,000.

In May, employment continued to decline in **government** (-585,000), following a drop of 963,000 in April. Employment in local government was down by 487,000 in May. Local government education accounted for almost two-thirds of the decrease (-310,000), reflecting school closures. Employment also continued to decline in state government (-84,000), particularly in state education (-63,000).

Employment in **information** fell by 38,000 in May, following a decline of 272,000 in April.

Mining continued to lose jobs in May (-20,000), with most of the decline occurring in support activities for mining (-16,000). Mining employment has declined by 77,000 over the past 3 months.

Employment in **transportation and warehousing** decreased in May (-19,000), after an April decline of 553,000. Air transportation lost 50,000 jobs over the month, following a loss of 79,000 jobs in April. In May, employment rose by 12,000 in couriers and messengers and 10,000 in transit and ground passenger transportation.

In May, **average hourly earnings for all employees** on private nonfarm payrolls fell by 29 cents to $29.75, following a gain of $1.35 in April. Average hourly earnings of private-sector **production and nonsupervisory employees** decreased by 14 cents to $25.00 in May. The decreases in average hourly earnings largely reflect job gains among lower-paid workers; this change put downward pressure on the average hourly earnings estimates. (See tables B-3 and B-8.)

The **average workweek for all employees** on private nonfarm payrolls increased by 0.5 hour to 34.7 hours in May. In manufacturing, the workweek rose by 0.8 hour to 38.9 hours, and overtime increased by 0.3 hour to 2.4 hours. The average workweek for **production and nonsupervisory employees** on private nonfarm payrolls increased by 0.6 hour to 34.1 hours. While employees in most industries saw an increase in their workweeks in May, the employment changes, especially in industries with shorter workweeks, complicate monthly comparisons of the average weekly hours estimates. (See tables B-2 and B-7.)

The change in total nonfarm payroll employment for March was revised down by 492,000, from -881,000 to -1.4 million, and the change for April was revised down by 150,000, from -20.5 million to -20.7 million. With these revisions, employment in March and April combined was 642,000 lower than previously reported. (Monthly revisions result from additional reports received from businesses and government agencies since the last published estimates and from the recalculation of seasonal factors. A methodological change to the establishment survey's birth-death model contributed to the revision for

March. For more information, see the box note on page 6.) After revisions, job losses have averaged 6.5 million per month over the past 3 months.

The Employment Situation for June is scheduled to be released on Thursday, July 2, 2020, at 8:30 a.m. (EDT).

Coronavirus (COVID-19) Impact on May 2020 Establishment and Household Survey Data

Data collection for both surveys was affected by the coronavirus (COVID-19) pandemic. In the establishment survey, approximately one-fifth of the data is collected at four regional data collection centers. Although these centers were closed, about three-quarters of the interviewers at these centers worked remotely to collect data by telephone. Additionally, BLS encouraged businesses to report electronically. The collection rate for the establishment survey in May was 69 percent, slightly lower than collection rates prior to the pandemic. The household survey is generally collected through in-person and telephone interviews, but personal interviews were not conducted for the safety of interviewers and respondents. The household survey response rate, at 67 percent, was about 15 percentage points lower than in months prior to the pandemic.

In the establishment survey, workers who are paid by their employer for all or any part of the pay period including the 12th of the month are counted as employed, even if they were not actually at their jobs. Workers who are temporarily or permanently absent from their jobs and are not being paid are not counted as employed, even if they are continuing to receive benefits.

The estimation methods used in the establishment survey were the same for May as they were for April. However, after further research, BLS extended the modifications that were made to the April birth-death model back to March, which accounted for a portion of the revision to March data. For more information, see www.bls.gov/cps/employment-situation-covid19-faq-may-2020.pdf .

In the household survey, individuals are classified as employed, unemployed, or not in the labor force based on their answers to a series of questions about their activities during the survey reference week (May 10th through May 16th). Workers who indicate they were not working during the entire survey reference week and expect to be recalled to their jobs should be classified as unemployed on temporary layoff. In May, a large number of persons were classified as unemployed on temporary layoff.

However, there was also a large number of workers who were classified as employed but absent from work. As was the case in March and April, household survey interviewers were instructed to classify employed persons absent from work due to coronavirus-related business closures as unemployed on temporary layoff. However, it is apparent that not all such workers were so classified. BLS and the Census Bureau are investigating why this misclassification error continues to occur and are taking additional steps to address the issue.

If the workers who were recorded as employed but absent from work due to “other reasons” (over and above the number absent for other reasons in a typical May) had been classified as unemployed on temporary layoff, the overall unemployment rate would have been about 3 percentage points higher than reported (on a not seasonally adjusted basis). However, according to usual practice, the data from the household survey are accepted as recorded. To maintain data integrity, no ad hoc actions are taken to reclassify survey responses.

More information is available at www.bls.gov/cps/employment-situation-covid19-faq-may-2020.pdf .

HOUSEHOLD DATA
Summary table A. Household data, seasonally adjusted
[Numbers in thousands]

Category	May 2019	Mar. 2020	Apr. 2020	May 2020	Change from: Apr. 2020-May 2020
Employment status					
Civilian noninstitutional population	258,861	259,758	259,896	260,047	151
Civilian labor force	162,782	162,913	156,481	158,227	1,746
Participation rate	62.9	62.7	60.2	60.8	0.6
Employed	156,844	155,772	133,403	137,242	3,839
Employment-population ratio	60.6	60.0	51.3	52.8	1.5
Unemployed	5,938	7,140	23,078	20,985	-2,093
Unemployment rate	3.6	4.4	14.7	13.3	-1.4
Not in labor force	96,079	96,845	103,415	101,820	-1,595
Unemployment rates					
Total, 16 years and over	3.6	4.4	14.7	13.3	-1.4
Adult men (20 years and over)	3.4	4.0	13.0	11.6	-1.4
Adult women (20 years and over)	3.3	4.0	15.5	13.9	-1.6
Teenagers (16 to 19 years)	12.6	14.3	31.9	29.9	-2.0
White	3.3	4.0	14.2	12.4	-1.8
Black or African American	6.2	6.7	16.7	16.8	0.1
Asian	2.5	4.1	14.5	15.0	0.5
Hispanic or Latino ethnicity	4.2	6.0	18.9	17.6	-1.3
Total, 25 years and over	2.9	3.5	13.1	11.6	-1.5
Less than a high school diploma	5.4	6.8	21.2	19.9	-1.3
High school graduates, no college	3.6	4.4	17.3	15.3	-2.0
Some college or associate degree	2.8	3.7	15.0	13.3	-1.7
Bachelor's degree and higher	2.1	2.5	8.4	7.4	-1.0
Reason for unemployment					
Job losers and persons who completed temporary jobs	2,674	3,946	20,626	18,291	-2,335
Job leavers	809	727	570	554	-16
Reentrants	1,850	1,778	1,477	1,645	168
New entrants	602	509	389	536	147
Duration of unemployment					
Less than 5 weeks	2,158	3,542	14,283	3,875	-10,408
5 to 14 weeks	1,572	1,794	7,004	14,814	7,810
15 to 26 weeks	822	808	833	1,078	245
27 weeks and over	1,298	1,164	939	1,164	225
Employed persons at work part time					
Part time for economic reasons	4,375	5,765	10,887	10,633	-254
Slack work or business conditions	2,647	4,043	9,939	9,543	-396
Could only find part-time work	1,341	1,321	697	843	146
Part time for noneconomic reasons	21,415	20,601	12,355	14,394	2,039
Persons not in the labor force					
Marginally attached to the labor force	1,475	1,426	2,281	2,394	113
Discouraged workers	388	514	574	662	88

NOTE: Persons whose ethnicity is identified as Hispanic or Latino may be of any race. Detail for the seasonally adjusted data shown in this table will not necessarily add to totals because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

ESTABLISHMENT DATA
Summary table B. Establishment data, seasonally adjusted

Category	May 2019	Mar. 2020	Apr. 2020p	May 2020p
EMPLOYMENT BY SELECTED INDUSTRY (Over-the-month change, in thousands)				
Total nonfarm	85	-1,373	-20,687	2,509
Total private	87	-1,356	-19,724	3,094
Goods-producing	11	-119	-2,373	669
Mining and logging	2	-8	-54	-20
Construction	9	-65	-995	464
Manufacturing	0	-46	-1,324	225
Durable goods[1]	0	-27	-907	119
Motor vehicles and parts	-0.1	-5.1	-359.2	27.7
Nondurable goods	0	-19	-417	106
Private service-providing	76	-1,237	-17,351	2,425
Wholesale trade	4.0	-12.0	-382.5	21.4
Retail trade	-12.3	-85.4	-2,285.8	367.8
Transportation and warehousing	3.0	-9.9	-553.3	-19.0
Utilities	1.0	-0.2	-3.6	-2.3
Information	8	-6	-272	-38
Financial activities	6	-18	-264	33
Professional and business services[1]	27	-94	-2,189	127
Temporary help services	-3.6	-51.4	-840.5	39.1
Education and health services[1]	30	-178	-2,590	424
Health care and social assistance	26.1	-134.5	-2,128.5	390.7
Leisure and hospitality	12	-743	-7,539	1,239
Other services	-3	-91	-1,272	272
Government	-2	-17	-963	-585
(3-month average change, in thousands)				
Total nonfarm	147	-303	-7,270	-6,517
Total private	135	-319	-6,953	-5,995
WOMEN AND PRODUCTION AND NONSUPERVISORY EMPLOYEES AS A PERCENT OF ALL EMPLOYEES[2]				
Total nonfarm women employees	49.9	50.0	49.2	49.2
Total private women employees	48.5	48.6	47.6	47.6
Total private production and nonsupervisory employees	82.3	82.0	80.3	80.5
HOURS AND EARNINGS ALL EMPLOYEES				
Total private				
Average weekly hours	34.4	34.1	34.2	34.7
Average hourly earnings	$27.87	$28.69	$30.04	$29.75
Average weekly earnings	$958.73	$978.33	$1,027.37	$1,032.33
Index of aggregate weekly hours (2007=100)[3]	110.6	109.9	93.3	97.3
Over-the-month percent change	0.1	-1.9	-15.1	4.3
Index of aggregate weekly payrolls (2007=100)[4]	147.3	150.7	134.0	138.4
Over-the-month percent change	0.3	-1.3	-11.1	3.3
DIFFUSION INDEX (Over 1-month span)[5]				
Total private (258 industries)	55.2	21.9	3.9	64.0
Manufacturing (76 industries)	47.4	26.3	3.3	70.4

[1] Includes other industries, not shown separately.

[2] Data relate to production employees in mining and logging and manufacturing, construction employees in construction, and nonsupervisory employees in the service-providing industries.

[3] The indexes of aggregate weekly hours are calculated by dividing the current month's estimates of aggregate hours by the corresponding annual average aggregate hours.

[4] The indexes of aggregate weekly payrolls are calculated by dividing the current month's estimates of aggregate weekly payrolls by the corresponding annual average aggregate weekly payrolls.

[5] Figures are the percent of industries with employment increasing plus one-half of the industries with unchanged employment, where 50 percent indicates an equal balance between industries with increasing and decreasing employment.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

Frequently Asked Questions about Employment and Unemployment Estimates

1. Why are there two monthly measures of employment?

The household survey and establishment survey both produce sample-based estimates of employment, and both have strengths and limitations. The establishment survey employment series has a smaller margin of error on the measurement of month-to-month change than the household survey because of its much larger sample size. An over-the-month employment change of about 100,000 is statistically significant in the establishment survey, while the threshold for a statistically significant change in the household survey is about 500,000. However, the household survey has a more expansive scope than the establishment survey because it includes self-employed workers whose businesses are unincorporated, unpaid family workers, agricultural workers, and private household workers, who are excluded by the establishment survey. The household survey also provides estimates of employment for demographic groups. For more information on the differences between the two surveys, please visit https://www.bls.gov/web/empsit/ces_cps_trends.htm.

2. Are undocumented immigrants counted in the surveys?

It is likely that both surveys include at least some undocumented immigrants. However, neither the establishment nor the household survey is designed to identify the legal status of workers. Therefore, it is not possible to determine how many are counted in either survey. The establishment survey does not collect data on the legal status of workers. The household survey does include questions which identify the foreign and native born, but it does not include questions about the legal status of the foreign born. Data on the foreign and native born are published each month in table A-7 of The Employment Situation news release.

3. Why does the establishment survey have revisions?

The establishment survey revises published estimates to improve its data series by incorporating additional information that was not available at the time of the initial publication of the estimates. The establishment survey revises its initial monthly estimates twice, in the immediately succeeding 2 months, to incorporate additional sample receipts from respondents in the survey and recalculated seasonal adjustment factors. For more information on the monthly revisions, please visit https://www.bls.gov/ces/cesrevinfo.htm.

On an annual basis, the establishment survey incorporates a benchmark revision that re-anchors estimates to nearly complete employment counts available from unemployment insurance tax records. The benchmark helps to control for sampling and modeling errors in the estimates. For more information on the annual benchmark revision, please visit https://www.bls.gov/web/empsit/cesbmart.htm.

4. Does the establishment survey sample include small firms?

Yes; about 40 percent of the establishment survey sample is comprised of business establishments with fewer than 20 employees. The establishment survey sample is designed to maximize the reliability of the statewide total nonfarm employment estimate; firms from all states, size classes, and industries are appropriately sampled to achieve that goal.

5. Does the establishment survey account for employment from new businesses?

Yes; monthly establishment survey estimates include an adjustment to account for the net employment change generated by business births and deaths. The adjustment comes from an econometric model that forecasts the monthly net jobs impact of business births and deaths based on the actual past values of the net impact that can be observed with a lag from the Quarterly Census of Employment and Wages. The establishment survey uses modeling rather than sampling for this purpose because the survey is not immediately able to bring new businesses into the sample. There is an unavoidable lag between the birth of a new firm and its appearance on the sampling frame and availability for selection. BLS adds new businesses to the survey twice a year.

6. Is the count of unemployed persons limited to just those people receiving unemployment insurance benefits?

No; the estimate of unemployment is based on a monthly sample survey of households. All persons who are without jobs and are actively seeking and available to work are included among the unemployed. (People on temporary layoff are included even if they do not actively seek work.) There is no requirement or question relating to unemployment insurance benefits in the monthly survey.

7. Does the official unemployment rate exclude people who want a job but are not currently looking for work?

Yes; however, there are separate estimates of persons outside the labor force who want a job, including those who are not currently looking because they believe no jobs are available (discouraged workers). In addition, alternative measures of labor underutilization (some of which include discouraged workers and other groups not officially counted as unemployed) are published each month in table A-15 of The Employment Situation news release. For more information about these alternative measures, please visit https://www.bls.gov/cps/lfcharacteristics.htm#altmeasures.

8. How can unusually severe weather affect employment and hours estimates?

In the establishment survey, the reference period is the pay period that includes the 12th of the month. Unusually severe weather is more likely to have an impact on average weekly hours than on employment. Average weekly hours are estimated for paid time during the pay period, including pay for holidays, sick leave, or other time off. The impact of severe weather on hours estimates typically, but not always, results in a reduction in average weekly hours. For example, some employees may be off work for part of the pay period and not receive pay for the time missed, while some workers, such as those dealing with cleanup or repair, may work extra hours.

Typically, it is not possible to precisely quantify the effect of extreme weather on payroll employment estimates. In order for severe weather conditions to reduce employment estimates, employees have to be off work without pay for the entire pay period. Employees who receive pay for any part of the pay period, even 1 hour, are counted in the payroll employment figures. For more information on how often employees are paid, please visit https://www.bls.gov/opub/btn/volume-3/how-frequently-do-private-businesses-pay-workers.htm.

In the household survey, the reference period is generally the calendar week that includes the 12th of the month. Persons who miss the entire week's work for weather-related events are counted as employed whether or not they are paid for the time off. The household survey collects data on the number of persons who had a job but were not at work due to bad weather. It also provides a measure of the number of persons who usually work full time but had reduced hours due to bad weather. Current and historical data are available on the household survey's most requested statistics page, please visit https://data.bls.gov/cgi-bin/surveymost?ln.

Technical Note

This news release presents statistics from two major surveys, the Current Population Survey (CPS; household survey) and the Current Employment Statistics survey (CES; establishment survey). The household survey provides information on the labor force, employment, and unemployment that appears in the "A" tables, marked HOUSEHOLD DATA. It is a sample survey of about 60,000 eligible households conducted by the U.S. Census Bureau for the U.S. Bureau of Labor Statistics (BLS).

The establishment survey provides information on employment, hours, and earnings of employees on nonfarm payrolls; the data appear in the "B" tables, marked ESTABLISHMENT DATA. BLS collects these data each month from the payroll records of a sample of nonagricultural business establishments. Each month the CES program surveys about 145,000 businesses and government agencies, representing approximately 697,000 individual worksites, in order to provide detailed industry data on employment, hours, and earnings of workers on nonfarm payrolls. The active sample includes approximately one-third of all nonfarm payroll jobs.

For both surveys, the data for a given month relate to a particular week or pay period. In the household survey, the reference period is generally the calendar week that contains the 12th day of the month. In the establishment survey, the reference period is the pay period including the 12th, which may or may not correspond directly to the calendar week.

Coverage, definitions, and differences between surveys

Household survey. The sample is selected to reflect the entire civilian noninstitutional population. Based on responses to a series of questions on work and job search activities, each person 16 years and over in a sample household is classified as employed, unemployed, or not in the labor force.

People are classified as *employed* if they did any work at all as paid employees during the reference week; worked in their own business, profession, or on their own farm; or worked without pay at least 15 hours in a family business or farm. People are also counted as employed if they were temporarily absent from their jobs because of illness, bad weather, vacation, labor-management disputes, or personal reasons.

People are classified as *unemployed* if they meet all of the following criteria: they had no employment during the reference week; they were available for work at that time; and they made specific active efforts to find employment sometime during the 4-week period ending with the reference week. Persons laid off from a job and expecting recall need not be looking for work to be counted as unemployed. The unemployment data derived from the household survey in no way depend upon the eligibility for or receipt of unemployment insurance benefits.

The *civilian labor force* is the sum of employed and unemployed persons. Those persons not classified as employed or unemployed are *not in the labor force*. The *unemployment rate* is the number unemployed as a percent of the labor force. The *labor force participation rate* is the labor force as a percent of the population, and the *employment-population ratio* is the employed as a percent of the population. Additional information about the household survey can be found at www.bls.gov/cps/documentation.htm.

Establishment survey. The sample establishments are drawn from private nonfarm businesses such as factories, offices, and stores, as well as from federal, state, and local government entities. *Employees on nonfarm payrolls* are those who worked or received pay for any part of the reference pay period, including persons on paid leave. Persons are counted in each job they hold. *Hours and earnings* data are produced for the private sector for all employees and for production and nonsupervisory employees. *Production and nonsupervisory* employees are defined as production and related employees in manufacturing and mining and logging, construction workers in construction, and non-supervisory employees in private service-providing industries.

Industries are classified on the basis of an establishment's principal activity in accordance with the 2017 version of the North American Industry Classification System. Additional information about the establishment survey can be found at www.bls.gov/ces/.

Differences in employment estimates. The numerous conceptual and methodological differences between the household and establishment surveys result in important distinctions in the employment estimates derived from the surveys. Among these are:

- The household survey includes agricultural workers, self-employed workers whose businesses are unincorporated, unpaid family workers, and private household workers among the employed. These groups are excluded from the establishment survey.

- The household survey includes people on unpaid leave among the employed. The establishment survey does not.

- The household survey is limited to workers 16 years of age and older. The establishment survey is not limited by age.

- The household survey has no duplication of individuals, because individuals are counted only once, even if they hold more than one job. In the establishment survey, employees working at more than one job and thus appearing on more than one payroll are counted separately for each appearance.

Seasonal adjustment

Over the course of a year, the size of the nation's labor force and the levels of employment and unemployment undergo regularly occurring fluctuations. These events may result from seasonal changes in weather, major holidays, and the opening and closing of schools. The effect of such seasonal variation can be very large.

Because these seasonal events follow a more or less regular pattern each year, their influence on the level of a series can be tempered by adjusting for regular seasonal variation. These adjustments make nonseasonal developments, such as declines in employment or increases in the participation of women in the labor force, easier to spot. For example, in the household survey, the large number of youth entering the labor force each June is likely to obscure any other changes that have taken place relative to May, making it difficult to determine if the level of economic activity has risen or declined. Similarly, in the establishment survey, payroll employment in education declines by about 20 percent at the end of the spring term and later rises with the start of the fall term, obscuring the underlying employment trends in the industry. Because seasonal employment changes at the end and beginning of the school year can be estimated, the statistics can be adjusted to make underlying employment patterns more discernable. The seasonally adjusted figures provide a more useful tool with which to analyze changes in month-to-month economic activity.

Many seasonally adjusted series are independently adjusted in both the household and establishment surveys. However, the adjusted series for many major estimates, such as total payroll employment, employment in most major sectors, total employment, and unemployment are computed by aggregating independently adjusted component series. For example, total unemployment is derived by summing the adjusted series for four major age-sex components; this differs from the unemployment estimate that would be obtained by directly adjusting the total or by combining the duration, reasons, or more detailed age categories. Percentage distributions of unemployment by reason and duration are derived from the sum of the independently seasonally adjusted component series, and will not necessarily match calculations made using the seasonally adjusted total unemployment level. Additional information about seasonal adjustment in the household survey can be found at www.bls.gov/cps/documentation.htm#sa.

For both the household and establishment surveys, a concurrent seasonal adjustment methodology is used in which new seasonal factors are calculated each month using all relevant data, up to and including the data for the current month. In the household survey, new seasonal factors are used to adjust only the current month's data. In the establishment survey, however, new seasonal factors are used each month to adjust the three most recent monthly estimates. The prior 2 months are routinely revised to incorporate additional sample reports and recalculated seasonal adjustment factors. In both surveys, 5-year revisions to historical data are made once a year.

Reliability of the estimates

Statistics based on the household and establishment surveys are subject to both sampling and nonsampling error. When a sample, rather than the entire population, is surveyed, there is a chance that the sample estimates may differ from the true population values they represent. The component of this difference that occurs because samples differ by chance is known as *sampling error*, and its variability is measured by the standard error of the estimate. There is about a 90-percent chance, or level of confidence, that an estimate based on a sample will differ by no more than 1.6 standard errors from the true population value because of sampling error. BLS analyses are generally conducted at the 90-percent level of confidence.

For example, the confidence interval for the monthly change in total nonfarm employment from the establishment survey is on the order of plus or minus 110,000. Suppose the estimate of nonfarm employment increases by 50,000 from one month to the next. The 90-percent confidence interval on the monthly change would range from -60,000 to +160,000 (50,000 +/- 110,000). These figures do not mean that the sample results are off by these magnitudes, but rather that there is about a 90-percent chance that the true over-the-month change lies within this interval. Since this range includes values of less than zero, we could not say with confidence that nonfarm employment had, in fact, increased that month. If, however, the reported nonfarm employment rise was 250,000, then all of the values within the 90-percent confidence interval would be greater than zero. In this case, it is likely (at least a 90-percent chance) that nonfarm employment had, in fact, risen that month. At an unemployment rate of around 6.0 percent, the 90-percent confidence interval for the monthly change in unemployment as measured by the household survey is about +/- 300,000, and for the monthly change in the unemployment rate it is about +/- 0.2 percentage point.

In general, estimates involving many individuals or establishments have lower standard errors (relative to the size of the estimate) than estimates which are based on a small number of observations. The precision of estimates also is improved when the data are cumulated over time, such as for quarterly and annual averages.

The household and establishment surveys are also affected by *nonsampling error*, which can occur for many reasons, including the failure to sample a segment of the population, inability to obtain information for all respondents in the sample, inability or unwillingness of respondents to provide correct information on a timely basis, mistakes made by respondents, and errors made in the collection or processing of the data.

For example, in the establishment survey, estimates for the most recent 2 months are based on incomplete returns; for this reason, these estimates are labeled preliminary in the tables. It is only after two successive revisions to a monthly estimate, when nearly all sample reports have been received, that the estimate is considered final.

Another major source of nonsampling error in the establishment survey is the inability to capture, on a timely

basis, employment generated by new firms. To correct for this systematic underestimation of employment growth, an estimation procedure with two components is used to account for business births. The first component excludes employment losses from business deaths from sample-based estimation in order to offset the missing employment gains from business births. This is incorporated into the sample-based estimation procedure by simply not reflecting sample units going out of business, but imputing to them the same employment trend as the other firms in the sample. This procedure accounts for most of the net birth/death employment.

The second component is an ARIMA time series model designed to estimate the residual net birth/death employment not accounted for by the imputation. The historical time series used to create and test the ARIMA model was derived from the unemployment insurance universe micro-level database, and reflects the actual residual net of births and deaths over the past 5 years.

The sample-based estimates from the establishment survey are adjusted once a year (on a lagged basis) to universe counts of payroll employment obtained from administrative records of the unemployment insurance program. The difference between the March sample-based employment estimates and the March universe counts is known as a benchmark revision, and serves as a rough proxy for total survey error. The new benchmarks also incorporate changes in the classification of industries. Over the past decade, absolute benchmark revisions for total nonfarm employment have averaged 0.2 percent, with a range from -0.7 percent to 0.3 percent.

Other information

Information in this release will be made available to sensory impaired individuals upon request. Voice phone: (202) 691-5200; Federal Relay Service: (800) 877-8339.

HOUSEHOLD DATA
Table A-1. Employment status of the civilian population by sex and age

[Numbers in thousands]

Employment status, sex, and age	Not seasonally adjusted			Seasonally adjusted[1]					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
TOTAL									
Civilian noninstitutional population	258,861	259,896	260,047	258,861	259,502	259,628	259,758	259,896	260,047
Civilian labor force	162,655	155,830	157,975	162,782	164,606	164,546	162,913	156,481	158,227
Participation rate	62.8	60.0	60.7	62.9	63.4	63.4	62.7	60.2	60.8
Employed	157,152	133,326	137,461	156,844	158,714	158,759	155,772	133,403	137,242
Employment-population ratio	60.7	51.3	52.9	60.6	61.2	61.1	60.0	51.3	52.8
Unemployed	5,503	22,504	20,514	5,938	5,892	5,787	7,140	23,078	20,985
Unemployment rate	3.4	14.4	13.0	3.6	3.6	3.5	4.4	14.7	13.3
Not in labor force	96,207	104,066	102,072	96,079	94,896	95,082	96,845	103,415	101,820
Persons who currently want a job	5,500	9,761	9,422	5,037	4,904	4,962	5,509	9,916	8,962
Men, 16 years and over									
Civilian noninstitutional population	125,197	125,707	125,782	125,197	125,513	125,575	125,639	125,707	125,782
Civilian labor force	86,532	82,820	83,963	86,412	87,088	87,008	86,123	83,139	83,900
Participation rate	69.1	65.9	66.8	69.0	69.4	69.3	68.5	66.1	66.7
Employed	83,561	71,810	74,004	83,213	83,940	83,871	82,357	71,916	73,702
Employment-population ratio	66.7	57.1	58.8	66.5	66.9	66.8	65.6	57.2	58.6
Unemployed	2,971	11,010	9,959	3,199	3,147	3,137	3,765	11,223	10,199
Unemployment rate	3.4	13.3	11.9	3.7	3.6	3.6	4.4	13.5	12.2
Not in labor force	38,665	42,887	41,818	38,785	38,426	38,568	39,516	42,569	41,881
Men, 20 years and over									
Civilian noninstitutional population	116,752	117,330	117,410	116,752	117,110	117,181	117,254	117,330	117,410
Civilian labor force	83,785	80,379	81,240	83,569	84,087	84,001	83,176	80,461	81,057
Participation rate	71.8	68.5	69.2	71.6	71.8	71.7	70.9	68.6	69.0
Employed	81,192	70,041	72,076	80,761	81,345	81,202	79,832	69,977	71,672
Employment-population ratio	69.5	59.7	61.4	69.2	69.5	69.3	68.1	59.6	61.0
Unemployed	2,594	10,338	9,164	2,808	2,743	2,799	3,344	10,483	9,385
Unemployment rate	3.1	12.9	11.3	3.4	3.3	3.3	4.0	13.0	11.6
Not in labor force	32,967	36,951	36,170	33,184	33,023	33,180	34,078	36,870	36,352
Women, 16 years and over									
Civilian noninstitutional population	133,664	134,189	134,265	133,664	133,988	134,053	134,119	134,189	134,265
Civilian labor force	76,122	73,010	74,011	76,370	77,518	77,538	76,790	73,343	74,327
Participation rate	57.0	54.4	55.1	57.1	57.9	57.8	57.3	54.7	55.4
Employed	73,591	61,516	63,457	73,631	74,774	74,888	73,415	61,487	63,540
Employment-population ratio	55.1	45.8	47.3	55.1	55.8	55.9	54.7	45.8	47.3
Unemployed	2,532	11,494	10,554	2,739	2,744	2,651	3,375	11,855	10,787
Unemployment rate	3.3	15.7	14.3	3.6	3.5	3.4	4.4	16.2	14.5
Not in labor force	57,542	61,179	60,254	57,294	56,470	56,514	57,329	60,847	59,938
Women, 20 years and over									
Civilian noninstitutional population	125,419	125,991	126,072	125,419	125,770	125,841	125,915	125,991	126,072
Civilian labor force	73,263	70,790	71,316	73,439	74,512	74,501	73,840	70,913	71,558
Participation rate	58.4	56.2	56.6	58.6	59.2	59.2	58.6	56.3	56.8
Employed	71,072	60,124	61,630	71,038	72,097	72,179	70,886	59,947	61,638
Employment-population ratio	56.7	47.7	48.9	56.6	57.3	57.4	56.3	47.6	48.9
Unemployed	2,191	10,666	9,686	2,401	2,415	2,323	2,954	10,966	9,920
Unemployment rate	3.0	15.1	13.6	3.3	3.2	3.1	4.0	15.5	13.9
Not in labor force	52,156	55,202	54,755	51,980	51,258	51,340	52,075	55,079	54,514
Both sexes, 16 to 19 years									
Civilian noninstitutional population	16,690	16,574	16,566	16,690	16,622	16,606	16,590	16,574	16,566
Civilian labor force	5,607	4,661	5,419	5,774	6,007	6,043	5,897	5,108	5,612
Participation rate	33.6	28.1	32.7	34.6	36.1	36.4	35.5	30.8	33.9
Employed	4,888	3,161	3,755	5,044	5,273	5,378	5,054	3,479	3,932
Employment-population ratio	29.3	19.1	22.7	30.2	31.7	32.4	30.5	21.0	23.7
Unemployed	718	1,500	1,663	730	734	665	843	1,628	1,681
Unemployment rate	12.8	32.2	30.7	12.6	12.2	11.0	14.3	31.9	29.9
Not in labor force	11,084	11,913	11,147	10,916	10,614	10,562	10,693	11,467	10,953

[1] The population figures are not adjusted for seasonal variation; therefore, identical numbers appear in the unadjusted and seasonally adjusted columns.

NOTE: Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-2. Employment status of the civilian population by race, sex, and age
[Numbers in thousands]

Employment status, race, sex, and age	Not seasonally adjusted			Seasonally adjusted[1]					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
WHITE									
Civilian noninstitutional population	200,658	201,082	201,154	200,658	200,918	200,968	201,023	201,082	201,154
Civilian labor force	126,042	120,795	122,552	126,091	127,288	127,146	126,021	121,242	122,661
Participation rate	62.8	60.1	60.9	62.8	63.4	63.3	62.7	60.3	61.0
Employed	122,269	104,083	107,761	121,970	123,332	123,189	121,042	104,065	107,499
Employment-population ratio	60.9	51.8	53.6	60.8	61.4	61.3	60.2	51.8	53.4
Unemployed	3,773	16,713	14,792	4,121	3,957	3,957	4,979	17,176	15,162
Unemployment rate	3.0	13.8	12.1	3.3	3.1	3.1	4.0	14.2	12.4
Not in labor force	74,616	80,287	78,602	74,568	73,630	73,821	75,002	79,840	78,493
Men, 20 years and over									
Civilian labor force	66,179	63,595	64,294	65,980	66,279	66,153	65,522	63,645	64,125
Participation rate	72.0	69.0	69.7	71.8	72.0	71.8	71.1	69.1	69.5
Employed	64,412	55,863	57,633	64,041	64,341	64,204	63,120	55,776	57,263
Employment-population ratio	70.1	60.6	62.5	69.7	69.9	69.7	68.5	60.5	62.1
Unemployed	1,767	7,732	6,661	1,938	1,938	1,950	2,402	7,869	6,862
Unemployment rate	2.7	12.2	10.4	2.9	2.9	2.9	3.7	12.4	10.7
Women, 20 years and over									
Civilian labor force	55,457	53,581	54,129	55,600	56,324	56,247	55,878	53,634	54,294
Participation rate	57.5	55.4	55.9	57.6	58.3	58.2	57.8	55.4	56.1
Employed	53,957	45,735	47,194	53,930	54,807	54,692	53,878	45,563	47,195
Employment-population ratio	55.9	47.3	48.8	55.9	56.7	56.6	55.7	47.1	48.8
Unemployed	1,500	7,846	6,935	1,670	1,517	1,555	2,000	8,071	7,099
Unemployment rate	2.7	14.6	12.8	3.0	2.7	2.8	3.6	15.0	13.1
Both sexes, 16 to 19 years									
Civilian labor force	4,407	3,620	4,129	4,511	4,686	4,746	4,621	3,963	4,242
Participation rate	36.0	29.8	34.0	36.8	38.4	39.0	38.0	32.6	34.9
Employed	3,900	2,485	2,934	3,999	4,184	4,294	4,043	2,727	3,041
Employment-population ratio	31.8	20.4	24.1	32.6	34.3	35.2	33.2	22.4	25.0
Unemployed	507	1,135	1,196	513	502	452	578	1,236	1,202
Unemployment rate	11.5	31.3	29.0	11.4	10.7	9.5	12.5	31.2	28.3
BLACK OR AFRICAN AMERICAN									
Civilian noninstitutional population	32,984	33,267	33,294	32,984	33,184	33,211	33,238	33,267	33,294
Civilian labor force	20,547	19,425	19,815	20,567	20,790	20,946	20,596	19,487	19,858
Participation rate	62.3	58.4	59.5	62.4	62.6	63.1	62.0	58.6	59.6
Employed	19,335	16,248	16,530	19,302	19,549	19,730	19,208	16,240	16,523
Employment-population ratio	58.6	48.8	49.6	58.5	58.9	59.4	57.8	48.8	49.6
Unemployed	1,212	3,177	3,285	1,265	1,241	1,216	1,387	3,247	3,334
Unemployment rate	5.9	16.4	16.6	6.2	6.0	5.8	6.7	16.7	16.8
Not in labor force	12,437	13,841	13,479	12,417	12,395	12,266	12,642	13,780	13,436
Men, 20 years and over									
Civilian labor force	9,444	8,856	8,979	9,418	9,445	9,499	9,477	8,880	8,970
Participation rate	68.2	63.2	64.0	68.0	67.6	68.0	67.7	63.4	63.9
Employed	8,887	7,431	7,606	8,840	8,918	8,945	8,812	7,448	7,583
Employment-population ratio	64.2	53.0	54.2	63.8	63.9	64.0	63.0	53.2	54.1
Unemployed	557	1,425	1,373	579	526	554	665	1,432	1,388
Unemployment rate	5.9	16.1	15.3	6.1	5.6	5.8	7.0	16.1	15.5
Women, 20 years and over									
Civilian labor force	10,446	9,997	10,065	10,480	10,617	10,721	10,374	9,995	10,097
Participation rate	62.7	59.4	59.7	62.9	63.3	63.8	61.7	59.4	59.9
Employed	9,949	8,413	8,439	9,947	10,067	10,207	9,830	8,351	8,426
Employment-population ratio	59.7	50.0	50.1	59.7	60.0	60.8	58.5	49.6	50.0
Unemployed	497	1,584	1,627	533	550	514	543	1,644	1,671
Unemployment rate	4.8	15.8	16.2	5.1	5.2	4.8	5.2	16.4	16.5
Both sexes, 16 to 19 years									
Civilian labor force	657	573	771	669	728	725	745	612	791
Participation rate	26.7	23.6	31.8	27.1	29.8	29.8	30.7	25.2	32.7
Employed	499	405	485	516	564	578	566	441	515
Employment-population ratio	20.3	16.7	20.0	20.9	23.1	23.7	23.3	18.2	21.3
Unemployed	158	168	285	153	164	148	180	171	276
Unemployment rate	24.0	29.4	37.0	22.9	22.5	20.4	24.1	28.0	34.9

See footnotes at end of table.

HOUSEHOLD DATA
Table A-2. Employment status of the civilian population by race, sex, and age — Continued

[Numbers in thousands]

Employment status, race, sex, and age	Not seasonally adjusted			Seasonally adjusted[1]					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
ASIAN									
Civilian noninstitutional population	16,361	16,363	16,385	16,361	16,178	16,421	16,419	16,363	16,385
Civilian labor force	10,290	9,893	9,932	10,317	10,332	10,574	10,470	9,938	9,968
Participation rate	62.9	60.5	60.6	63.1	63.9	64.4	63.8	60.7	60.8
Employed	10,049	8,476	8,462	10,057	10,017	10,312	10,037	8,499	8,475
Employment-population ratio	61.4	51.8	51.6	61.5	61.9	62.8	61.1	51.9	51.7
Unemployed	240	1,418	1,470	260	315	262	433	1,438	1,493
Unemployment rate	2.3	14.3	14.8	2.5	3.0	2.5	4.1	14.5	15.0
Not in labor force	6,072	6,470	6,453	6,045	5,847	5,848	5,948	6,425	6,417

[1] The population figures are not adjusted for seasonal variation; therefore, identical numbers appear in the unadjusted and seasonally adjusted columns.

NOTE: Estimates for the above race groups will not sum to totals shown in table A-1 because data are not presented for all races. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-3. Employment status of the Hispanic or Latino population by sex and age

[Numbers in thousands]

Employment status, sex, and age	Not seasonally adjusted			Seasonally adjusted[1]					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
HISPANIC OR LATINO ETHNICITY									
Civilian noninstitutional population	43,370	43,975	44,053	43,370	43,742	43,820	43,895	43,975	44,053
Civilian labor force	28,680	27,752	28,173	28,704	29,672	29,852	29,443	27,841	28,218
Participation rate	66.1	63.1	64.0	66.2	67.8	68.1	67.1	63.3	64.1
Employed	27,608	22,625	23,321	27,507	28,397	28,531	27,672	22,579	23,241
Employment-population ratio	63.7	51.5	52.9	63.4	64.9	65.1	63.0	51.3	52.8
Unemployed	1,072	5,126	4,852	1,197	1,275	1,322	1,771	5,263	4,977
Unemployment rate	3.7	18.5	17.2	4.2	4.3	4.4	6.0	18.9	17.6
Not in labor force	14,690	16,223	15,880	14,666	14,070	13,968	14,452	16,133	15,834
Men, 20 years and over									
Civilian labor force	15,732	15,319	15,496	15,728	16,114	16,035	15,844	15,337	15,493
Participation rate	80.4	77.2	77.9	80.3	81.6	81.1	80.0	77.2	77.9
Employed	15,248	12,817	13,217	15,185	15,571	15,519	15,037	12,776	13,154
Employment-population ratio	77.9	64.6	66.5	77.6	78.9	78.5	75.9	64.3	66.1
Unemployed	483	2,502	2,279	543	543	516	807	2,561	2,338
Unemployment rate	3.1	16.3	14.7	3.5	3.4	3.2	5.1	16.7	15.1
Women, 20 years and over									
Civilian labor force	11,816	11,341	11,490	11,821	12,242	12,441	12,245	11,348	11,510
Participation rate	59.6	56.4	57.0	59.7	61.2	62.1	61.0	56.4	57.1
Employed	11,381	9,090	9,350	11,341	11,701	11,834	11,507	9,060	9,326
Employment-population ratio	57.4	45.2	46.4	57.2	58.5	59.1	57.3	45.0	46.3
Unemployed	436	2,251	2,140	480	541	607	738	2,288	2,184
Unemployment rate	3.7	19.8	18.6	4.1	4.4	4.9	6.0	20.2	19.0
Both sexes, 16 to 19 years									
Civilian labor force	1,132	1,092	1,187	1,154	1,316	1,377	1,354	1,157	1,216
Participation rate	28.4	27.3	29.6	29.0	32.9	34.4	33.8	28.9	30.3
Employed	979	719	754	981	1,125	1,177	1,128	743	761
Employment-population ratio	24.6	18.0	18.8	24.6	28.1	29.4	28.2	18.6	19.0
Unemployed	153	373	433	174	191	199	225	414	454
Unemployment rate	13.5	34.2	36.5	15.0	14.5	14.5	16.7	35.8	37.4

[1] The population figures are not adjusted for seasonal variation; therefore, identical numbers appear in the unadjusted and seasonally adjusted columns.

NOTE: Persons whose ethnicity is identified as Hispanic or Latino may be of any race. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-4. Employment status of the civilian population 25 years and over by educational attainment

[Numbers in thousands]

Educational attainment	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
Less than a high school diploma									
Civilian labor force	10,143	8,688	8,450	9,915	9,621	9,710	9,251	8,595	8,212
Participation rate	45.6	43.3	43.1	44.6	45.9	47.8	45.7	42.8	41.9
Employed	9,692	6,872	6,887	9,383	9,090	9,160	8,626	6,774	6,577
Employment-population ratio	43.6	34.2	35.1	42.2	43.4	45.1	42.6	33.7	33.5
Unemployed	451	1,816	1,563	532	531	550	625	1,821	1,634
Unemployment rate	4.4	20.9	18.5	5.4	5.5	5.7	6.8	21.2	19.9
High school graduates, no college[1]									
Civilian labor force	35,840	33,203	33,756	35,830	36,230	36,309	35,232	33,252	33,792
Participation rate	57.5	54.5	55.0	57.5	58.7	58.3	57.4	54.6	55.0
Employed	34,664	27,557	28,708	34,552	34,861	34,986	33,687	27,505	28,605
Employment-population ratio	55.6	45.2	46.8	55.4	56.5	56.2	54.9	45.1	46.6
Unemployed	1,176	5,646	5,048	1,278	1,369	1,323	1,545	5,747	5,187
Unemployment rate	3.3	17.0	15.0	3.6	3.8	3.6	4.4	17.3	15.3
Some college or associate degree									
Civilian labor force	37,559	35,935	36,278	37,642	37,283	37,325	37,381	35,860	36,381
Participation rate	65.2	62.6	63.1	65.3	64.6	64.8	64.7	62.5	63.3
Employed	36,612	30,634	31,581	36,600	36,243	36,209	36,013	30,485	31,559
Employment-population ratio	63.6	53.4	54.9	63.5	62.8	62.9	62.3	53.1	54.9
Unemployed	947	5,301	4,697	1,042	1,040	1,116	1,368	5,376	4,821
Unemployment rate	2.5	14.8	12.9	2.8	2.8	3.0	3.7	15.0	13.3
Bachelor's degree and higher[2]									
Civilian labor force	58,145	60,075	60,269	58,217	60,176	59,894	60,487	60,127	60,442
Participation rate	73.7	71.5	71.7	73.8	73.7	73.1	73.0	71.6	71.9
Employed	57,007	55,151	55,933	56,973	59,002	58,736	59,000	55,084	55,992
Employment-population ratio	72.2	65.7	66.6	72.2	72.3	71.7	71.2	65.6	66.6
Unemployed	1,137	4,924	4,336	1,244	1,174	1,158	1,487	5,043	4,450
Unemployment rate	2.0	8.2	7.2	2.1	2.0	1.9	2.5	8.4	7.4

[1] Includes persons with a high school diploma or equivalent.

[2] Includes persons with bachelor's, master's, professional, and doctoral degrees.

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to totals for those 25 years and over because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-5. Employment status of the civilian population 18 years and over by veteran status, period of service, and sex, not seasonally adjusted

[Numbers in thousands]

Employment status, veteran status, and period of service	Total		Men		Women	
	May 2019	May 2020	May 2019	May 2020	May 2019	May 2020
VETERANS, 18 years and over						
Civilian noninstitutional population	18,870	18,516	16,989	16,615	1,881	1,901
Civilian labor force	9,267	8,934	8,223	7,861	1,044	1,073
Participation rate	49.1	48.2	48.4	47.3	55.5	56.4
Employed	9,014	8,134	7,998	7,145	1,016	989
Employment-population ratio	47.8	43.9	47.1	43.0	54.0	52.0
Unemployed	253	800	225	716	29	84
Unemployment rate	2.7	9.0	2.7	9.1	2.7	7.8
Not in labor force	9,603	9,582	8,766	8,754	837	828
Gulf War-era II veterans						
Civilian noninstitutional population	4,302	4,511	3,595	3,755	707	756
Civilian labor force	3,464	3,570	2,992	3,088	472	482
Participation rate	80.5	79.1	83.2	82.2	66.7	63.8
Employed	3,367	3,202	2,910	2,768	457	434
Employment-population ratio	78.3	71.0	80.9	73.7	64.6	57.4
Unemployed	97	369	82	320	15	49
Unemployment rate	2.8	10.3	2.8	10.4	3.1	10.1
Not in labor force	838	941	603	667	235	274
Gulf War-era I veterans						
Civilian noninstitutional population	3,078	3,031	2,562	2,529	516	502
Civilian labor force	2,337	2,252	2,014	1,903	323	349
Participation rate	75.9	74.3	78.6	75.2	62.7	69.6
Employed	2,287	2,144	1,967	1,813	320	331
Employment-population ratio	74.3	70.7	76.8	71.7	62.0	66.0
Unemployed	50	108	47	90	3	18
Unemployment rate	2.1	4.8	2.3	4.7	1.0	5.2
Not in labor force	741	779	548	626	193	153
World War II, Korean War, and Vietnam-era veterans						
Civilian noninstitutional population	7,263	6,875	7,013	6,635	250	240
Civilian labor force	1,465	1,224	1,406	1,194	60	31
Participation rate	20.2	17.8	20.0	18.0	23.9	12.7
Employed	1,425	1,079	1,369	1,056	56	22
Employment-population ratio	19.6	15.7	19.5	15.9	22.3	9.4
Unemployed	40	145	36	137	4	8
Unemployment rate	2.7	11.9	2.6	11.5	–	–
Not in labor force	5,798	5,651	5,607	5,441	190	209
Veterans of other service periods						
Civilian noninstitutional population	4,227	4,099	3,819	3,696	408	403
Civilian labor force	2,001	1,887	1,812	1,677	189	210
Participation rate	47.3	46.0	47.4	45.4	46.4	52.2
Employed	1,935	1,710	1,752	1,508	183	201
Employment-population ratio	45.8	41.7	45.9	40.8	44.8	50.0
Unemployed	66	178	60	169	7	9
Unemployment rate	3.3	9.4	3.3	10.1	3.4	4.3
Not in labor force	2,226	2,212	2,007	2,019	219	193
NONVETERANS, 18 years and over						
Civilian noninstitutional population	231,312	232,888	103,735	104,870	127,577	128,018
Civilian labor force	151,517	147,156	77,350	75,234	74,166	71,923
Participation rate	65.5	63.2	74.6	71.7	58.1	56.2
Employed	146,537	128,043	74,764	66,250	71,773	61,793
Employment-population ratio	63.4	55.0	72.1	63.2	56.3	48.3
Unemployed	4,980	19,113	2,586	8,984	2,394	10,129
Unemployment rate	3.3	13.0	3.3	11.9	3.2	14.1
Not in labor force	79,795	85,732	26,384	29,637	53,410	56,095

NOTE: Veterans served on active duty in the U.S. Armed Forces and were not on active duty at the time of the survey. Nonveterans never served on active duty in the U.S. Armed Forces. Veterans could have served anywhere in the world during these periods of service: Gulf War era II (September 2001-present), Gulf War era I (August 1990-August 2001), Vietnam era (August 1964-April 1975), Korean War (July 1950-January 1955), World War II (December 1941-December 1946), and other service periods (all other time periods). Veterans who served in more than one wartime period are classified only in the most recent one. Veterans who served during one of the selected wartime periods and another period are classified only in the wartime period. Dash indicates no data or data that do not meet publication criteria (values not shown where base is less than 75,000). Updated population controls introduced with the release of January 2020 data.

HOUSEHOLD DATA
Table A-6. Employment status of the civilian population by sex, age, and disability status, not seasonally adjusted

[Numbers in thousands]

Employment status, sex, and age	Persons with a disability		Persons with no disability	
	May 2019	May 2020	May 2019	May 2020
TOTAL, 16 years and over				
Civilian noninstitutional population	30,764	29,761	228,097	230,286
Civilian labor force	6,326	6,064	156,328	151,910
Participation rate	20.6	20.4	68.5	66.0
Employed	5,929	4,976	151,223	132,485
Employment-population ratio	19.3	16.7	66.3	57.5
Unemployed	397	1,088	5,106	19,426
Unemployment rate	6.3	17.9	3.3	12.8
Not in labor force	24,438	23,696	71,769	78,376
Men, 16 to 64 years				
Civilian labor force	2,707	2,738	77,968	75,633
Participation rate	36.1	36.8	82.8	80.5
Employed	2,514	2,249	75,323	66,766
Employment-population ratio	33.6	30.2	80.0	71.1
Unemployed	193	489	2,645	8,866
Unemployment rate	7.1	17.8	3.4	11.7
Not in labor force	4,781	4,709	16,141	18,313
Women, 16 to 64 years				
Civilian labor force	2,371	2,245	69,079	67,264
Participation rate	29.6	31.5	71.5	69.2
Employed	2,238	1,790	66,819	57,888
Employment-population ratio	28.0	25.1	69.1	59.6
Unemployed	133	455	2,260	9,375
Unemployment rate	5.6	20.3	3.3	13.9
Not in labor force	5,633	4,891	27,596	29,943
Both sexes, 65 years and over				
Civilian labor force	1,248	1,081	9,282	9,014
Participation rate	8.2	7.1	24.9	23.0
Employed	1,177	937	9,080	7,830
Employment-population ratio	7.7	6.2	24.3	20.0
Unemployed	71	145	202	1,184
Unemployment rate	5.7	13.4	2.2	13.1
Not in labor force	14,024	14,096	28,032	30,120

NOTE: A person with a disability has at least one of the following conditions: is deaf or has serious difficulty hearing; is blind or has serious difficulty seeing even when wearing glasses; has serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition; has serious difficulty walking or climbing stairs; has difficulty dressing or bathing; or has difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-7. Employment status of the civilian population by nativity and sex, not seasonally adjusted

[Numbers in thousands]

Employment status and nativity	Total		Men		Women	
	May 2019	May 2020	May 2019	May 2020	May 2019	May 2020
Foreign born, 16 years and over						
Civilian noninstitutional population	43,408	42,496	20,918	20,354	22,490	22,142
Civilian labor force	28,473	26,622	16,347	15,276	12,126	11,346
Participation rate	65.6	62.6	78.1	75.1	53.9	51.2
Employed	27,678	22,434	15,976	13,178	11,702	9,256
Employment-population ratio	63.8	52.8	76.4	64.7	52.0	41.8
Unemployed	795	4,188	371	2,098	424	2,090
Unemployment rate	2.8	15.7	2.3	13.7	3.5	18.4
Not in labor force	14,935	15,874	4,571	5,078	10,364	10,796
Native born, 16 years and over						
Civilian noninstitutional population	215,453	217,551	104,279	105,428	111,174	112,123
Civilian labor force	134,182	131,353	70,186	68,688	63,996	62,665
Participation rate	62.3	60.4	67.3	65.2	57.6	55.9
Employed	129,474	115,027	67,586	60,826	61,889	54,201
Employment-population ratio	60.1	52.9	64.8	57.7	55.7	48.3
Unemployed	4,707	16,326	2,600	7,861	2,107	8,465
Unemployment rate	3.5	12.4	3.7	11.4	3.3	13.5
Not in labor force	81,271	86,198	34,094	36,740	47,178	49,458

NOTE: The foreign born are those residing in the United States who were not U.S. citizens at birth. That is, they were born outside the United States or one of its outlying areas such as Puerto Rico or Guam, to parents neither of whom was a U.S. citizen. The native born are persons who were born in the United States or one of its outlying areas such as Puerto Rico or Guam or who were born abroad of at least one parent who was a U.S. citizen. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-8. Employed persons by class of worker and part-time status

[In thousands]

Category	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
CLASS OF WORKER									
Agriculture and related industries	2,476	2,303	2,365	2,423	2,412	2,466	2,399	2,424	2,341
Wage and salary workers[1]	1,744	1,585	1,568	1,713	1,750	1,829	1,715	1,695	1,568
Self-employed workers, unincorporated	706	693	764	694	647	645	660	701	738
Unpaid family workers	25	25	33	–	–	–	–	–	–
Nonagricultural industries	154,677	131,023	135,096	154,486	156,337	156,283	153,359	131,052	134,965
Wage and salary workers[1]	145,859	123,485	127,045	145,718	147,467	147,347	144,494	123,401	126,942
Government	20,992	19,485	19,879	20,776	21,390	20,943	21,081	19,156	19,692
Private industries	124,867	104,001	107,166	124,904	126,042	126,282	123,412	104,200	107,228
Private households	807	492	498	–	–	–	–	–	–
Other industries	124,060	103,509	106,667	124,090	125,234	125,487	122,693	103,713	106,723
Self-employed workers, unincorporated	8,786	7,514	8,010	8,724	8,808	8,897	8,818	7,544	7,945
Unpaid family workers	31	23	41	–	–	–	–	–	–
PERSONS AT WORK PART TIME[2]									
All industries									
Part time for economic reasons[3]	4,160	10,684	10,429	4,375	4,182	4,318	5,765	10,887	10,633
Slack work or business conditions	2,490	9,843	9,369	2,647	2,655	2,776	4,043	9,939	9,543
Could only find part-time work	1,383	728	892	1,341	1,294	1,317	1,321	697	843
Part time for noneconomic reasons[4]	21,672	13,149	14,669	21,415	22,154	22,175	20,601	12,355	14,394
Nonagricultural industries									
Part time for economic reasons[3]	4,070	10,524	10,286	4,269	4,091	4,225	5,681	10,730	10,485
Slack work or business conditions	2,423	9,694	9,237	2,569	2,580	2,719	3,965	9,780	9,408
Could only find part-time work	1,379	723	888	1,334	1,308	1,313	1,312	695	836
Part time for noneconomic reasons[4]	21,321	12,779	14,289	21,075	21,784	21,770	20,236	11,971	14,009

[1] Includes self-employed workers whose businesses are incorporated.

[2] Refers to those who worked 1 to 34 hours during the survey reference week and excludes employed persons who were absent from their jobs for the entire week.

[3] Refers to those who worked 1 to 34 hours during the reference week for an economic reason such as slack work or unfavorable business conditions, inability to find full-time work, or seasonal declines in demand.

[4] Refers to persons who usually work part time for noneconomic reasons such as childcare problems, family or personal obligations, school or training, retirement or Social Security limits on earnings, and other reasons. This excludes persons who usually work full time but worked only 1 to 34 hours during the reference week for reasons such as vacations, holidays, illness, and bad weather.

- Data not available.

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to totals because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-9. Selected employment indicators
[Numbers in thousands]

Characteristic	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
AGE AND SEX									
Total, 16 years and over	157,152	133,326	137,461	156,844	158,714	158,759	155,772	133,403	137,242
16 to 19 years	4,888	3,161	3,755	5,044	5,273	5,378	5,054	3,479	3,932
16 to 17 years	1,601	1,101	1,284	1,711	1,949	1,972	1,800	1,302	1,420
18 to 19 years	3,287	2,060	2,471	3,308	3,311	3,401	3,269	2,154	2,495
20 years and over	152,264	130,165	133,706	151,799	153,441	153,381	150,719	129,924	133,310
20 to 24 years	14,288	9,951	10,596	14,309	14,214	14,278	13,428	10,023	10,608
25 years and over	137,975	120,214	123,109	137,468	139,215	139,188	137,392	119,906	122,691
25 to 54 years	100,933	87,910	90,147	100,662	101,487	101,426	100,313	87,769	89,943
25 to 34 years	35,703	30,456	31,356	35,628	36,129	36,123	35,501	30,453	31,299
35 to 44 years	33,080	29,658	30,163	32,989	33,412	33,402	33,168	29,607	30,088
45 to 54 years	32,150	27,796	28,628	32,045	31,945	31,901	31,644	27,709	28,555
55 years and over	37,042	32,304	32,963	36,806	37,728	37,762	37,079	32,137	32,748
Men, 16 years and over	83,561	71,810	74,004	83,213	83,940	83,871	82,357	71,916	73,702
16 to 19 years	2,370	1,769	1,928	2,452	2,596	2,669	2,525	1,939	2,030
16 to 17 years	799	566	609	843	860	891	817	632	659
18 to 19 years	1,571	1,203	1,319	1,604	1,733	1,784	1,715	1,277	1,355
20 years and over	81,192	70,041	72,076	80,761	81,345	81,202	79,832	69,977	71,672
20 to 24 years	7,313	5,183	5,475	7,291	7,307	7,272	6,818	5,222	5,445
25 years and over	73,879	64,858	66,601	73,507	74,057	73,982	73,159	64,758	66,271
25 to 54 years	53,919	47,282	48,647	53,720	53,840	53,770	53,374	47,236	48,488
25 to 34 years	19,225	16,390	16,869	19,170	19,145	19,175	19,002	16,396	16,822
35 to 44 years	17,837	16,090	16,408	17,760	17,884	17,874	17,790	16,049	16,335
45 to 54 years	16,856	14,803	15,370	16,790	16,810	16,720	16,582	14,792	15,330
55 years and over	19,960	17,575	17,954	19,787	20,217	20,213	19,785	17,522	17,783
Women, 16 years and over	73,591	61,516	63,457	73,631	74,774	74,888	73,415	61,487	63,540
16 to 19 years	2,518	1,392	1,827	2,592	2,677	2,709	2,529	1,541	1,902
16 to 17 years	802	536	675	868	1,089	1,081	983	670	761
18 to 19 years	1,716	856	1,152	1,704	1,578	1,616	1,554	877	1,140
20 years and over	71,072	60,124	61,630	71,038	72,097	72,179	70,886	59,947	61,638
20 to 24 years	6,976	4,768	5,122	7,018	6,907	7,006	6,610	4,801	5,163
25 years and over	64,097	55,356	56,508	63,962	65,158	65,206	64,232	55,147	56,420
25 to 54 years	47,014	40,627	41,499	46,942	47,647	47,657	46,939	40,533	41,455
25 to 34 years	16,477	14,066	14,487	16,458	16,984	16,949	16,499	14,058	14,478
35 to 44 years	15,242	13,568	13,755	15,229	15,528	15,528	15,378	13,558	13,753
45 to 54 years	15,294	12,993	13,257	15,255	15,135	15,180	15,062	12,917	13,225
55 years and over	17,082	14,729	15,009	17,019	17,510	17,549	17,293	14,615	14,964
MARITAL STATUS									
Married men, spouse present[1]	46,041	41,843	43,039	45,805	46,257	46,067	45,920	41,683	42,822
Married women, spouse present[1]	36,167	32,034	33,079	36,017	36,869	36,597	36,353	31,860	32,978
Women who maintain families[2]	9,680	7,908	7,768	–	–	–	–	–	–
FULL- OR PART-TIME STATUS									
Full-time workers[3]	130,059	113,656	116,620	129,830	131,099	131,109	129,298	114,322	116,523
Part-time workers[4]	27,093	19,670	20,841	26,974	27,529	27,726	26,553	19,106	20,741
MULTIPLE JOBHOLDERS									
Total multiple jobholders	7,857	5,360	5,509	7,937	8,152	8,070	7,268	5,451	5,598
Percent of total employed	5.0	4.0	4.0	5.1	5.1	5.1	4.7	4.1	4.1
SELF-EMPLOYMENT									
Self-employed workers, incorporated	6,061	6,405	6,249	–	–	–	–	–	–
Self-employed workers, unincorporated	9,493	8,207	8,773	9,417	9,455	9,542	9,478	8,245	8,682

[1] Beginning with data for January 2020, refers to persons in both opposite-sex and same-sex married couples. Prior to January 2020, referred to persons in opposite-sex married couples only.

[2] Beginning with data for January 2020, refers to female householders residing with one or more family members, but not a spouse of either sex. Prior to January 2020, referred to female householders residing with one or more family members, but not an opposite-sex spouse.

[3] Employed full-time workers are persons who usually work 35 hours or more per week.

[4] Employed part-time workers are persons who usually work less than 35 hours per week.

- Data not available.

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to totals because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-10. Selected unemployment indicators, seasonally adjusted

Characteristic	Number of unemployed persons (in thousands)			Unemployment rates					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
AGE AND SEX									
Total, 16 years and over	5,938	23,078	20,985	3.6	3.6	3.5	4.4	14.7	13.3
16 to 19 years	730	1,628	1,681	12.6	12.2	11.0	14.3	31.9	29.9
16 to 17 years	278	496	613	14.0	11.8	9.8	16.4	27.6	30.1
18 to 19 years	447	1,126	1,058	11.9	12.5	12.0	12.8	34.3	29.8
20 years and over	5,208	21,449	19,305	3.3	3.3	3.2	4.0	14.2	12.6
20 to 24 years	1,076	3,466	3,207	7.0	6.6	6.4	8.7	25.7	23.2
25 years and over	4,104	18,008	16,107	2.9	2.9	2.9	3.5	13.1	11.6
25 to 54 years	3,055	12,909	11,708	2.9	3.0	3.0	3.6	12.8	11.5
25 to 34 years	1,304	5,176	4,857	3.5	3.7	3.7	4.1	14.5	13.4
35 to 44 years	909	3,849	3,414	2.7	2.8	2.8	3.4	11.5	10.2
45 to 54 years	843	3,884	3,436	2.6	2.5	2.5	3.2	12.3	10.7
55 years and over	1,037	5,071	4,398	2.7	2.6	2.6	3.3	13.6	11.8
Men, 16 years and over	3,199	11,223	10,199	3.7	3.6	3.6	4.4	13.5	12.2
16 to 19 years	391	739	814	13.8	13.5	11.2	14.3	27.6	28.6
16 to 17 years	156	168	254	15.6	14.4	10.8	14.8	21.0	27.8
18 to 19 years	235	567	555	12.8	12.9	12.0	13.4	30.8	29.1
20 years and over	2,808	10,483	9,385	3.4	3.3	3.3	4.0	13.0	11.6
20 to 24 years	657	1,601	1,576	8.3	6.8	6.7	9.1	23.5	22.4
25 years and over	2,128	8,886	7,814	2.8	2.9	3.0	3.5	12.1	10.5
25 to 54 years	1,608	6,477	5,773	2.9	3.0	3.1	3.5	12.1	10.6
25 to 34 years	680	2,711	2,512	3.4	3.9	3.9	4.2	14.2	13.0
35 to 44 years	478	1,870	1,709	2.6	2.6	2.8	3.2	10.4	9.5
45 to 54 years	450	1,896	1,552	2.6	2.5	2.5	3.1	11.4	9.2
55 years and over	520	2,409	2,040	2.6	2.6	2.7	3.4	12.1	10.3
Women, 16 years and over	2,739	11,855	10,787	3.6	3.5	3.4	4.4	16.2	14.5
16 to 19 years	338	889	867	11.5	11.0	10.8	14.3	36.6	31.3
16 to 17 years	123	328	358	12.4	9.6	8.9	17.8	32.9	32.0
18 to 19 years	212	558	503	11.1	12.1	12.0	12.1	38.9	30.6
20 years and over	2,401	10,966	9,920	3.3	3.2	3.1	4.0	15.5	13.9
20 to 24 years	419	1,865	1,631	5.6	6.5	6.1	8.3	28.0	24.0
25 years and over	1,976	9,122	8,293	3.0	2.9	2.8	3.5	14.2	12.8
25 to 54 years	1,448	6,432	5,934	3.0	3.0	2.9	3.6	13.7	12.5
25 to 34 years	624	2,464	2,346	3.7	3.5	3.4	4.0	14.9	13.9
35 to 44 years	431	1,979	1,705	2.8	2.9	2.8	3.6	12.7	11.0
45 to 54 years	393	1,988	1,884	2.5	2.5	2.6	3.3	13.3	12.5
55 years and over	537	2,671	2,358	3.1	2.4	2.4	3.3	15.5	13.6
MARITAL STATUS									
Married men, spouse present[1]	813	4,457	3,858	1.7	1.7	2.0	2.3	9.7	8.3
Married women, spouse present[1]	873	4,811	4,292	2.4	2.1	2.2	3.0	13.1	11.5
Women who maintain families[2]	483	1,495	1,461	4.7	5.4	4.1	5.3	15.9	15.8
FULL- OR PART-TIME STATUS									
Full-time workers[3]	4,780	16,885	15,897	3.6	3.5	3.5	4.1	12.9	12.0
Part-time workers[4]	1,173	6,194	5,090	4.2	4.1	3.7	6.1	24.5	19.7

[1] Beginning with data for January 2020, refers to persons in both opposite-sex and same-sex married couples. Prior to January 2020, referred to persons in opposite-sex married couples only.

[2] Data are not seasonally adjusted. Beginning with data for January 2020, refers to female householders residing with one or more family members, but not a spouse of either sex. Prior to January 2020, referred to female householders residing with one or more family members, but not an opposite-sex spouse.

[3] Full-time workers are unemployed persons who have expressed a desire to work full time (35 hours or more per week) or are on layoff from full-time jobs.

[4] Part-time workers are unemployed persons who have expressed a desire to work part time (less than 35 hours per week) or are on layoff from part-time jobs.

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to totals because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-11. Unemployed persons by reason for unemployment

[Numbers in thousands]

Reason	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
NUMBER OF UNEMPLOYED									
Job losers and persons who completed temporary jobs	2,281	20,384	17,834	2,674	2,665	2,723	3,946	20,626	18,291
On temporary layoff	594	17,878	15,034	865	742	801	1,848	18,063	15,343
Not on temporary layoff	1,687	2,506	2,801	1,810	1,923	1,922	2,099	2,563	2,948
Permanent job losers	1,229	1,951	2,206	1,300	1,289	1,279	1,456	2,000	2,295
Persons who completed temporary jobs	458	555	595	510	634	644	643	563	653
Job leavers	774	520	513	809	836	777	727	570	554
Reentrants	1,891	1,329	1,674	1,850	1,838	1,803	1,778	1,477	1,645
New entrants	557	271	492	602	557	505	509	389	536
PERCENT DISTRIBUTION									
Job losers and persons who completed temporary jobs	41.5	90.6	86.9	45.1	45.2	46.9	56.7	89.4	87.0
On temporary layoff	10.8	79.4	73.3	14.6	12.6	13.8	26.5	78.3	73.0
Not on temporary layoff	30.7	11.1	13.7	30.5	32.6	33.1	30.2	11.1	14.0
Job leavers	14.1	2.3	2.5	13.6	14.2	13.4	10.5	2.5	2.6
Reentrants	34.4	5.9	8.2	31.2	31.2	31.0	25.5	6.4	7.8
New entrants	10.1	1.2	2.4	10.1	9.4	8.7	7.3	1.7	2.5
UNEMPLOYED AS A PERCENT OF THE CIVILIAN LABOR FORCE									
Job losers and persons who completed temporary jobs	1.4	13.1	11.3	1.6	1.6	1.7	2.4	13.2	11.6
Job leavers	0.5	0.3	0.3	0.5	0.5	0.5	0.4	0.4	0.4
Reentrants	1.2	0.9	1.1	1.1	1.1	1.1	1.1	0.9	1.0
New entrants	0.3	0.2	0.3	0.4	0.3	0.3	0.3	0.2	0.3

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to total unemployed in table A-1 because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-12. Unemployed persons by duration of unemployment

[Numbers in thousands]

Duration	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
NUMBER OF UNEMPLOYED									
Less than 5 weeks	2,082	13,880	3,835	2,158	2,059	2,013	3,542	14,283	3,875
5 to 14 weeks	1,261	6,728	14,401	1,572	1,755	1,803	1,794	7,004	14,814
15 weeks and over	2,159	1,897	2,278	2,120	2,053	1,927	1,971	1,772	2,242
15 to 26 weeks	888	968	1,146	822	887	825	808	833	1,078
27 weeks and over	1,271	929	1,132	1,298	1,166	1,102	1,164	939	1,164
Average (mean) duration, in weeks	24.8	7.7	10.9	24.1	21.9	20.9	17.1	6.1	9.9
Median duration, in weeks	9.7	4.0	8.0	9.1	9.3	9.1	7.0	2.0	7.7
PERCENT DISTRIBUTION									
Less than 5 weeks	37.8	61.7	18.7	36.9	35.1	35.1	48.5	61.9	18.5
5 to 14 weeks	22.9	29.9	70.2	26.9	29.9	31.4	24.5	30.4	70.8
15 weeks and over	39.2	8.4	11.1	36.2	35.0	33.6	27.0	7.7	10.7
15 to 26 weeks	16.1	4.3	5.6	14.0	15.1	14.4	11.1	3.6	5.2
27 weeks and over	23.1	4.1	5.5	22.2	19.9	19.2	15.9	4.1	5.6

NOTE: Detail for the seasonally adjusted data shown in this table will not necessarily add to total unemployed in table A-1 because of the independent seasonal adjustment of the various series. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-13. Employed and unemployed persons by occupation, not seasonally adjusted

[Numbers in thousands]

Occupation	Employed		Unemployed		Unemployment rates	
	May 2019	May 2020	May 2019	May 2020	May 2019	May 2020
Total, 16 years and over[1]	157,152	137,461	5,503	20,514	3.4	13.0
Management, professional, and related occupations	63,594	62,330	1,086	4,432	1.7	6.6
Management, business, and financial operations occupations	26,534	26,592	398	1,432	1.5	5.1
Professional and related occupations	37,060	35,738	688	3,000	1.8	7.7
Service occupations	27,390	19,087	1,140	5,884	4.0	23.6
Sales and office occupations	32,997	26,931	1,316	4,360	3.8	13.9
Sales and related occupations	15,429	12,434	582	2,412	3.6	16.2
Office and administrative support occupations	17,568	14,497	735	1,948	4.0	11.8
Natural resources, construction, and maintenance occupations	14,355	12,362	560	1,876	3.8	13.2
Farming, fishing, and forestry occupations	1,330	1,118	93	101	6.6	8.3
Construction and extraction occupations	8,123	6,872	314	1,232	3.7	15.2
Installation, maintenance, and repair occupations	4,901	4,372	152	543	3.0	11.0
Production, transportation, and material moving occupations	18,816	16,751	803	3,446	4.1	17.1
Production occupations	8,660	6,868	276	1,228	3.1	15.2
Transportation and material moving occupations	10,156	9,883	527	2,217	4.9	18.3

[1] Persons with no previous work experience and persons whose last job was in the U.S. Armed Forces are included in the unemployed total.

NOTE: Updated population controls are introduced annually with the release of January data. Effective with January 2020 data, occupations reflect the introduction of the 2018 Census occupational classification system into the Current Population Survey, or household survey. This classification system is derived from the 2018 Standard Occupational Classification (SOC). No historical data have been revised. Data for 2020 are not strictly comparable with earlier years.

HOUSEHOLD DATA
Table A-14. Unemployed persons by industry and class of worker, not seasonally adjusted

Industry and class of worker	Number of unemployed persons (in thousands)		Unemployment rates	
	May 2019	May 2020	May 2019	May 2020
Total, 16 years and over[1]	5,503	20,514	3.4	13.0
Nonagricultural private wage and salary workers	4,204	17,404	3.3	14.0
Mining, quarrying, and oil and gas extraction	35	64	5.0	8.4
Construction	294	1,187	3.2	12.7
Manufacturing	369	1,782	2.3	11.6
Durable goods	215	1,243	2.2	13.1
Nondurable goods	154	539	2.5	9.3
Wholesale and retail trade	822	2,895	4.2	15.1
Transportation and utilities	299	1,023	4.1	14.2
Information	77	259	3.0	10.9
Financial activities	162	559	1.7	5.7
Professional and business services	600	1,578	3.4	9.0
Education and health services	609	2,458	2.4	10.1
Leisure and hospitality	745	4,434	5.0	35.9
Other services	194	1,165	2.9	18.4
Agriculture and related private wage and salary workers	99	105	5.4	6.5
Government workers	445	1,598	2.1	7.4
Self-employed workers, unincorporated, and unpaid family workers	198	915	2.0	9.4

[1] Persons with no previous work experience and persons whose last job was in the U.S. Armed Forces are included in the unemployed total.

NOTE: Updated population controls are introduced annually with the release of January data. Effective with January 2020 data, industries reflect the introduction of the 2017 Census industry classification system into the Current Population Survey. This industry classification system is derived from the 2017 North American Industry Classification System (NAICS). No historical data have been revised.

HOUSEHOLD DATA
Table A-15. Alternative measures of labor underutilization

[Percent]

Measure	Not seasonally adjusted			Seasonally adjusted					
	May 2019	Apr. 2020	May 2020	May 2019	Jan. 2020	Feb. 2020	Mar. 2020	Apr. 2020	May 2020
U-1 Persons unemployed 15 weeks or longer, as a percent of the civilian labor force	1.3	1.2	1.4	1.3	1.2	1.2	1.2	1.1	1.4
U-2 Job losers and persons who completed temporary jobs, as a percent of the civilian labor force	1.4	13.1	11.3	1.6	1.6	1.7	2.4	13.2	11.6
U-3 Total unemployed, as a percent of the civilian labor force (official unemployment rate)	3.4	14.4	13.0	3.6	3.6	3.5	4.4	14.7	13.3
U-4 Total unemployed plus discouraged workers, as a percent of the civilian labor force plus discouraged workers	3.6	14.8	13.3	3.9	3.8	3.8	4.7	15.1	13.6
U-5 Total unemployed, plus discouraged workers, plus all other persons marginally attached to the labor force, as a percent of the civilian labor force plus all persons marginally attached to the labor force	4.2	15.6	14.2	4.5	4.4	4.4	5.2	16.0	14.6
U-6 Total unemployed, plus all persons marginally attached to the labor force, plus total employed part time for economic reasons, as a percent of the civilian labor force plus all persons marginally attached to the labor force	6.7	22.4	20.7	7.2	6.9	7.0	8.7	22.8	21.2

NOTE: Persons marginally attached to the labor force are those who currently are neither working nor looking for work but indicate that they want and are available for a job and have looked for work sometime in the past 12 months. Discouraged workers, a subset of the marginally attached, have given a job-market related reason for not currently looking for work. Persons employed part time for economic reasons are those who want and are available for full-time work but have had to settle for a part-time schedule. Updated population controls are introduced annually with the release of January data.

HOUSEHOLD DATA
Table A-16. Persons not in the labor force and multiple jobholders by sex, not seasonally adjusted

[Numbers in thousands]

Category	Total		Men		Women	
	May 2019	May 2020	May 2019	May 2020	May 2019	May 2020
NOT IN THE LABOR FORCE						
Total not in the labor force	96,207	102,072	38,665	41,818	57,542	60,254
Persons who currently want a job	5,500	9,422	2,762	4,535	2,738	4,886
Marginally attached to the labor force[1]	1,395	2,292	732	1,242	663	1,050
Discouraged workers[2]	338	598	210	341	127	257
Other persons marginally attached to the labor force[3]	1,058	1,694	522	901	536	793
MULTIPLE JOBHOLDERS						
Total multiple jobholders[4]	7,857	5,509	3,774	2,703	4,083	2,807
Percent of total employed	5.0	4.0	4.5	3.7	5.5	4.4
Primary job full time, secondary job part time	4,414	3,121	2,328	1,687	2,086	1,434
Primary and secondary jobs both part time	1,990	1,262	690	418	1,299	843
Primary and secondary jobs both full time	325	285	204	193	121	92
Hours vary on primary or secondary job	1,061	805	503	390	558	415

[1] Data refer to persons who want a job, have searched for work during the prior 12 months, and were available to take a job during the reference week, but had not looked for work in the past 4 weeks.

[2] Includes those who did not actively look for work in the prior 4 weeks for reasons such as thinks no work available, could not find work, lacks schooling or training, employer thinks too young or old, and other types of discrimination.

[3] Includes those who did not actively look for work in the prior 4 weeks for such reasons as school or family responsibilities, ill health, and transportation problems, as well as a number for whom reason for nonparticipation was not determined.

[4] Includes a small number of persons who work part time on their primary job and full time on their secondary job(s), not shown separately.

NOTE: Updated population controls are introduced annually with the release of January data.

ESTABLISHMENT DATA

Table B-1. Employees on nonfarm payrolls by industry sector and selected industry detail

[In thousands]

Industry	Not seasonally adjusted				Seasonally adjusted				
	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	Change from: Apr.2020 - May2020[p]
Total nonfarm	151,109	150,073	130,411	133,342	150,577	151,090	130,403	132,912	2,509
Total private	128,253	127,009	108,267	111,864	128,026	128,362	108,638	111,732	3,094
Goods-producing	21,089	20,738	18,554	19,418	21,050	21,086	18,713	19,382	669
Mining and logging	739	696	641	631	743	706	652	632	-20
Logging	48.1	52.9	46.6	49.0	49.5	54.5	49.7	50.1	0.4
Mining	690.7	643.2	594.8	581.8	693.3	651.2	602.2	582.3	-19.9
Oil and gas extraction	147.3	155.0	151.4	146.6	147.8	156.4	153.9	147.0	-6.9
Mining, except oil and gas	194.2	184.7	175.5	181.3	192.4	187.7	177.1	179.8	2.7
Coal mining	51.8	49.3	41.5	46.3	51.9	49.3	41.6	46.6	5.0
Metal ore mining	42.6	40.9	40.8	39.1	42.3	41.0	40.9	39.1	-1.8
Nonmetallic mineral mining and quarrying	99.8	94.5	93.2	95.9	98.2	97.4	94.6	94.1	-0.5
Support activities for mining	349.2	303.5	267.9	253.9	353.1	307.1	271.2	255.5	-15.7
Construction	7,540	7,295	6,486	7,110	7,478	7,574	6,579	7,043	464
Construction of buildings	1,647.1	1,636.1	1,439.2	1,564.7	1,650.4	1,677.9	1,461.5	1,566.4	104.9
Residential building	811.4	814.6	706.1	782.3	811.7	837.5	716.9	782.5	65.6
Nonresidential building	835.7	821.5	733.1	782.4	838.7	840.4	744.6	783.9	39.3
Heavy and civil engineering construction	1,106.8	1,007.5	977.3	1,055.9	1,074.3	1,083.4	993.5	1,027.2	33.7
Specialty trade contractors	4,785.9	4,650.9	4,069.4	4,489.3	4,753.1	4,813.0	4,124.1	4,449.4	325.3
Residential specialty trade contractors	2,102.6	2,034.9	1,778.5	1,988.1	2,083.4	2,105.4	1,803.8	1,964.2	160.4
Nonresidential specialty trade contractors	2,683.3	2,616.0	2,290.9	2,501.2	2,669.7	2,707.6	2,320.3	2,485.2	164.9
Manufacturing	12,810	12,747	11,427	11,677	12,829	12,806	11,482	11,707	225
Durable goods	8,052	8,013	7,109	7,234	8,056	8,031	7,124	7,243	119
Wood products	406.1	405.7	372.0	376.0	407.1	409.9	373.4	376.4	3.0
Nonmetallic mineral products	423.8	417.8	376.7	399.9	419.8	425.1	376.4	396.8	20.4
Primary metals	387.8	372.5	341.3	332.5	387.4	371.9	342.5	333.1	-9.4
Fabricated metal products	1,492.2	1,472.0	1,363.5	1,388.8	1,492.0	1,475.0	1,365.3	1,390.1	24.8
Machinery	1,127.7	1,104.0	1,018.6	1,042.5	1,128.2	1,105.4	1,021.2	1,043.8	22.6
Computer and electronic products	1,070.7	1,096.6	1,083.8	1,078.7	1,074.8	1,097.9	1,086.9	1,081.9	-5.0
Computer and peripheral equipment	160.7	169.0	169.8	169.8	161.8	169.4	170.2	170.3	0.1
Communications equipment	82.6	84.6	83.0	81.1	83.3	84.4	83.2	81.3	-1.9
Semiconductors and electronic components	374.4	377.8	373.4	369.5	375.3	377.5	374.3	370.9	-3.4
Electronic instruments	420.1	432.2	425.2	425.1	421.4	433.3	426.2	426.2	0.0
Miscellaneous computer and electronic products	32.9	33.0	32.4	33.2	33.0	33.3	33.0	33.2	0.2
Electrical equipment and appliances	402.6	402.1	383.0	367.5	404.7	404.0	384.6	369.3	-15.3
Transportation equipment[1]	1,734.2	1,741.7	1,335.2	1,360.3	1,736.1	1,737.9	1,337.3	1,363.3	26.0
Motor vehicles and parts[2]	1,002.8	1,000.0	635.9	661.3	1,002.8	993.6	634.4	662.1	27.7
Furniture and related products	388.1	385.2	309.0	330.0	387.7	385.8	309.6	330.5	20.9
Miscellaneous durable goods manufacturing	618.3	615.1	525.7	557.4	617.7	617.7	527.1	558.1	31.0
Nondurable goods	4,758	4,734	4,318	4,443	4,773	4,775	4,358	4,464	106
Food manufacturing	1,619.4	1,625.0	1,526.7	1,558.2	1,636.3	1,649.3	1,555.5	1,580.4	24.9
Textile mills	109.4	104.9	85.3	88.9	110.0	105.2	85.5	88.4	2.9
Textile product mills	113.2	108.6	86.1	98.1	114.0	109.6	86.5	98.2	11.7
Apparel	112.3	103.5	63.4	76.4	111.7	103.8	63.5	76.3	12.8
Paper and paper products	366.6	362.8	355.1	355.4	365.7	363.4	354.9	354.8	-0.1
Printing and related support activities	424.0	411.5	335.3	352.9	425.6	413.2	337.1	353.5	16.4
Petroleum and coal products	117.0	110.3	105.3	106.5	115.7	113.8	106.4	105.3	-1.1
Chemicals	849.1	849.0	829.3	832.3	848.6	849.7	831.4	833.8	2.4
Plastics and rubber products	735.8	744.4	671.3	702.2	734.6	745.3	671.4	701.2	29.8
Miscellaneous nondurable goods manufacturing	310.8	313.7	260.5	272.3	311.2	321.3	265.9	272.3	6.4
Private service-providing	107,164	106,271	89,713	92,446	106,976	107,276	89,925	92,350	2,425
Trade, transportation, and utilities	27,554	27,399	24,283	24,790	27,667	27,723	24,498	24,866	368
Wholesale trade	5,900.7	5,895.9	5,523.3	5,560.7	5,897.7	5,922.2	5,539.7	5,561.1	21.4
Durable goods	3,196.3	3,208.4	3,012.9	3,021.9	3,199.1	3,218.2	3,020.4	3,024.5	4.1
Nondurable goods	2,176.1	2,158.4	2,015.5	2,038.6	2,169.0	2,173.9	2,021.8	2,034.4	12.6

See footnotes at end of table.

ESTABLISHMENT DATA
Table B-1. Employees on nonfarm payrolls by industry sector and selected industry detail — Continued
[In thousands]

Industry	Not seasonally adjusted				Seasonally adjusted				
	May 2019	Mar. 2020	Apr. 2020p	May 2020p	May 2019	Mar. 2020	Apr. 2020p	May 2020p	Change from: Apr.2020 - May2020p
Wholesale trade - Continued									
Electronic markets and agents and brokers	528.3	529.1	494.9	500.2	529.6	530.1	497.5	502.2	4.7
Retail trade	15,540.7	15,365.1	13,190.7	13,640.3	15,618.8	15,586.6	13,300.8	13,668.6	367.8
Motor vehicle and parts dealers	2,033.9	2,042.9	1,685.6	1,752.4	2,030.5	2,052.8	1,688.5	1,746.3	57.8
Automobile dealers	1,299.8	1,296.2	1,020.5	1,108.2	1,300.6	1,299.6	1,023.7	1,108.4	84.7
Other motor vehicle dealers	170.0	161.0	121.3	134.7	163.9	165.3	119.9	128.8	8.9
Auto parts, accessories, and tire stores	564.1	585.7	543.8	509.5	566.0	587.9	544.9	509.1	-35.8
Furniture and home furnishings stores	468.2	456.0	246.9	287.9	473.2	458.5	252.5	292.9	40.4
Electronics and appliance stores	472.5	468.1	430.7	335.5	478.1	471.4	434.3	339.6	-94.7
Building material and garden supply stores	1,352.2	1,329.5	1,321.1	1,398.4	1,287.5	1,320.8	1,271.3	1,327.1	55.8
Food and beverage stores	3,058.5	3,046.2	3,025.7	3,087.0	3,070.8	3,078.6	3,049.3	3,092.8	43.5
Health and personal care stores	1,043.5	1,050.7	946.2	925.9	1,049.2	1,056.8	953.2	931.6	-21.6
Gasoline stations	940.5	930.4	890.9	895.0	940.8	942.5	897.7	894.2	-3.5
Clothing and clothing accessories stores	1,261.7	1,224.7	483.8	578.1	1,303.0	1,265.4	500.1	594.9	94.8
Sporting goods, hobby, book, and music stores	530.7	517.0	331.3	367.3	548.0	534.1	342.7	378.9	36.2
General merchandise stores	2,974.2	2,978.6	2,794.2	2,891.9	3,031.4	3,055.3	2,860.6	2,944.6	84.0
Department stores	1,036.8	1,041.4	771.5	817.4	1,077.1	1,081.8	802.0	849.1	47.1
General merchandise stores, including warehouse clubs and supercenters	1,937.4	1,937.2	2,022.7	2,074.5	1,954.3	1,973.5	2,058.6	2,095.5	36.9
Miscellaneous store retailers	844.1	781.7	535.6	601.6	839.6	804.1	543.8	598.3	54.5
Nonstore retailers	560.7	539.3	498.7	519.3	566.7	546.3	506.8	527.4	20.6
Transportation and warehousing	5,564.7	5,592.8	5,029.7	5,050.8	5,601.6	5,668.2	5,114.9	5,095.9	-19.0
Air transportation	501.2	510.7	433.3	384.7	500.1	512.1	433.5	383.2	-50.3
Rail transportation	178.0	159.2	154.9	152.9	177.3	159.4	155.3	153.2	-2.1
Water transportation	67.1	62.0	57.8	57.5	65.8	64.3	59.0	56.8	-2.2
Truck transportation	1,533.7	1,499.4	1,417.0	1,429.1	1,532.4	1,522.6	1,432.8	1,431.6	-1.2
Transit and ground passenger transportation	517.6	515.3	333.4	346.9	499.8	501.8	319.1	329.2	10.1
Pipeline transportation	51.7	51.3	50.5	51.1	51.5	51.4	50.5	51.1	0.6
Scenic and sightseeing transportation	38.3	27.9	11.8	18.7	35.8	35.4	13.0	17.2	4.2
Support activities for transportation	749.8	751.8	670.0	669.9	751.7	754.6	672.0	673.3	1.3
Couriers and messengers	753.6	808.8	786.8	816.2	801.1	850.0	853.6	865.7	12.1
Warehousing and storage	1,173.7	1,206.4	1,114.2	1,123.8	1,186.1	1,216.6	1,126.1	1,134.6	8.5
Utilities	548.2	545.4	539.3	537.9	549.0	545.9	542.3	540.0	-2.3
Information	2,842	2,874	2,613	2,570	2,853	2,888	2,616	2,578	-38
Publishing industries, except Internet	752.2	768.0	741.9	737.0	757.9	771.4	746.7	742.0	-4.7
Motion picture and sound recording industries	444.2	441.8	230.8	219.9	440.1	451.4	226.1	215.4	-10.7
Broadcasting, except Internet	265.7	260.0	245.8	239.3	267.5	259.5	246.2	240.3	-5.9
Telecommunications	712.4	698.4	694.0	683.5	716.3	697.1	695.5	687.7	-7.8
Data processing, hosting and related services	334.5	348.8	344.9	340.2	336.1	349.5	343.4	339.8	-3.6
Other information services	333.2	356.9	355.3	350.1	335.0	359.2	357.8	353.1	-4.7
Financial activities	8,707	8,780	8,518	8,573	8,727	8,827	8,563	8,596	33
Finance and insurance	6,393.2	6,472.7	6,415.0	6,429.7	6,411.8	6,484.0	6,440.3	6,448.7	8.4
Monetary authorities - central bank	19.8	19.6	19.6	19.7	19.8	19.6	19.7	19.7	0.0
Credit intermediation and related activities	2,638.6	2,674.9	2,637.6	2,650.5	2,646.1	2,680.0	2,647.5	2,654.8	7.3
Depository credit intermediation[1]	1,772.5	1,783.6	1,771.4	1,775.7	1,774.8	1,784.0	1,775.0	1,776.1	1.1
Commercial banking	1,389.7	1,391.5	1,383.8	1,387.7	1,391.0	1,391.6	1,387.1	1,388.3	1.2
Nondepository credit intermediation	568.9	583.9	570.4	574.2	571.9	588.8	576.3	576.9	0.6
Activities related to credit intermediation.	297.2	307.4	295.8	300.6	299.3	307.2	296.2	301.8	5.6
Securities, commodity contracts, investments, and funds and trusts	956.6	966.9	961.3	961.1	961.7	971.2	966.8	967.6	0.8
Insurance carriers and related activities	2,778.2	2,811.3	2,796.5	2,798.4	2,784.2	2,813.2	2,806.3	2,806.6	0.3
Real estate and rental and leasing	2,313.8	2,307.6	2,102.5	2,143.7	2,315.0	2,342.8	2,123.0	2,147.1	24.1
Real estate	1,707.3	1,722.7	1,627.5	1,638.6	1,712.3	1,743.6	1,640.2	1,643.6	3.4
Rental and leasing services	583.4	561.6	452.2	482.1	579.5	575.7	459.6	480.4	20.8

See footnotes at end of table.

ESTABLISHMENT DATA
Table B-1. Employees on nonfarm payrolls by industry sector and selected industry detail — Continued
[In thousands]

Industry	Not seasonally adjusted				Seasonally adjusted				
	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	Change from: Apr.2020 - May2020[p]
Real estate and rental and leasing - Continued									
Lessors of nonfinancial intangible assets	23.1	23.3	22.8	23.0	23.2	23.5	23.2	23.1	-0.1
Professional and business services	21,239	21,173	19,222	19,384	21,253	21,456	19,267	19,394	127
Professional and technical services	9,442.6	9,717.2	9,199.4	9,133.1	9,502.2	9,698.5	9,159.0	9,198.8	39.8
Legal services	1,143.9	1,154.8	1,088.6	1,094.6	1,147.4	1,160.3	1,094.3	1,097.5	3.2
Accounting and bookkeeping services	977.5	1,143.4	1,056.4	939.1	1,023.9	1,042.8	972.1	985.3	13.2
Architectural and engineering services	1,508.8	1,519.5	1,449.2	1,465.7	1,509.8	1,537.8	1,460.2	1,467.1	6.9
Specialized design services	144.3	142.6	125.9	126.5	143.3	144.0	126.6	126.4	-0.2
Computer systems design and related services	2,191.3	2,225.2	2,163.2	2,153.3	2,193.4	2,249.8	2,170.8	2,158.1	-12.7
Management and technical consulting services	1,513.1	1,539.2	1,468.0	1,479.1	1,518.5	1,557.9	1,478.1	1,485.1	7.0
Scientific research and development services	721.4	746.7	726.6	732.3	722.2	750.9	730.9	734.1	3.2
Advertising and related services	492.9	487.4	448.9	448.0	491.8	489.9	449.9	448.4	-1.5
Other professional and technical services	749.4	758.4	672.6	694.5	751.9	765.1	676.1	696.8	20.7
Management of companies and enterprises	2,418.4	2,432.3	2,339.6	2,328.8	2,420.6	2,445.1	2,353.8	2,332.0	-21.8
Administrative and waste services	9,378.0	9,023.9	7,682.6	7,922.0	9,329.7	9,312.3	7,754.2	7,863.5	109.3
Administrative and support services	8,928.1	8,564.4	7,234.8	7,469.4	8,879.9	8,845.9	7,303.4	7,412.1	108.7
Office administrative services	526.6	525.4	489.2	492.4	525.7	529.5	490.5	491.7	1.2
Facilities support services	163.1	163.8	152.8	150.3	163.6	164.4	153.3	151.0	-2.3
Employment services[1]	3,606.3	3,471.3	2,581.6	2,668.2	3,630.7	3,593.6	2,642.1	2,683.4	41.3
Temporary help services	2,925.3	2,780.6	1,993.2	2,072.9	2,947.2	2,888.4	2,047.9	2,087.0	39.1
Business support services	868.1	861.2	751.9	747.6	882.4	866.0	756.9	757.8	0.9
Travel arrangement and reservation services	221.1	210.9	174.8	170.8	218.4	212.1	174.7	169.3	-5.4
Investigation and security services	956.5	958.4	885.0	886.6	956.9	966.2	890.2	885.7	-4.5
Services to buildings and dwellings	2,246.3	2,035.1	1,911.0	2,056.2	2,167.0	2,173.6	1,908.5	1,976.9	68.4
Other support services	340.1	338.3	288.5	297.3	335.1	340.5	287.2	296.3	9.1
Waste management and remediation services	449.9	459.5	447.8	452.6	449.8	466.4	450.8	451.4	0.6
Education and health services	24,121	24,518	21,985	22,281	24,076	24,408	21,818	22,242	424
Educational services	3,771.1	3,924.3	3,494.1	3,386.7	3,743.4	3,784.8	3,323.4	3,356.8	33.4
Health care and social assistance	20,349.8	20,593.9	18,490.7	18,894.6	20,332.1	20,623.2	18,494.7	18,885.4	390.7
Health care[3]	16,202.0	16,380.7	14,908.6	15,226.9	16,217.2	16,417.1	14,936.6	15,249.0	312.4
Ambulatory health care services	7,666.3	7,749.7	6,520.8	6,906.6	7,664.1	7,766.1	6,529.7	6,905.4	375.7
Offices of physicians	2,660.7	2,690.6	2,427.0	2,481.6	2,663.8	2,695.9	2,432.5	2,483.8	51.3
Offices of dentists	968.3	941.0	434.1	679.4	968.5	942.8	434.7	679.5	244.8
Offices of other health practitioners	966.5	966.6	752.4	829.1	963.4	970.9	754.4	827.5	73.1
Outpatient care centers	958.6	979.2	895.7	905.3	958.3	977.9	895.0	905.8	10.8
Medical and diagnostic laboratories	280.4	287.4	257.1	257.4	281.5	287.8	258.0	258.4	0.4
Home health care services	1,518.7	1,565.5	1,460.9	1,460.4	1,516.1	1,570.7	1,460.7	1,457.7	-3.0
Other ambulatory health care services	313.1	319.4	293.6	293.4	312.4	320.1	294.4	292.7	-1.7
Hospitals	5,167.7	5,262.6	5,131.9	5,094.2	5,181.6	5,265.8	5,138.7	5,112.0	-26.7
Nursing and residential care facilities	3,368.0	3,368.4	3,255.9	3,226.1	3,371.5	3,385.2	3,268.2	3,231.6	-36.6
Nursing care facilities	1,593.8	1,579.7	1,534.3	1,519.1	1,597.1	1,588.4	1,540.9	1,522.9	-18.0
Residential mental health facilities	646.7	651.3	621.7	612.2	646.2	653.2	623.4	612.6	-10.8
Community care facilities for the elderly	963.7	971.7	941.0	935.7	964.2	977.0	944.6	936.3	-8.3
Other residential care facilities	163.8	165.7	158.9	159.1	164.0	166.6	159.3	159.8	0.5
Social assistance	4,147.8	4,213.2	3,582.1	3,667.7	4,114.9	4,206.1	3,558.1	3,636.4	78.3
Individual and family services	2,604.2	2,691.3	2,460.1	2,492.2	2,595.5	2,695.9	2,453.9	2,483.3	29.4
Emergency and other relief services	182.6	185.6	176.2	178.5	182.9	185.6	177.1	179.3	2.2
Vocational rehabilitation services	324.2	318.7	257.6	261.1	323.2	321.2	258.9	261.2	2.3
Child day care services	1,036.8	1,017.6	688.2	735.9	1,013.3	1,003.4	668.2	712.6	44.4
Leisure and hospitality	16,788	15,714	8,520	9,978	16,519	16,124	8,585	9,824	1,239
Arts, entertainment, and recreation	2,499.2	2,233.9	1,125.8	1,207.4	2,418.7	2,420.3	1,154.7	1,172.2	17.5
Performing arts and spectator sports	552.6	463.0	275.2	282.5	518.1	489.7	270.4	265.6	-4.8
Museums, historical sites, and similar institutions	178.0	163.0	124.5	125.9	171.3	173.5	126.4	122.3	-4.1

See footnotes at end of table.

ESTABLISHMENT DATA
Table B-1. Employees on nonfarm payrolls by industry sector and selected industry detail — Continued

[In thousands]

Industry	Not seasonally adjusted				Seasonally adjusted				
	May 2019	Mar. 2020	Apr. 2020p	May 2020p	May 2019	Mar. 2020	Apr. 2020p	May 2020p	Change from: Apr.2020 - May2020p
Arts, entertainment, and recreation - Continued									
Amusements, gambling, and recreation	1,768.6	1,607.9	726.1	799.0	1,729.3	1,757.1	757.9	784.3	26.4
Accommodation and food services	14,288.6	13,480.5	7,394.2	8,771.0	14,100.3	13,703.9	7,429.8	8,652.2	1,222.4
Accommodation	2,086.2	1,965.5	1,129.8	1,033.4	2,075.7	2,034.0	1,178.5	1,030.3	-148.2
Food services and drinking places	12,202.4	11,515.0	6,264.4	7,737.6	12,024.6	11,669.9	6,251.3	7,621.9	1,370.6
Other services	5,913	5,813	4,572	4,870	5,881	5,850	4,578	4,850	272
Repair and maintenance	1,354.5	1,358.7	1,139.5	1,222.4	1,344.9	1,361.9	1,136.1	1,213.3	77.2
Personal and laundry services	1,545.0	1,461.4	691.5	881.1	1,526.6	1,475.0	689.9	872.2	182.3
Membership associations and organizations	3,013.7	2,992.8	2,740.7	2,766.7	3,009.4	3,013.3	2,751.9	2,764.6	12.7
Government	22,856	23,064	22,144	21,478	22,551	22,728	21,765	21,180	-585
Federal	2,826.0	2,866.0	2,874.0	2,870.0	2,826.0	2,886.0	2,887.0	2,873.0	-14.0
Federal, except U.S. Postal Service	2,219.2	2,271.0	2,279.0	2,268.7	2,218.7	2,285.7	2,285.8	2,270.5	-15.3
U.S. Postal Service	607.2	595.0	595.2	601.0	607.4	600.5	601.3	602.1	0.8
State government	5,159.0	5,309.0	5,142.0	4,898.0	5,158.0	5,162.0	4,995.0	4,911.0	-84.0
State government education	2,468.6	2,603.9	2,441.4	2,212.2	2,474.2	2,451.2	2,286.9	2,223.6	-63.3
State government, excluding education	2,689.9	2,705.4	2,701.0	2,685.8	2,683.6	2,710.6	2,707.6	2,686.9	-20.7
Local government	14,871.0	14,889.0	14,128.0	13,710.0	14,567.0	14,680.0	13,883.0	13,396.0	-487.0
Local government education	8,301.8	8,356.8	7,916.7	7,590.1	7,992.7	8,041.6	7,592.7	7,282.8	-309.9
Local government, excluding education	6,569.3	6,532.1	6,211.7	6,120.3	6,574.3	6,638.4	6,289.8	6,112.9	-176.9

[1] Includes other industries, not shown separately.
[2] Includes motor vehicles, motor vehicle bodies and trailers, and motor vehicle parts.
[3] Includes ambulatory health care services, hospitals, and nursing and residential care facilities.
p Preliminary
NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-2. Average weekly hours and overtime of all employees on private nonfarm payrolls by industry sector, seasonally adjusted

Industry	May 2019	Mar. 2020	Apr. 2020p	May 2020p
AVERAGE WEEKLY HOURS				
Total private	34.4	34.1	34.2	34.7
Goods-producing	40.3	40.1	38.2	39.0
Mining and logging	46.3	45.2	43.0	43.0
Construction	39.1	39.1	37.9	38.9
Manufacturing	40.6	40.4	38.1	38.9
Durable goods	41.0	40.7	38.0	39.0
Nondurable goods	39.9	39.8	38.2	38.8
Private service-providing	33.3	32.9	33.4	33.8
Trade, transportation, and utilities	34.3	34.1	33.8	34.3
Wholesale trade	38.9	38.8	37.7	38.0
Retail trade	30.7	30.6	30.5	31.3
Transportation and warehousing	38.6	37.9	37.1	37.7
Utilities	42.1	42.2	42.4	42.2
Information	36.4	36.3	36.5	36.6
Financial activities	37.6	37.6	37.7	37.8
Professional and business services	36.2	36.0	35.9	36.4
Education and health services	33.0	32.9	32.6	32.9
Leisure and hospitality	25.9	24.1	24.2	25.7
Other services	31.9	31.5	32.3	32.7
AVERAGE OVERTIME HOURS				
Manufacturing	3.3	3.0	2.1	2.4
Durable goods	3.3	2.9	1.7	2.1
Nondurable goods	3.4	3.3	2.8	3.0

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA
Table B-3. Average hourly and weekly earnings of all employees on private nonfarm payrolls by industry sector, seasonally adjusted

Industry	Average hourly earnings				Average weekly earnings			
	May 2019	Mar. 2020	Apr. 2020p	May 2020p	May 2019	Mar. 2020	Apr. 2020p	May 2020p
Total private	$27.87	$28.69	$30.04	$29.75	$958.73	$978.33	$1,027.37	$1,032.33
Goods-producing	28.89	29.64	30.24	30.09	1,164.27	1,188.56	1,155.17	1,173.51
Mining and logging	33.47	34.75	35.15	35.10	1,549.66	1,570.70	1,511.45	1,509.30
Construction	30.70	31.33	31.37	31.46	1,200.37	1,225.00	1,188.92	1,223.79
Manufacturing	27.57	28.35	29.28	28.96	1,119.34	1,145.34	1,115.57	1,126.54
Durable goods	29.03	29.75	30.78	30.39	1,190.23	1,210.83	1,169.64	1,185.21
Nondurable goods	25.04	25.96	26.83	26.62	999.10	1,033.21	1,024.91	1,032.86
Private service-providing	27.63	28.46	30.00	29.66	920.08	936.33	1,002.00	1,002.51
Trade, transportation, and utilities	24.13	24.75	25.67	25.45	827.66	843.98	867.65	872.94
Wholesale trade	31.30	31.82	32.56	32.62	1,217.57	1,234.62	1,227.51	1,239.56
Retail trade	19.55	20.30	21.10	20.88	600.19	621.18	643.55	653.54
Transportation and warehousing	24.78	25.15	25.75	25.67	956.51	953.19	955.33	967.76
Utilities	41.81	42.53	43.14	42.95	1,760.20	1,794.77	1,829.14	1,812.49
Information	42.00	43.19	43.68	43.46	1,528.80	1,567.80	1,594.32	1,590.64
Financial activities	35.82	36.81	37.33	37.81	1,346.83	1,384.06	1,407.34	1,429.22
Professional and business services	33.52	34.45	35.78	35.45	1,213.42	1,240.20	1,284.50	1,290.38
Education and health services	27.43	27.94	28.29	28.43	905.19	919.23	922.25	935.35
Leisure and hospitality	16.51	16.86	17.95	17.39	427.61	406.33	434.39	446.92
Other services	25.16	25.69	27.47	26.95	802.60	809.24	887.28	881.27

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-4. Indexes of aggregate weekly hours and payrolls for all employees on private nonfarm payrolls by industry sector, seasonally adjusted

[2007=100]

Industry	Index of aggregate weekly hours[1]					Index of aggregate weekly payrolls[2]				
	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	Percent change from: Apr. 2020 - May 2020[p]	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	Percent change from: Apr. 2020 - May 2020[p]
Total private	110.6	109.9	93.3	97.3	4.3	147.3	150.7	134.0	138.4	3.3
Goods-producing	96.6	96.3	81.4	86.1	5.8	126.2	129.1	111.3	117.1	5.2
Mining and logging	108.1	100.3	88.1	85.4	-3.1	145.3	139.9	124.3	120.3	-3.2
Construction	100.8	102.1	86.0	94.4	9.8	134.4	139.0	117.2	129.1	10.2
Manufacturing	93.7	93.1	78.7	81.9	4.1	120.1	122.7	107.2	110.3	2.9
Durable goods	93.0	92.0	76.2	79.5	4.3	119.9	121.6	104.2	107.3	3.0
Nondurable goods	95.1	94.9	83.1	86.5	4.1	120.8	125.0	113.1	116.8	3.3
Private service-providing	114.7	113.6	96.7	100.5	3.9	154.0	157.2	141.0	144.9	2.8
Trade, transportation, and utilities	103.5	103.2	90.4	93.1	3.0	134.7	137.7	125.1	127.7	2.1
Wholesale trade	101.2	101.4	92.1	93.2	1.2	132.5	134.9	125.5	127.2	1.4
Retail trade	97.4	96.8	82.4	86.9	5.5	125.8	129.9	114.9	119.9	4.4
Transportation and warehousing	124.2	123.4	109.0	110.4	1.3	156.6	157.9	142.8	144.2	1.0
Utilities	100.0	99.7	99.5	98.6	-0.9	138.1	140.1	141.8	139.9	-1.3
Information	94.8	95.7	87.2	86.2	-1.1	141.8	147.2	135.6	133.3	-1.7
Financial activities	107.5	108.7	105.8	106.5	0.7	150.2	156.1	154.0	157.0	1.9
Professional and business services	120.6	121.1	108.5	110.7	2.0	163.7	168.9	157.1	158.9	1.1
Education and health services	129.7	131.1	116.1	119.5	2.9	171.2	176.2	158.1	163.4	3.4
Leisure and hospitality	122.1	110.9	59.3	72.0	21.4	162.6	150.8	85.8	101.1	17.8
Other services	108.2	106.2	85.3	91.4	7.2	149.2	149.6	128.4	135.1	5.2

[1] The indexes of aggregate weekly hours are calculated by dividing the current month's estimates of aggregate hours by the corresponding 2007 annual average aggregate hours. Aggregate hours estimates are the product of estimates of average weekly hours and employment.

[2] The indexes of aggregate weekly payrolls are calculated by dividing the current month's estimates of aggregate weekly payrolls by the corresponding 2007 annual average aggregate weekly payrolls. Aggregate payrolls estimates are the product of estimates of average hourly earnings, average weekly hours, and employment.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA
Table B-5. Employment of women on nonfarm payrolls by industry sector, seasonally adjusted

Industry	Women employees (in thousands)				Percent of all employees			
	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]
Total nonfarm	75,094	75,519	64,222	65,365	49.9	50.0	49.2	49.2
Total private	62,082	62,378	51,685	53,189	48.5	48.6	47.6	47.6
Goods-producing	4,698	4,745	4,206	4,340	22.3	22.5	22.5	22.4
Mining and logging	95	95	93	93	12.8	13.5	14.3	14.7
Construction	969	988	892	941	13.0	13.0	13.6	13.4
Manufacturing	3,634	3,662	3,221	3,306	28.3	28.6	28.1	28.2
Durable goods	1,931	1,949	1,720	1,736	24.0	24.3	24.1	24.0
Nondurable goods	1,703	1,713	1,501	1,570	35.7	35.9	34.4	35.2
Private service-providing	57,384	57,633	47,479	48,849	53.6	53.7	52.8	52.9
Trade, transportation, and utilities	11,078	11,088	9,368	9,550	40.0	40.0	38.2	38.4
Wholesale trade	1,774.8	1,784.7	1,635.6	1,654.3	30.1	30.1	29.5	29.7
Retail trade	7,753.9	7,712.6	6,347.3	6,526.8	49.6	49.5	47.7	47.8
Transportation and warehousing	1,417.5	1,458.7	1,253.2	1,236.5	25.3	25.7	24.5	24.3
Utilities	131.7	132.4	132.3	132.3	24.0	24.3	24.4	24.5
Information	1,130	1,147	1,045	1,028	39.6	39.7	39.9	39.9
Financial activities	4,947	4,993	4,859	4,849	56.7	56.6	56.7	56.4
Professional and business services	9,683	9,849	8,731	8,774	45.6	45.9	45.3	45.2
Education and health services	18,614	18,870	16,720	17,071	77.3	77.3	76.6	76.8
Leisure and hospitality	8,788	8,575	4,492	5,119	53.2	53.2	52.3	52.1
Other services	3,144	3,111	2,264	2,458	53.5	53.2	49.5	50.7
Government	13,012	13,141	12,537	12,176	57.7	57.8	57.6	57.5

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-6. Employment of production and nonsupervisory employees on private nonfarm payrolls by industry sector, seasonally adjusted[1]

[In thousands]

Industry	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]
Total private	105,399	105,303	87,268	89,984
Goods-producing	15,084	15,076	13,055	13,592
Mining and logging	548	506	460	442
Construction	5,566	5,640	4,772	5,173
Manufacturing	8,970	8,930	7,823	7,977
Durable goods	5,545	5,510	4,698	4,773
Nondurable goods	3,425	3,420	3,125	3,204
Private service-providing	90,315	90,227	74,213	76,392
Trade, transportation, and utilities	23,416	23,422	20,532	20,836
Wholesale trade	4,739.7	4,738.9	4,388.5	4,400.7
Retail trade	13,343.7	13,297.4	11,300.1	11,607.5
Transportation and warehousing	4,892.7	4,949.6	4,409.6	4,395.4
Utilities	440.0	436.0	433.5	432.1
Information	2,296	2,316	2,073	2,034
Financial activities	6,757	6,823	6,558	6,550
Professional and business services	17,302	17,366	15,300	15,433
Education and health services	21,148	21,397	19,062	19,439
Leisure and hospitality	14,526	14,093	7,020	8,194
Other services	4,870	4,810	3,668	3,906

[1] Data relate to production employees in mining and logging and manufacturing, construction employees in construction, and nonsupervisory employees in the service-providing industries. These groups account for approximately four-fifths of the total employment on private nonfarm payrolls.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-7. Average weekly hours and overtime of production and nonsupervisory employees on private nonfarm payrolls by industry sector, seasonally adjusted[1]

Industry	May 2019	Mar. 2020	Apr. 2020[p]	May 2020[p]
AVERAGE WEEKLY HOURS				
Total private	33.6	33.4	33.5	34.1
Goods-producing	41.1	40.8	38.6	39.6
Mining and logging	46.9	45.1	43.1	43.7
Construction	39.7	39.6	38.2	39.5
Manufacturing	41.5	41.3	38.5	39.4
Durable goods	41.8	41.5	38.2	39.4
Nondurable goods	41.0	41.0	39.0	39.5
Private service-providing	32.4	32.1	32.6	33.1
Trade, transportation, and utilities	33.8	33.9	33.6	34.3
Wholesale trade	38.7	38.4	37.1	37.7
Retail trade	30.2	30.5	30.5	31.4
Transportation and warehousing	37.9	37.9	37.1	38.0
Utilities	42.4	42.6	42.2	41.6
Information	35.4	35.3	35.6	35.9
Financial activities	36.9	36.7	36.9	37.1
Professional and business services	35.4	35.4	35.2	35.7
Education and health services	32.2	32.2	31.8	32.1
Leisure and hospitality	24.6	22.8	22.2	24.1
Other services	30.8	30.5	31.2	31.8
AVERAGE OVERTIME HOURS				
Manufacturing	4.2	3.9	2.8	3.2
Durable goods	4.2	3.9	2.5	3.0
Nondurable goods	4.3	3.9	3.2	3.6

[1] Data relate to production employees in mining and logging and manufacturing, construction employees in construction, and nonsupervisory employees in the service-providing industries. These groups account for approximately four-fifths of the total employment on private nonfarm payrolls.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-8. Average hourly and weekly earnings of production and nonsupervisory employees on private nonfarm payrolls by industry sector, seasonally adjusted[1]

Industry	Average hourly earnings				Average weekly earnings			
	May 2019	Mar. 2020	Apr. 2020p	May 2020p	May 2019	Mar. 2020	Apr. 2020p	May 2020p
Total private	$23.42	$24.10	$25.14	$25.00	$786.91	$804.94	$842.19	$852.50
Goods-producing	24.67	25.24	25.23	25.38	1,013.94	1,029.79	973.88	1,005.05
Mining and logging	29.95	30.91	31.17	30.67	1,404.66	1,394.04	1,343.43	1,340.28
Construction	28.49	29.02	28.63	28.98	1,131.05	1,149.19	1,093.67	1,144.71
Manufacturing	22.04	22.60	22.78	22.71	914.66	933.38	877.03	894.77
Durable goods	22.95	23.58	23.62	23.64	959.31	978.57	902.28	931.42
Nondurable goods	20.53	21.00	21.54	21.33	841.73	861.00	840.06	842.54
Private service-providing	23.16	23.86	25.12	24.92	750.38	765.91	818.91	824.85
Trade, transportation, and utilities	20.68	20.97	21.65	21.70	698.98	710.88	727.44	744.31
Wholesale trade	26.06	26.38	26.98	27.10	1,008.52	1,012.99	1,000.96	1,021.67
Retail trade	16.63	17.01	17.63	17.96	502.23	518.81	537.72	563.94
Transportation and warehousing	22.53	22.61	23.00	22.80	853.89	856.92	853.30	866.40
Utilities	37.03	37.77	38.00	37.65	1,570.07	1,609.00	1,603.60	1,566.24
Information	33.62	34.78	35.64	35.29	1,190.15	1,227.73	1,268.78	1,266.91
Financial activities	27.56	28.32	28.75	29.12	1,016.96	1,039.34	1,060.88	1,080.35
Professional and business services	27.63	28.52	29.79	29.64	978.10	1,009.61	1,048.61	1,058.15
Education and health services	24.13	24.85	25.24	25.35	776.99	800.17	802.63	813.74
Leisure and hospitality	14.43	14.60	14.63	14.43	354.98	332.88	324.79	347.76
Other services	21.35	21.92	23.20	22.68	657.58	668.56	723.84	721.22

[1] Data relate to production employees in mining and logging and manufacturing, construction employees in construction, and nonsupervisory employees in the service-providing industries. These groups account for approximately four-fifths of the total employment on private nonfarm payrolls.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

ESTABLISHMENT DATA

Table B-9. Indexes of aggregate weekly hours and payrolls for production and nonsupervisory employees on private nonfarm payrolls by industry sector, seasonally adjusted[1]

[2002=100]

Industry	Index of aggregate weekly hours[2]					Index of aggregate weekly payrolls[3]				
	May 2019	Mar. 2020	Apr. 2020p	May 2020p	Percent change from: Apr. 2020 - May 2020p	May 2019	Mar. 2020	Apr. 2020p	May 2020p	Percent change from: Apr. 2020 - May 2020p
Total private	118.0	117.2	97.4	102.2	4.9	184.7	188.8	163.7	170.9	4.4
Goods-producing	94.7	94.0	77.0	82.3	6.9	143.1	145.3	119.0	127.8	7.4
Mining and logging	136.6	121.3	105.4	102.6	-2.7	237.9	218.0	191.0	183.1	-4.1
Construction	110.6	111.8	91.3	102.3	12.0	170.2	175.2	141.1	160.1	13.5
Manufacturing	85.5	84.7	69.1	72.1	4.3	123.2	125.1	103.0	107.2	4.1
Durable goods	87.1	85.9	67.4	70.7	4.9	124.8	126.5	99.4	104.3	4.9
Nondurable goods	82.7	82.6	71.8	74.6	3.9	120.0	122.6	109.3	112.4	2.8
Private service-providing	124.7	123.4	103.1	107.7	4.5	198.1	202.0	177.6	184.1	3.7
Trade, transportation, and utilities	110.7	111.0	96.5	99.9	3.5	163.6	166.4	149.3	155.0	3.8
Wholesale trade	108.9	108.0	96.6	98.5	2.0	167.4	168.2	153.9	157.5	2.3
Retail trade	102.0	102.6	87.2	92.2	5.7	145.3	149.6	131.8	141.9	7.7
Transportation and warehousing	140.3	142.0	123.8	126.4	2.1	201.3	204.3	181.3	183.4	1.2
Utilities	95.4	95.0	93.6	91.9	-1.8	147.5	149.8	148.4	144.5	-2.6
Information	92.8	93.3	84.2	83.3	-1.1	154.4	160.7	148.6	145.6	-2.0
Financial activities	117.3	117.9	113.9	114.4	0.4	199.0	205.3	201.5	204.9	1.7
Professional and business services	136.9	137.5	120.4	123.2	2.3	225.0	233.1	213.3	217.1	1.8
Education and health services	145.2	146.9	129.2	133.0	2.9	231.2	240.9	215.3	222.6	3.4
Leisure and hospitality	130.9	117.7	57.1	72.3	26.6	214.5	195.1	94.8	118.5	25.0
Other services	105.2	102.9	80.3	87.1	8.5	163.6	164.3	135.7	144.0	6.1

[1] Data relate to production employees in mining and logging and manufacturing, construction employees in construction, and nonsupervisory employees in the service-providing industries. These groups account for approximately four-fifths of the total employment on private nonfarm payrolls.

[2] The indexes of aggregate weekly hours are calculated by dividing the current month's estimates of aggregate hours by the corresponding 2002 annual average aggregate hours. Aggregate hours estimates are the product of estimates of average weekly hours and employment.

[3] The indexes of aggregate weekly payrolls are calculated by dividing the current month's estimates of aggregate weekly payrolls by the corresponding 2002 annual average aggregate weekly payrolls. Aggregate payrolls estimates are the product of estimates of average hourly earnings, average weekly hours, and employment.

p Preliminary

NOTE: Data have been revised to reflect March 2019 benchmark levels and updated seasonal adjustment factors.

State	SEP dates	Enrollment Dates Covered	COVID	Existing	Total	% Increase Over Prior Year
California	March 20–June 30, 2020	Through April 24			84,000	250%
Colorado	March 20–April 30, 2020	Entire SEP			14,263	
Connecticut	March 19–April 17, 2020	Entire SEP			5,629	
District of Columbia	Through September 15, 2020[f]	Through April 19	2,209		2,072	66%
Maryland	March 16–June 15, 2020	March	4,445	4,956	9,401	
Massachusetts	March 11–May 25, 2020	Through April 28	8,300		20,000	
Minnesota	March 23–April 21, 2020		6,023	3,459	9,482	
Nevada	March 17–May 15, 2020	Through April 15			2,712	
Rhode Island	March 14–April 30, 2020	Through April 19	1,364	1,169	2,533	
Washington	March 10–May 8, 2020	Through May 6	7,000	12,500	19,500	
Vermont	March 20–June 15, 2020	Through May 11	373	515	888	
FFE States		March to April		379,206	379,206	49%
FFE States 2019				253,755	253,755	

2020 Plan Selections	Existing SEPS as % of OE Plan Selections	SEPs as % of OE Plan Selections	Description
1,538,819		5.5%	As of April 24, 2020, more than 84,000 people[d] signed up for marketplace coverage since the COVID-19 SEP was announced on March 20, a sign-up rate more than 2.5 times the pace of enrollments during the same period in 2019.
166,852		8.5%	During the COVID-19 SEP, 14,263 people enrolled in marketplace coverage through the COVID-19 SEP and the Loss of MEC SEP.
107,833		5.2%	During the COVID-19 SEP, 5,629 people signed up for marketplace plans, including 2,209 through the COVID-19 SEP; as of April 10, special enrollments were up[e] more than 70% compared to last year's benchmark.
17,538		11.8%	As of April 19, 2020, 2,072 people enrolled in marketplace coverage through an SEP, including the COVID-19 SEP and the Loss of MEC SEP, a 66% increase in enrollments compared to this period in 2019.
158,934	3.1%	5.9%	In March 2020,[g] 4,445 people enrolled in marketplace coverage through the COVID-19 SEP, 3,711 enrolled through the Loss of MEC SEP, and 1,245 enrolled through the Reduced Income SEP.
319,612		6.3%	On April 28, 2020, the marketplace announced[h] there have been more than 20,000 new marketplace enrollments since the beginning of March, including approximately 8,300[i] individuals who enrolled through the COVID-19 SEP as of April 20.
110,042	3.1%	8.6%	During the COVID-19 SEP,[j] 6,023 people enrolled in marketplace coverage through the COVID-19 SEP and 3,459 people enrolled through other SEPs, such as the Loss of MEC.
77,410		3.5%	From the beginning of March through April 15, 2020, the marketplace saw 2,712 enrollments through the COVID-19 SEP.
34,634	3.4%	7.3%	As of April 19, 2020, 1,364 accounts (which may include multiple enrollees) were approved for marketplace enrollment through the COVID-19 SEP; from March 15 to April 22, 2020, 1,169 accounts selected marketplace plans through the Loss of MEC SEP.
212,188	5.9%	9.2%	On May 6, the marketplace announced[k] that more than 19,500 people signed up for marketplace coverage since the COVID-19 SEP launched, including 7,000 through the COVID-19 SEP and 12,500 through other SEPs, such as Loss of MEC and Reduced Income.
27,335	1.9%	3.2%	Between March 20 and May 11, 2020, Vermont's marketplace enrolled 888 individuals in marketplace coverage, including 373 who enrolled through the COVID-19 SEP.[l]
8,286,871	4.6%	4.6%	
8,411,614	3.0%	3.0%	

Financial Effects of an Influenza Pandemic on US Hospitals

Jason Matheny, Eric Toner, and Richard Waldhorn

We estimate the financial effects of an influenza pandemic on US hospitals, including the cost of deferring elective admissions and the cost of uncompensated care for uninsured patients. Using US pandemic planning assumptions and national data on health care costs and revenues, a 1918-like pandemic would cause US hospitals to absorb a net loss of $3.9 billion, or an average $784,592 per hospital. Policymakers should consider contingencies to ensure that hospitals do not become insolvent as a result of a severe pandemic. Key words: *influenza pandemic, SARS, elective admissions, hospitalization, bed use, FluSurge.*

THE US Department of Health and Human Services (HHS) estimates that a severe influenza pandemic could cause 90 million Americans to become infected and 9.9 million to be hospitalized.[1] There are only a million hospital beds in the United States, so such an event would quickly overwhelm hospital capacity.

As one strategy to respond to this excess demand, HHS has advised hospitals in a pandemic to "Defer elective admissions and procedures until local epidemic wanes," freeing capacity for influenza patients.[2] These deferrals are likely to decrease hospitals' profits, as elective surgical procedures are generally more profitable than treatment for influenza is. The Congressional Research Service reports:

> Presuming a surge of patients in the healthcare system, non-urgent procedures could be postponed for weeks or months at a time. This has raised questions regarding whether there would be shifts in overall revenue to providers for services rendered during a pandemic, and how such shifts could affect providers and insurers.[3]

The United States has no plan to compensate hospitals for revenues lost during a pandemic.[4] The Stafford Act has no provision for compensation of lost revenues,[5] and Federal Emergency Management Agency (FEMA) policy specifically excludes it.[6]

Hospitals' experiences during past surge events suggest these losses could be significant. Following the 2001 terrorist attack on the World Trade Center, public agencies directed area hospitals to cancel elective services. As a result, the hospitals lost an estimated $200 million in revenues, which were never reimbursed by the government.[7]

During the 2003 SARS outbreak in Toronto, hospitals anticipated a surge of SARS admissions and were directed to defer elective cases. In the first eight weeks

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of restrictions, the rates of most urgent surgical admissions went unchanged; elective noncardiac surgery rates decreased 22 percent and elective cardiac surgery rates decreased 66 percent.[8] Limiting entry during these weeks cost Toronto's University Health Network an estimated $4.7 million in lost revenues,[9] almost twice the direct costs of excess supplies and services provided.[10] Hospitals in Taiwan faced similar losses, and increased their admissions of SARS patients only after the Taiwanese government agreed to reimburse lost revenues.[11]

In contrast to SARS, in an influenza pandemic, elective admissions are expected to decrease whereas overall admissions are expected to increase. Other commentators[12] have noted the possible financial effects of a pandemic on US hospitals, including the cost of deferring elective admissions and the cost of "uncompensated care" for uninsured patients. To our knowledge none has estimated the magnitudes involved. Here we estimate these magnitudes with national data on costs and margins for elective and flu cases.

Exhibit 1. FluSurge Parameters for Average Community Hospital

Parameter	HHS Moderate*	HHS Severe*
Rate of Illness	30%	30%
Hospitalization Rate for Ill Persons	1%	11%
Total Hospital Admissions	175	2006
Percentage of Patients Needing ICU Care	15%	15%
Percentage of Patients Needing Ventilators	7.5%	7.5%
Pandemic Duration (weeks)	8	8
Pandemic Attack Rate	25%	25%
Catchment Population: 0–19 yrs**	16,607	16,607
Catchment Population: 20–64 yrs**	35,826	35,826
Catchment Population: 65+ yrs**	7,434	7,434
Staffed Hospital Beds***	163	163
ICU Deds+	18	18
Non-ICU Beds	145	145
Ventilators++	20	20

*U.S. Department of Health and Human Services, 2005.
**2006 *Statistical Abstract of the United States: Table 12. Resident Population Projections by Sex and Age*: US Census Bureau, 2006.
***American Hospital Association, 2007.
+Halpern, *et al.*, 2004.
++Congressional Budget Office, 2006.

Methods

We used FluSurge 2.0, a spreadsheet model developed by the Centers for Disease Control (CDC), to project hospitalizations during a flu pandemic.[13] Model parameters were estimated for an "average hospital," by dividing aggregate national data by the number of US community hospitals (4,936).[14] Two scenarios were considered using HHS Pandemic Influenza Plan assumptions for "moderate" (1958/1968-like) and "severe" (1918-like) pandemics (*see* Exhibit 1).[15]

We assumed ICU flu patients will have a principal diagnosis of acute respiratory failure (ARF) (518.81), whereas non-ICU flu patients will have an equal mix of influenza (487) and pneumonia (480) diagnoses.

Average all-payor case volume, length-of-stay, revenues, costs, and contribution margins (revenues minus variable costs) were obtained from a proprietary database, based on a national sample of Medicare, Medicaid, and private insurance claims from 2005 (The Advisory Board Company, Washington, DC).

Results

Bed Use

In 2000, the estimated occupancy rates for non-ICU and ICU licensed hospital

Exhibit 2. FluSurge Results for Average Community Hospital

Scenario		1	2	3	4	5	6	7	8
HHS Moderate	Weekly admissions	11	18	26	33	33	26	18	11
	Avg # of flu patients in hospital	8	13	19	24	25	22	17	11
	Avg # of flu patients on ventilators	1	2	3	3	4	4	3	2
HHS Severe	Weekly admissions	120	201	301	381	381	301	201	120
	Avg # of flu patients in hospital	88	147	221	280	290	255	196	128
	Avg # of flu patients on ventilators	9	19	29	39	42	41	32	22

beds were 57 percent and 66 percent, respectively,[16] leaving around 62 non-ICU and six ICU licensed beds unoccupied per hospital. On any given day, 15 of 20 ventilators are being used,[17] leaving five free ventilators per hospital, on average.

During an eight-week period, a hospital admits, on average, 179 elective surgical cases, with an average length-of-stay of 3.9 days. Deferring these cases would free 698 bed-days, or an average 12.5 beds per day. Combining existing free capacity with elective deferrals, a hospital would thus have around 81 free beds, on average.

At the moderate pandemic's peak, 25 flu patients would require beds and four would require ventilators. At the severe pandemic's peak, 290 would require beds and 42 would require ventilators (*see* Exhibit 2).

Financial Effects of Deferring Elective Surgical Cases

During a severe pandemic, the shortage of beds would force hospitals to defer elective surgical cases. Elective surgical cases generate $805,795 in contribution margins per eight-week period (*see* Exhibit 3). Replacing these cases with influenza, pneumonia, and ARF cases generates margins of $451,810. The net loss from the deferrals is thus $353,985.

Costs of Uncompensated Care

During a pandemic, hospitals would face an increase in uncompensated costs, because of a surge in the number of uninsured patients. If a hospital admits all of the cases projected by FluSurge, these cases will generate variable costs of $671,853 during a moderate

Exhibit 3. Effect of Replacing Elective Surgical Cases with Flu Cases per Eight Weeks

	Elective Surgical Cases Deferred	Influenza Cases	Pneumonia Cases	ARF Cases
Number of Cases	179	74	74	13
Bed-Days per Case	3.9	3.7	4.1	9.5
Bed-Days Deferred/Admitted	698	270	304	124
Margin per Case ($)	4,498	1,738	2,444	11,000
Margin per Bed Day ($)	1,154	475	593	1,157
Total Margins ($)	805,795	128,226	180,336	143,248

Exhibit 4. Costs of Uncompensated Care During Eight-Week Pandemic

		Influenza Cases	Pneumonia Cases	ARF Cases	Total
Scenario					
	Variable costs per case ($)	2,539	3,072	9,660	
Moderate	Number of cases	74	74	26	175
	Total variable costs ($)	189,113	228,813	253,927	671,853
	Uncompensated costs ($)	10,590	12,814	14,220	37,624
Severe	Number of cases	852	852	301	2,006
	Total variable costs ($)	2,164,412	2,618,785	2,906,219	7,689,416
	Uncompensated costs ($)	121,207	146,652	162,748	430,607

pandemic, and $7.7 million during a severe pandemic (*see* Exhibit 4). In 2005, 5.6 percent of hospital costs were uncompensated.[18] At this rate, a hospital will face uncompensated care costs of $37,624 during a moderate pandemic, and $430,607 during a severe pandemic.

Limitations

Because our analysis was limited to average data from a national sample, these results have stronger implications for national policymakers than for individual hospitals, whose margins may significantly differ from national averages. If a pandemic disproportionately affected Medicare and Medicaid populations, then contribution margins on flu cases would be lower than those we used. (For instance, the average margin per Medicare ARF case is $154 lower than the all-payor average, per bed-day.) If a pandemic disproportionately affected uninsured populations, then uncompensated care costs would be higher than those we estimated.

As our analysis focuses on margins during a pandemic, we did not estimate regained income from rescheduled elective cases. After a pandemic, hospitals may admit some deferred elective cases; some deferred patients will recover or die before receiving hospital care, whereas others will be lost to competing facilities.

We did not estimate the effects of a pandemic on overhead or non-influenza margins. Non-influenza costs could increase, because of overtime costs, supply shortages, and increased lengths of stay; the costs may decrease, as hospitals might discharge non-flu patients early or increase patient-to-staff ratios. We ignored hospitals' other revenue-generating activities, such as outpatient services and retail sales.

Discussion

During a moderate pandemic, an average hospital could absorb HHS' projected flu patients without deferring elective cases, and would accrue only $37,624 in uncompensated care costs. With broad variation among hospitals in the percentage of uncompensated care, the financial burden would be higher for some hospitals than for others.

The financial effects of a severe pandemic would be more significant. Bed shortages would require deferring elective surgeries and replacing them with flu cases, causing an average cash flow loss of $353,985 per hospital. The costs of uncompensated care

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would average $430,607 per hospital. The combined cash flow loss would average $784,592 per hospital, or $3.9 billion for all US hospitals. Some hospitals may not have sufficient cash on hand to cover these losses.[19]

Combined with preexisting unoccupied beds, deferring elective surgical admissions will free only 81 of the 290 beds a hospital needs, on average, during a severe pandemic's peak—and will free at most 20 of the 42 ventilators needed. Deferring elective surgical admissions by itself is insufficient; other surge strategies to expand capacity in and outside the walls of the hospital are needed.

Although hospitals are expected to increase admissions during a flu pandemic, our analysis suggests that these admissions will decrease hospital profits. This study looks at only two components of hospital finances that may be affected by a pandemic. Actual losses may be higher than this study suggests. The severity and duration of a pandemic could be greater than HHS assumes. H5N1 now has an inpatient mortality rate greater than 50 percent; HHS assumes rates of 19 percent and 24 percent. A severe pandemic could cause staff absences and medical supply interruptions that severely compromise the ability of hospitals to deliver care.[20]

The expected negative financial impact on hospitals of a severe pandemic is significant. Under the existing disaster assistance system, much of hospitals' financial loss is not reimbursable. As such, hospitals should include their financial personnel in pandemic planning. Federal policymakers should consider contingencies to ensure that hospitals do not become insolvent as a result of a pandemic.[21]

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SIMULATION METHODS IN HEALTH SERVICES RESEARCH: APPLICATIONS FOR POLICY, MANAGEMENT, AND PRACTICE

Microsimulation of Financial Impact of Demand Surge on Hospitals: The H1N1 Influenza Pandemic of Fall 2009

Sabina Braithwaite, Bernard Friedman, Ryan Mutter, and Michael Handrigan

Objective. Microsimulation was used to assess the financial impact on hospitals of a surge in influenza admissions in advance of the H1N1 pandemic in the fall of 2009. The goal was to estimate net income and losses (nationally, and by hospital type) of a response of filling unused hospital bed capacity proportionately and postponing elective admissions (a "passive" supply response).

Methods. Epidemiologic assumptions were combined with assumptions from other literature (e.g., staff absenteeism, profitability by payer class), Census data on age groups by region, and baseline hospital utilization data. Hospital discharge records were available from the Healthcare Cost and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS). Hospital bed capacity and staffing were measured with the American Hospital Association's (AHA) Annual Survey.

Results. Nationwide, in a scenario of relatively severe epidemiologic assumptions, we estimated aggregate net income of $119 million for about 1 million additional influenza-related admissions, and a net loss of $37 million for 52,000 postponed elective admissions.

Implications. Aggregate and distributional results did not suggest that a policy of promising additional financial compensation to hospitals in anticipation of the surge in flu cases was necessary. The analysis identified needs for better information of several types to improve simulations of hospital behavior and impacts during demand surges.

Key Words. Microsimulation, H1N1, hospital preparedness, hospital finance

This study was undertaken in the summer of 2009 at the request, and with the support, of the Emergency Care Coordination Center, within the Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services. A pandemic of H1N1 influenza was expected to cause widespread illness in a largely unprotected U.S. population during the fall of 2009.

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Prior to the H1N1 epidemic, epidemiologists had been analyzing and quantifying some of the historical and likely impacts of influenza pandemics: infection rates in various age groups, rates of emergency visits, hospitalization, intensive care services, and rates of death (Meltzer, Cox, and Fukuda 1999; Germann et al. 2006). Those models and new parametric assumptions in 2009 generated a range of estimates for infection in a given region along with the implied levels of demand for care that exceeded normal utilization of hospital resources (U.S. Centers for Disease Control [CDC] 2011a,b). The purpose of this study was to estimate the potential financial impacts of the predicted demand surge on hospitals of various kinds. Two outcomes of interest were projected: net income (or loss) from additional influenza cases accepted and losses from postponing profitable elective admissions.

For consistency of terminology in this study, "cost" refers to the hospital's cost of production of services. "Revenue" is the amount received for patient care from patients, insurers, and government programs. Finally, "net income" or "loss" is the difference between revenue and cost. Profit will be synonymous with net income.

The primary goal of the study was to estimate how hospitals would be affected financially if every hospital in an area adopted a passive response of accepting a "fair share" of the overall surge in demand to occupy unused bed capacity and to displace elective admissions as needed. If losses from following a passive response, under a broad range of parametric assumptions, would be substantial for many hospitals, or even for narrow classes of hospitals, then assuming a passive response and proportionate distribution of burdens would be unrealistic. Some hospitals concerned about solvency would begin to refuse a proportionate share of extra cases, leading others to be unwilling to impair their own solvency by taking a disproportionate burden of cases. Policy makers could use simulation results to help decide whether to promise, in advance, partial compensation for incremental losses incurred.

At the time this study was done, there was only a limited amount of literature addressing the systemic economic impact of demand surges at the

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hospital, regional, and national levels (Keogh-Brown et al. 2010). Meltzer, Cox, and Fukuda (1999) estimated economic impact of vaccination-based interventions to support priority setting. They estimated the age distribution of those infected and the rates of hospitalization by age, based on experience in three pandemics in the 20th century. The U.S. Health and Human Services Pandemic Influenza Plan (2006) recommended that hospitals defer elective admissions to increase their capacity to treat influenza patients in the event of a surge in demand. However, there were neither specific regulations in place to enforce that recommendation nor a plan for financial incentives to encourage or facilitate it.

Lim et al. (2004) and Wu, Yang, and Wu (2004) found that deferrals of elective admissions during the severe acute respiratory syndrome (SARS) viral outbreaks in Toronto and Taiwan, respectively, resulted in hospitals losing net revenue, at least in the short term. Matheny, Toner, and Waldhorn (2007) estimated that an influenza outbreak in the United States similar to the one that occurred in 1918 could result in an "average" hospital losing more than $350,000 because of deferred cases and increases in uncompensated care. Questions could be raised about the assumptions of that study, which, as we note below, highlights the importance of continued research on the capacity of the U.S. health care system and the likely response of different health care "actors" (e.g., hospitals, physicians, nurses, and payers) to disasters and other surge events.

Most hospitals have some level of unused capacity to allow a community to meet temporary increases in demand (Joskow 1980). However, hospitals differ in baseline capacity and staffing, occupancy rate, the flow of elective admissions, diagnostic case mix, and payer mix. Hospitals of any particular size or type that are already operating at a relatively high capacity utilization would not be as easily able to accept a surge of new cases as would other hospitals in their peer group. Microsimulation models can find a new market solution for all hospitals and the population according to some equilibrium criterion, despite substantial variety in hospital types, capacities, and baseline conditions. Microsimulation is appropriate when individual actors can behave differently, but their combined responses generate feedback loops that affect all actors. An iterative method can be designed to find a new equilibrium for each market or regional area.

Microsimulation has been used in the literature of health economics, at least as far back as the work of Martin Feldstein and colleagues in the 1970s (e.g., Feldstein, Friedman, and Luft 1972) in which health insurance was assumed to change for various population segments classified by age and

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income. Microsimulation models have been used by the Congressional Budget Office and the Agency for Healthcare Research and Quality (AHRQ) with its Medical Expenditure Panel Survey program to project budget impact of complex health policies of the past decades, including the 2010 Patient Protection and Affordable Care Act (Cohen and Hudson 2009; Elmendorf 2011).

The microsimulation described here assumes a passive response in the supply of services. Specifically, this is defined as a proportional response by each hospital to meeting the area's excess demand, depending on the hospital's unused capacity plus capacity freed up by postponing elective admissions. Some hospitals could reach an upper limit on feasible utilization. (That idiosyncratic limit is unknown to the analyst and must be assumed.) For a large enough increase in demand, the entire area may use up its total available capacity and therefore special arrangements would have to be made for treatment outside of the usual sources of acute care (and thus outside of the model for this analysis). Indeed, in the case of the 2009 H1N1 epidemic, alternative sites of care were under active consideration by a federal interagency group, the Council on Emergency Medical Care, representing the relevant civilian and defense departments. For this analysis, we used an iterative model to spread excess hospital demand in a proportional manner during each iteration, subject to constraints. If every hospital postponed elective admissions in the assumed way, then after the surge, each hospital would presumably be able to admit the patients it deferred. However, there would also be a temptation for a hospital to act as a "free rider" by not postponing elective admissions and even proceeding to accept elective admissions that were postponed at other hospitals. No attempt to prevent free riders was assumed in our model. If the simulated results on net financial impact under a range of the assumptions in the simulation were found to be modest, then a potentially costly compensation program to discourage free riders—with possible problems of its own—could be avoided.

This study adds to the literature by the explicit approach to microsimulation of financial impacts on different types of hospitals of a demand surge: allowing outcomes to vary in different geographic regions; recognizing the preexisting distributions of occupancy rates for different types of hospitals; and recognizing likely system and individual behavioral changes in a pandemic as suggested by Beutels, Edmunds, and Smith (2008), including staff absenteeism and changes in elective caseload.

As with any microsimulation model based on multiple behavioral assumptions, the results are a complex mix of the underlying parameters and

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differences in starting positions (e.g., occupancy rates, staffing ratios). The simulation is not intended to produce an unconditional prediction of what would happen, but rather what could occur with a particular kind of response in the acceptance of burdens of a surge in demand.

Data and Methods

Data sources and overall modeling assumptions. The microsimulation incorporated inputs from multiple sources. Epidemiologic parameters specific to H1N1 were built into the Centers for Disease Control (CDC) FluSurge Special Edition (CDC 2011a). Based on that work, and considering possible vaccine effectiveness, the President's Council of Advisors on Science and Technology (PCAST) forecasted an attack rate net of vaccine effectiveness of between 15 and 25 percent for the fall of 2009. The hospital admission rate for affected patients was estimated to be 0.01336 (President's Council of Advisors on Science and Technology's 2009). The net hospitalization demand was the product of the attack rate and hospital admission rate for affected patients. Population counts by region were based on the July 2008 census estimates. Based on past research by Meltzer, Cox, and Fukuda (1999), supplemented by interviews with experts and on-site interviews conducted during a preparatory simulation exercise at a hospital, we assumed that an excess demand for visits that could be treated in the emergency department would be handled in the emergency department and would not require inpatient capacity.

Baseline hospital utilization was taken from the 2007 Nationwide Inpatient Sample (NIS) database, which was the most recent year available at the time of the analysis. The NIS is a product of the Healthcare Cost and Utilization Project (HCUP), a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the AHRQ. The NIS includes more than 8 million hospital discharges from over 1,000 hospitals in 40 states. The NIS sample is designed to be a 20 percent stratified sample of U.S. acute care, community hospitals, retaining all discharges of each sampled hospital. The strata for random sampling are defined by Census region, hospital bed size, urban/rural location, teaching status, and ownership/control of the hospital (Healthcare Cost and Utilization Project 2009a). The NIS was selected for this work because of its ability not only to make national estimates but also to estimate hospital behavior for different regions and hospital types. The NIS captures age, primary expected payer, billed charges, and an indicator for whether the case was an elective admission.

Hospital bed capacity, full-time equivalent (FTE) employee staffing, and other hospital-level variables were taken from the American Hospital Association (AHA) Annual Survey of Hospitals for 2007 to correspond with the 2007 NIS. Hospitals were classified by Census region and within Census region by five types: (Type 1) for-profit ownership, under 300 beds; (Type 2) nonprofit and government owned, under 100 beds; (Type 3) nonprofit and government owned, 100–299 beds; (Type 4) 300 + beds, nonteaching; (Type 5) 300 + beds, teaching. These hospital types or "peer groups" are relevant due to the sampling design in the NIS, which recognizes that hospital behavior varies by bed size, ownership, and teaching status.

Hospital staff absenteeism was an issue in planning for the H1N1 pandemic, but timely information on this subject was sparse and mostly did not apply to a situation where health care workers could not be vaccinated, or effective antiviral medication was not quickly available for all workers. Published interview studies suggested that without vaccination staff absenteeism rates could range between 21 percent (Barr et al. 2008) and 38 percent (Martinese et al. 2009). For the simulations here, 20 and 40 percent were selected.

Flu cases treated at each hospital, both in the base year and accepted during the demand surge were defined by specific International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes (Marsden-Haug et al. 2007). Elective cases were identified by using the HCUP admission source and type of admission variables to separate emergency from elective admissions. Each type of case—flu, elective, and other nonelective—had its own average length of stay (LOS) and average cost at a particular hospital.

Cost for each case was estimated as the product of total charges and the hospital's cost to charge ratio, based on standard files from the Centers for Medicare and Medicaid Services (CMS) that provide all-payer, inpatient accounting data. This information is prepared for HCUP hospitals each year (Healthcare Cost and Utilization Project 2009b) and earlier years. The rate of hospital net income for privately insured patients (24 percent over cost) was taken from national data (Medpac, 2006, p. 100). For Medicaid and self-pay, the experience of four large states with mandated hospital accounting reports was used (Friedman et al. 2004, p. 242). The combined assumptions for the net income or profit percentage over cost were Medicare, 0 percent; private insurance, 24 percent; Medicaid, −19 percent; and self-pay and charity, −13 percent, respectively. These rates are net, after assigning all discounts, allowances, and subsidies to the relevant payers.

Overview of Simulation. For each Census region and hospital type, we first estimated a potential reduction in usable bed capacity based on staff absenteeism. Then we calculated the percentage increase in new cases (demand) for the region. Then the proportional assignment of patients to a hospital was calculated based on its share of unused bed capacity plus elective admissions. That comprised the first-round assignment of patient encounters to hospitals. During the first round, some patients may not be placed in hospitals and some hospitals may reach their usable inpatient capacity limit. All unplaced patients from the first round were then assigned in a second round to those hospitals with remaining capacity. The series of assignments then proceeded iteratively until either all patients were placed, or all hospitals were at capacity with some patients unplaced. We assumed that if there were unplaced cases at the end, they would be cared for, but at alternative sites of care outside community hospitals. For each hospital, the payer and cost of influenza cases accepted, and elective cases postponed, determined the estimated short-term profit or loss impact of H1N1 for that hospital. Financial impact was aggregated by hospital type within region, as well as nationally.

Detailed Simulation Methods and Specific Assumptions. The following assumptions were made independently of the epidemiologic parameters for the demand surge. Although they were made partly for convenience, and partly based on feedback from advisors, in general, they had the effect of making hospitals look more like the "extreme" hospitals in their category in 2007 in response to the demand surge (i.e., they generally made hospitals in each category have high occupancy rates or low rates of staff to bed capacity). The assumptions were as follows:

- The surge of demand arrived at a steady rate during the fourth calendar quarter of 2009, rather than gradually building up, peaking, and coming down gradually over a longer period. The exact time profile of impacts was not a key interest of the study.
- FTE staff per "usable bed" had to be kept above a cutoff set as the lower 25th percentile level of preexisting staff per bed for the hospital type in 2007. Thus, the number of "usable beds" could be calculated by reducing actual beds after taking absenteeism into account. Any hospital already below that cutoff in 2007 was assumed to remain at the preexisting ratio of staff per usable bed.
- When a hospital reached a trigger point of unused bed capacity—set as the 10th percentile of unoccupied capacity rate for hospitals in its

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type—it began to postpone elective admissions. Postponing elective admissions is a potentially controversial issue within a hospital affecting relations with particular groups of physicians and other staff. We selected the trigger point so that it would not be reached by most hospitals in a seasonal surge in demand.

- After postponing elective admissions, larger hospitals during a pandemic were assumed to be capable of reaching an unoccupied capacity rate of 0 percent, whereas smaller hospitals (Types 1 and 2 defined above) could reach an unoccupied capacity rate of 15 percent. Larger hospitals tend to run at higher occupancy rates than smaller hospitals, but the specific assumptions are admittedly arbitrary selections, nationally representing more than the 95th percentile of occupancy for both smaller and larger hospitals in the baseline year.

In the simulation, the following variables were defined for each hospital h. B_h, usable acute medical-surgical bed capacity; N_{eh}, baseline quarterly flow of elective patients with an average LOS of L_e; N_{oh}, baseline quarterly flow of other patients with LOS of L_o; D_h, total baseline bed days used. $D_h = (N_{eh}*L_e + N_{oh}*L_o)$; UC_h, unused capacity for bed days. $UC_h = 90*B_h - D_h$; Z_h, the lowest rate to which unused capacity can be pushed for h; N_f, additional flu patients seeking admission in the region, with average LOS of L_f.

The total additional demand for bed days of care in the fourth quarter of the year was N_f*L_f. The total capacity available in the area, including postponable elective cases was as follows:

$$CA = \Sigma_h[UC_h{}^*(1 - Z_h) + N_{eh}{}^*L_e]$$

where $\sum h$ [...] was the sum over all h in the region. The uniform proportional burden of added cases placed on the region in round 1 of the calculation was as follows:

$$R_1 = (N_f * L_f)/CA$$

Therefore, each hospital was assigned (i.e., we assumed it would accept) a number of flu cases determined by:

$$R_1{}^*[UC_h{}^*(1 - Z_h) + N_{eh}{}^*L_e]$$

A hospital gave priority to filling its available unused bed days until a trigger rate was reached at which time it began to postpone elective admissions. But a hospital could eventually reach its lower limit constraint on unused capacity, Z_h, with no remaining postponable elective admissions.

At the end of the first-round calculation, the sum of all cases that could not be accepted by their first hospital, divided by the remaining total capacity was R_2. The second round of calculations applied the R_2 proportion to the available capacity of each hospital with remaining capacity. Again, if some hospitals could not accept their assigned cases, the process continued with a third round and so forth. Eventually, either all flu cases for the region were assigned to a hospital, or all hospitals reached their constraint on capacity utilization with some flu patients unassigned to a hospital. At this new equilibrium, for each hospital the number of flu cases was known, the number of postponed elective admissions was known, the cost of such cases was known in 2007 dollars, and the payer mix for elective and for flu patients at the hospital was known. Therefore, for each hospital the net income or loss from additional flu patients, and the losses from postponed elective patients could be calculated.

RESULTS

Table 1 provides some baseline national data to illustrate key variables that play a role in the simulations. The actual data in the simulations were at the regional or individual hospital level. Section (a) of the table illustrates occupancy rates of acute care, community hospitals by hospital type. It is clear from the occupancy rates that, on average, there was a substantial amount of unused inpatient capacity in the U.S. health care system, and also that the two categories of larger hospitals tended to run at higher occupancy ratios. Section (b) of the table shows how much of the baseline occupancy was utilized for elective admissions—between one fifth and one third of total occupied capacity for all but the smallest hospitals. An examination of these cases revealed that 56 percent were nonemergency admissions with major procedures using the operating rooms (e.g., spine and disc procedures, hip or knee joint replacements, coronary artery bypass or angioplasty procedures, hysterectomy, insertion of pacemaker, open prostatectomy, etc.). Another 24 percent of these admissions involved minor therapeutic or diagnostic procedures, and 16 percent were medical, not involving therapeutic or diagnostic intervention codes. The classification of major or minor procedures used the diagnosis-related group for the case, with software downloadable from the HCUP User Support website.

Section (c) of Table 1 provides data on the average cost of influenza cases and the other broad types of cases in the baseline period. (In the simulations, cost was calculated using each hospital's cost to charge ratio applied to

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Table 1: National Baseline Data, 2007 (Regional Data Will Be Used in the Simulations) (from AHA Annual Survey Matched to NIS)*

Hospital Category	*Short-Stay Community Hospitals*	*Nonbirth Discharges (000)*	*Mean LOS*	*Mean Beds*	*Occupancy Rate, %*
(a) Occupancy rates					
1. For-profit, under 300 beds	984	3,230	4.74	89	47.9
2. Nonprofit and government, under 100 beds	1,990	2,731	3.81	43	33.3
3. Nonprofit and government, 100–299 beds	1,329	10,814	4.50	183	54.8
4. 300+ beds, nonteaching	542	10,291	4.84	435	57.8
5. 300+ beds, teaching	254	7,950	5.31	599	76.0

Hospital Category	*Short-Stay Community Hospitals*	*Elective Discharges (000)*	*Mean LOS*	*Mean Beds*	*Occupancy Rate, %*
(b) Occupancy rates, elective					
1. For-profit under 300 beds	984	881	5.11	89	14.1
2. Nonprofit and gov't under 100 beds	1,990	703	3.89	43	8.8
3. Nonprofit and gov't 100–299 beds	1,329	2,908	4.07	183	13.3
4. 300+ beds, nonteaching	542	3,159	4.28	435	15.7
5. 300+ beds, teaching	254	2,077	4.29	599	16.1

	LOS	*Cost*
(c) Length of stay and average cost		
Elective	4.27	$10,039
All nonelective	4.94	$9,223
Flu	3.74	$6,120

	Elective, %	*Flu, %*
(d) Primary payer, by case type		
Medicare	33.6	30.2
Medicaid	16.1	29.5
Private Insurance	43.5	33.6
Uninsured	3.1	4.3

Note: *NIS discharge data are a stratified 20% sample of hospitals, weighted for national estimates.

the charges for each case type at the hospital.) Section (d) provides data on the payer breakdown for elective and flu cases. Interestingly, the proportion of uninsured inpatient cases was not much greater for flu cases than for elective admissions. Elective cases were much less likely to be Medicaid beneficiaries who tend to generate losses. Profitability by payer, together with the average cost of different types of admissions at a particular hospital, determined the calculated net income or losses for individual hospitals.

Table 2 shows that a high percentage of absenteeism could potentially decide which hospitals would have to postpone more elective admissions to accept the proportional burden of new flu cases. With a 20 percent reduction in FTE staff, the average FTE/bed in each category would not be brought down to the previous lower cutoff point. Of course, with a skewed distribution of FTE/bed the behavior of the average might not show that a substantial number of hospitals would be brought down to the cutoff point and their number of usable beds would fall. Clearly, with a 40 percent reduction, a hospital at the previous average of FTE/bed would have to make a substantial reduction in usable beds. For a large teaching hospital in that position, usable beds would fall about 22 percent below actual beds.

Even with a 40 percent FTE absenteeism assumption, and the higher 25 percent net attack rate, the simulation did not project a large adverse impact on hospital net income compared with the 2007 baseline for any hospital type. This is shown in Table 3. Slightly over 1 million H1N1 flu cases would be admitted, but only 52,000 elective cases would be postponed. That would be a very small percentage of all elective cases. Occupancy rates would be driven up by the basic assumption of proportional acceptance of the burden of the demand surge. The largest increases in occupancy were projected for medium-sized hospitals and large nonteaching hospitals. In teaching hospitals, occupancy rates were not driven up on average, presumably because they were already operating at higher occupancy rates and were more affected by the staff absenteeism reducing usable capacity. A loss was calculated for all postponed admissions, but it was less than the net income from flu cases ($36.5 million vs. $119.2 million).

Clearly, many of the assumptions in the simulation algorithm could be varied, and substantially different results would be calculated for the number of postponed elective cases and the distribution across hospital types. The number of additional flu admissions would not change, however. Unless the resulting occupancy rates for the medium-sized hospitals and large nonteaching hospitals shown here were considered to be unreachable levels, the number of postponed elective admissions would not come close to the number of additional flu cases.

Discussion

The simulation with relatively extreme parameter assumptions did not project a large adverse impact on hospital net income compared with baseline for any

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Table 2: Illustrative Effects of Absenteeism, Using National Data

FTE per Bed Hospital Type	Mean Hospital Beds	FTE Staff/Bed	Lowest Quartile	Average FTE/Bed after Reduction (a) −20%	Average FTE/Bed after Reduction (b) −40%
1. For-profit, under 300 beds	89	3.81	2.92	3.05	2.29
2. Nonprofit and gov't under 100 beds	43	5.18	3.24	4.14	3.11
3. Nonprofit and gov't, 100–299 beds	183	5.28	3.76	4.22	3.17
4. 300+ beds, nonteaching	435	5.14	3.83	4.11	3.08
5. 300+ beds, teaching	599	7.59	5.77	6.07	4.55

Table 3: Impacts of Relatively Severe Assumptions (National totals or weighted averages, dollar amounts in 2007 $)

	New H1N1 Flu Cases Admitted (000)	Postponed Elective Cases (000)	Duplicative Elective Cases Accepted, %	Occupancy, Weighted Average, %	Loss for Elective Cases ($000)	Net Income for Flu Cases ($000)
Hospital type						
1: For-profit, under 300 beds	115.9	3.3	98.5	60.7	3,205	13,477
2: N-P and gov't, under 100 beds	107.8	6.6	96.0	49.8	4,341	12,531
3: N-P and gov't, 100–299 beds	313.8	13.1	98.7	67.0	8,257	36,493
4: 300+ beds, nonteaching	315.5	26.7	97.6	72.0	19,002	36,686
5: 300+ beds, teaching	171.8	2.2	99.7	75.0	1,703	19,983
Total	1,024.8	52.0	97.6		36,509	119,169

Note. For the severe assumptions: net attack rate 25%, length of stay for flu cases 5 days, 40% absenteeism.

hospital type. Therefore, other simulation runs were not reported. The results in Table 3 from a national perspective can be linked to several key influences and assumptions. First, the increase in number of flu cases, driven by national epidemiologic assumptions, represented only a 2.9 percent increase in total admissions demanded compared with baseline. This was not large in relation to the unused bed occupancy in the medium size, and large, nonteaching hospitals combined (Table 1). Second, the net income percentage over cost

for any patient depended only on the patient's payer. Additional influenza patients were more likely to be Medicaid patients than were elective cases, but Medicaid and self-pay were together only about one third of the extra flu cases and therefore did not result in an overall loss for flu patients. Clearly from section (d) of Table 1, flu patients were less profitable than elective cases that were postponed, but they did generate a positive net income on average and relatively few elective cases were postponed.

There were a number of substantial limitations in this microsimulation that must be highlighted. In most cases they represent a challenge for better data resources and research on decision making in hospitals. One fundamental issue is the accurate measurement of capacity. The acute care bed capacity measured by AHA attempts to capture beds that are "set up" and usable, but the counts give rise to occupancy rates that are suspiciously low. If it is possible that the bed count is accurate, patients in a semiprivate room greatly appreciate the other bed being usually empty. However, is there actually sufficient staff readily available for handling patients in both beds, or do hospitals plan to raise and lower staff overtime and temporary staffing flexibly with occupancy? In the latter case, the marginal cost of additional occupants could be greater than the baseline average cost per case.

A related question is how low the FTE staffing per bed can be driven for a short period without forcing hospitals to close bed units rather than see quality of care decline. In the absence of published research on this topic we used a relative yardstick that is admittedly arbitrary, assuming that all hospitals in a given category and area could fall to the 25th percentile of FTE/bed in the baseline year as a result of absenteeism, before deciding to take beds out of service. If a higher percentile cutoff was used, more beds would have been removed from available capacity and more elective admissions would have been postponed. However, if hospitals are able to hire temporary employees to replace some of those who are absent, more available capacity would be preserved, but cost per case would likely increase.

Cost per patient for the H1N1 cases could increase compared with previous flu cases, due to either of the two staffing issues raised above, or other costs such as obtaining special equipment and supplies. As Medicare, Medicaid, and some private insurers have negotiated or set payment levels earlier, the extra costs may be partially unreimbursed. In the results above, if unreimbursed costs of reaching the increased occupancy rates projected for medium-sized and large nonteaching hospitals were substantial, this would tend to close the gap between the net income from the additional flu cases versus the losses from postponed elective cases.

In planning the simulation, we hoped to address separately the use of intensive care unit (ICU) beds. The number of ICU beds might become more of a bottleneck than routine acute care beds during a pandemic influenza attack. Specialized equipment that could be used in other bed units for patients with pulmonary disease might also become a bottleneck, but we did not have useful data on that issue. It is reasonable to suppose that hospitals with fewer ICU beds, regardless of total unused routine beds, would be constrained to accept fewer flu cases and would postpone more elective surgeries. The use of ICU beds was not measurable for hospitals in many of the states participating in HCUP. We were able to examine ICU utilization data for a dozen states which collect standardized detailed charge information for each hospital stay. An investigation of data on ICU bed utilization compared with data on ICU capacity from the AHA did not yield plausible baseline occupancy rates (the results were too low). Therefore, we did not make ICU bed capacity one of the constraints in the simulation.

The results are potentially sensitive to what we called the "trigger" percentile of unused capacity (specific to the hospital category and area in the baseline year) at which elective admissions would start to be postponed. There was no quantitative evidence on this managerial issue. Our advice from a small number of experts was to expect a highly nonlinear response, that is, that available beds would have to be very low before any elective cases would be deferred. Therefore, we set the trigger at a fairly low percentile of unused capacity. For example, in the category of large, nonteaching hospitals, the 10th percentile cutoff of unused capacity implies 17 percent of total capacity (data not presented above). This is similar to the average occupancy rate for elective cases, shown for that category in section (b) of Table 1. A lower trigger could be argued on the basis of the advice we received. A higher trigger could result in somewhat more postponement of elective admissions. However, in view of the high unused capacity in relation to the 2.9 percent increase in admissions, the higher trigger would likely make little difference in the current results. Some emergency planners would make assumptions sensitive to the etiology and duration of demand surge (i.e., no notice, short term, long term, localized vs. widespread geographic impact). For surge events that far outstrip system capacity, further evaluation of the viability of early discharge home, as proposed by Kelen et al. (2009), provides an additional opportunity to meet demand.

We used the HCUP NIS to make the levels of analysis regional as well as national. In addition, the NIS is available to researchers broadly for replicable simulations. However, the use of the NIS required the assumption that

any inpatient bed within the Census region is available to any patient within that region. The Census region is overly broad for a realistic simulation of what could happen in local communities. Future simulations should at least test a more focused state or local-level picture, for those states with complete data releasable to analysts, incorporating various thresholds for surge specific to that area (Kaji, Koenig, and Bey 2006). Such single-state or local area databases do not yield national estimates but would better reveal the range of possible local results.

Fortunately, the H1N1 pandemic of 2009 proved to be less severe than feared. However, there were a variety of impacts on access, utilization of hospitals, and outcomes of care that continue to be analyzed. Rubinson et al. (2013) examine the impact of H1N1-related surge on in-hospital mortality for congestive heart failure, acute myocardial infarction, acute stroke, and injury.

CONCLUSIONS

The study demonstrates the feasibility and limitations of a microsimulation that estimated the financial impact on hospitals of a large-scale surge event. Demand was accommodated in proportion to unused capacity and postponable elective admissions at baseline, subject to constraints of effective capacity. Although behavior of hospitals in responding to a regional surge in demand would likely be much more complex, the simulation can give an early indication about whether promises should be made for compensation in accepting new patients. The study exposed numerous challenges related to lack of information in the literature on hospital response to surge—notably, the likely responses to absenteeism during an epidemic, special capacity constraints for resources such as intensive care beds, levels of occupancy at which elective admissions would be postponed, and cost increases to meet a demand surge. Illustrative results of a relatively severe scenario did not support an argument for promising some kind of compensation for losses incurred, and such payment policies were not adopted.

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of the authors and do not reflect the policies of federal or state governments or private associations supplying data used in the study.

Disclosure: None.

Disclaimer: None.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix AS1. Author Matrix.

The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid

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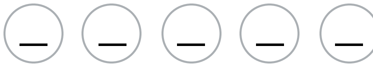

ISSUE BRIEF

While millions of people have gained coverage through the expansion of Medicaid under the Affordable Care Act (ACA), state decisions not to implement the expansion leave many without an affordable coverage option. Under the ACA, Medicaid eligibility is extended to nearly all low-income individuals with incomes at or below 138 percent of poverty ($17,236 for an individual in 2019).[1] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-1) This expansion fills in historical gaps in Medicaid eligibility for adults and was envisioned as the vehicle for extending insurance coverage to low-income individuals, with premium tax credits for Marketplace coverage serving as the vehicle for covering people with moderate incomes. While the Medicaid expansion was intended to be national, the June 2012 Supreme Court ruling essentially made it optional for states. As of January 2020, 14 states had not expanded their programs.[2] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-2)

Medicaid eligibility for adults in states that did not expand their programs is quite limited: the median income limit for parents in these states is just 40% of poverty, or an annual income of $8,532 for a family of three in 2019, and in nearly all states not expanding, childless adults remain ineligible.[3] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-3) Further, because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many

adults, including all childless adults, fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the poverty level, which is the lower limit for Marketplace premium tax credits (Figure 1).

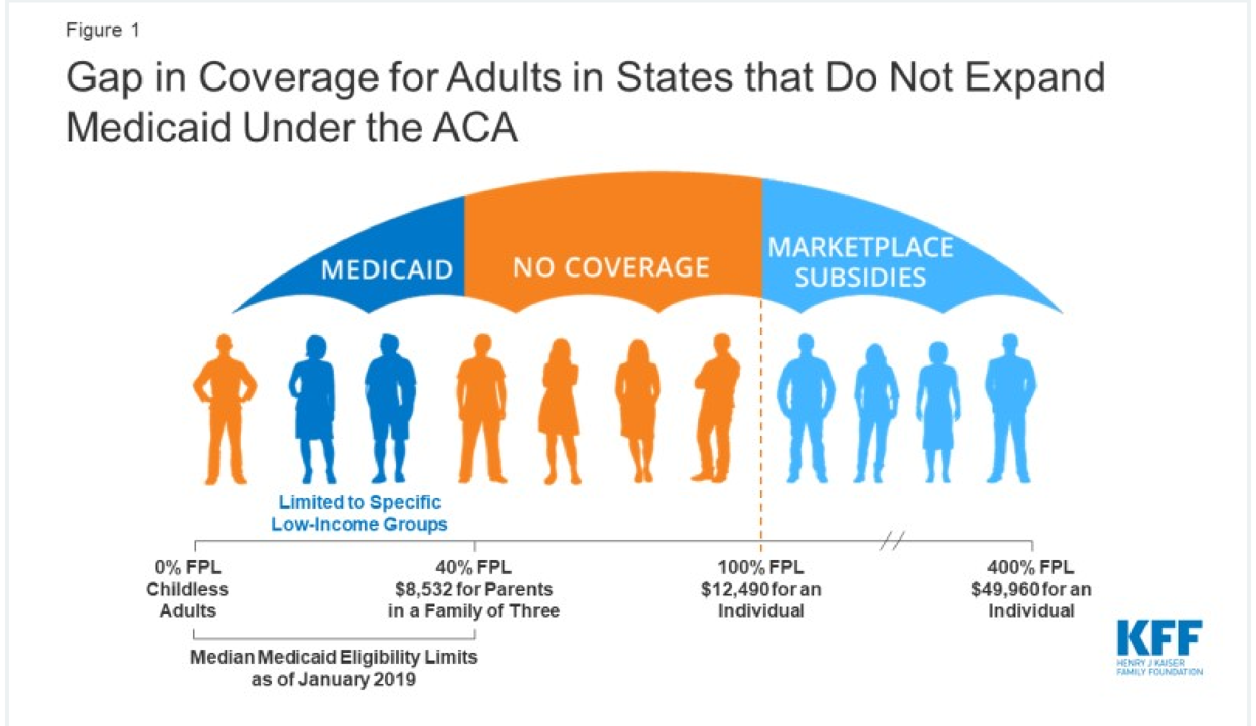

Figure 1: Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA

This brief presents estimates of the number of people in non-expansion states who could be reached by Medicaid if their states adopted the expansion, and discusses the implications of them being left out of ACA coverage expansions. An overview of the methodology underlying the analysis can be found in the Data and Methods (https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-data-and-methods/), and more detail is available in the Technical Appendices (https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-technical-appendix-a-household-construction).

How Many Uninsured People Who Could Have Been Eligible for Medicaid Are in the Coverage Gap?

Nationally, more than two million[4] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-4) poor uninsured adults fall into the “coverage gap” that results from state decisions not to expand Medicaid (Table 1), meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would

be eligible for Medicaid had their state chosen to expand coverage. Reflecting limits on Medicaid eligibility outside ACA pathways, most people in the coverage gap (76%) are adults without dependent children.[5] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-5)

Adults left in the coverage gap are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations. A third of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Seventeen percent live in Florida, eleven percent in Georgia, and eight percent in North Carolina. There are no uninsured adults in the coverage gap in Wisconsin because the state is providing Medicaid eligibility to adults up to the poverty level under a Medicaid waiver.

The geographic distribution of the population in the coverage gap reflects both population distribution and regional variation in state take-up of the ACA Medicaid expansion. The South has relatively higher numbers of poor uninsured adults than in other regions, has higher uninsured rates and more limited Medicaid eligibility than other regions, and accounts for the majority (9 out of 14) of states that opted not to expand Medicaid.[6] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-6) As a result, more than nine in ten people in the coverage gap reside in the South (Figure 2).

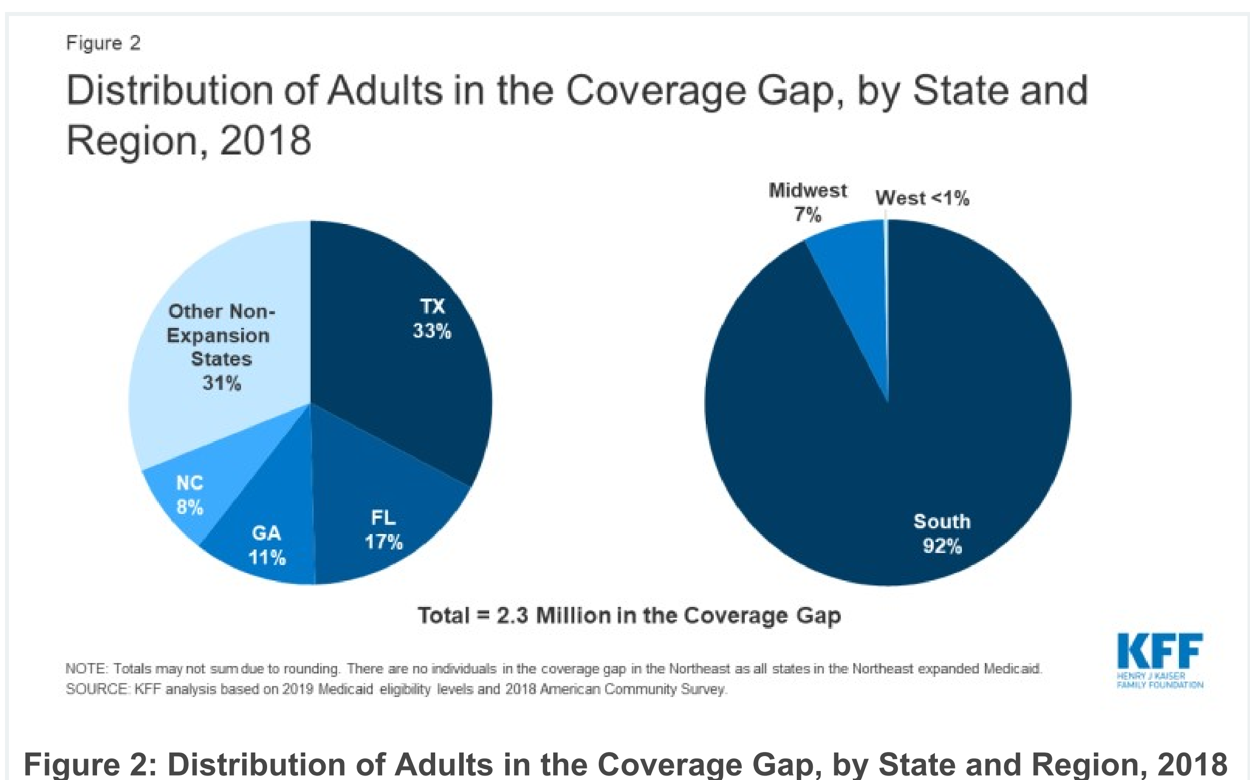

Figure 2: Distribution of Adults in the Coverage Gap, by State and Region, 2018

What Would Happen if All States Expanded Medicaid?

If states that are currently not expanding their programs adopt the Medicaid expansion, all of the 2.3 million adults in the coverage gap would gain Medicaid eligibility. In addition, 2.1 million uninsured adults with incomes between 100 and 138% of poverty[7] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-7) (most of whom are currently eligible for Marketplace coverage) would also gain Medicaid eligibility (Figure 3 and Table 1). Though most of these adults are eligible for substantial tax credits to purchase Marketplace coverage,[8] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-8) Medicaid coverage would likely provide more comprehensive benefits and lower premiums or cost-sharing than they would face under Marketplace coverage. For example, research from early implementation of the ACA showed that coverage of behavioral health services, prescription drugs, rehabilitative and habilitative services, and long-term services and supports may be more limited in the Marketplace compared to Medicaid.[9] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-9),[10] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-10) In addition, research examining the population with incomes between 100-138% FPL in expansion and non-expansion states finds that Medicaid expansion coverage produced far greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.[11] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-11)

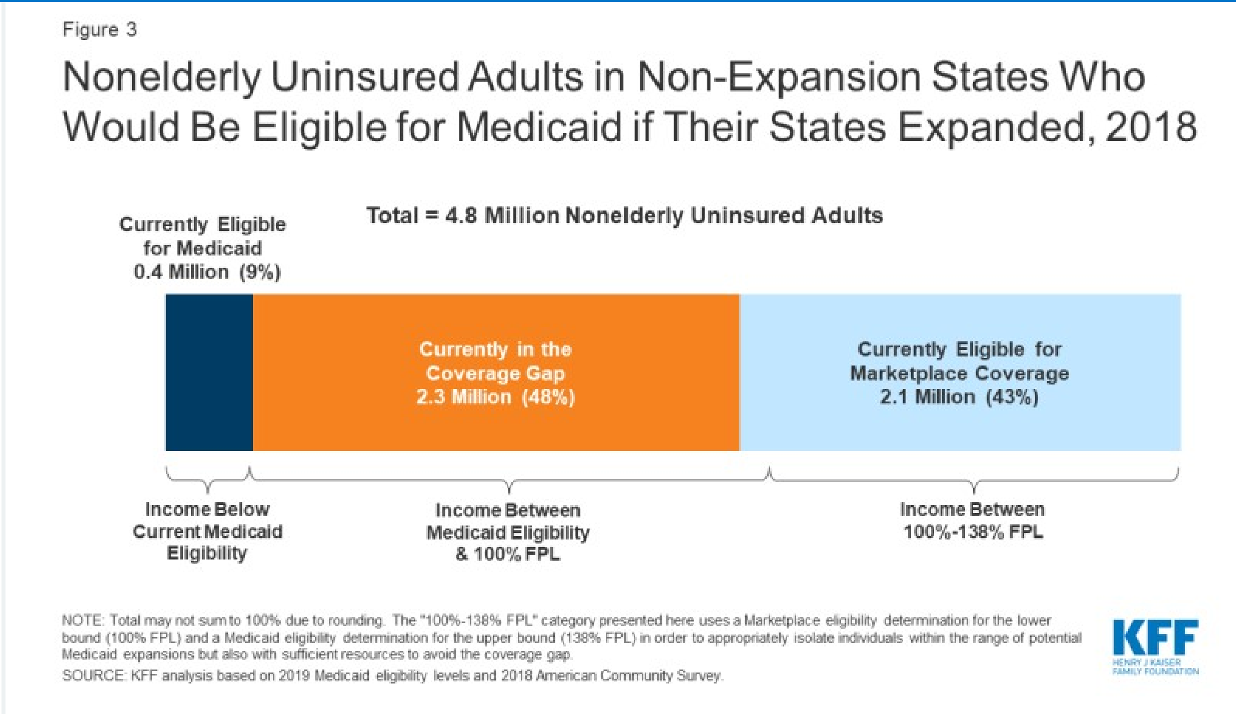

Figure 3: Nonelderly Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded, 2018

A smaller number (about 418,000) of uninsured adults in non-expansion states are already eligible for Medicaid under eligibility pathways in place before the ACA. If all states expanded Medicaid, those in the coverage gap and those who are instead eligible for Marketplace coverage would bring the number of nonelderly uninsured adults eligible for Medicaid to more than 4.8 million people in the fourteen current non-expansion states. The potential scope of Medicaid varies by state (Table 1).

Discussion

The ACA Medicaid expansion was designed to address the high uninsured rates among low-income adults, providing a coverage option for people with limited access to employer coverage and limited income to purchase coverage on their own. In states that expanded Medicaid, millions of people gained coverage, and the uninsured rate dropped significantly as a result of the expansion.[12] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-12) However, with many states opting not to implement the Medicaid expansion, millions of uninsured adults remain outside the reach of the ACA and continue to have limited options for affordable health coverage. From 2017 to 2018, non-expansion states saw a significant increase in their uninsured rate, while expansion states did not.[13] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-13)

By definition, people in the coverage gap have limited family income and live below the poverty level. They are likely in families employed in very low-wage jobs, employed part-time, or with a fragile or unpredictable connection to the workforce. Given limited offer rates of employer-based coverage for employees with these work characteristics, it is likely that they will continue to fall between the cracks in the employer-based system.

It is unlikely that people who fall into the coverage gap will be able to afford ACA coverage, as they are not eligible for premium subsidies: in 2020, the national average unsubsidized premium for a 40-year-old non-smoking individual purchasing coverage through the Marketplace was $442 per month for the lowest-cost silver plan and $331 per month for a bronze plan,[14] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-14) which equates to nearly eighty percent of income for those at the lower income range of people in the gap (below 40% FPL) and nearly a third of income for those at the higher income range of people in the gap.

If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require and receive medical care, potentially serious financial consequences. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured under the ACA, this system has been stretched in recent years due to increasing demand and limited resources.

Most people in the coverage gap live in the South, leading state decisions about Medicaid expansion to exacerbate geographic disparities in health coverage. In addition, because several states that have not expanded Medicaid have large populations of people of color, state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans.[15] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-15) As a result, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color.

There is no deadline for states to opt to expand Medicaid under the ACA, and debate continues in some states about whether to expand. For example, legislatures in Kansas and Wyoming are likely to take up the issue in the upcoming 2020 session.[16] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-16) Further, initiatives in several states, including Missouri, Oklahoma, and South Dakota, may put the question of Medicaid expansion on the ballot in upcoming elections. The three states (Idaho, Nebraska, and Utah) that adopted the Medicaid expansion via ballot initiative in the November 2018

election all plan to implement expansion in 2020 with state Medicaid waiver proposals that condition the scope and structure of expansion. The Trump Administration has indicated to states that it is open to these types of proposals, which may lead additional states to consider extending coverage. However, some proposed waivers that could expand coverage for some people in the coverage gap also place new restrictions or requirements on that coverage.[17] (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/view/footnotes/#footnote-444945-17) Thus, it is uncertain what insurance options, if any, adults in the coverage gap may have in the future, and these adults are likely to remain uninsured without policy action to develop affordable coverage options.

Table 1: Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded, by Current Eligibility for Coverage, 2018

State	Total	Currently Eligible for Medicaid	Currently in the Coverage Gap (<100% FPL)	Currently May Be Eligible for Marketplace Coverage (100%-138% FPL**)
All States Not Expanding Medicaid	4,850,000	418,000	2,324,000	2,108,000
Alabama	242,000	17,000	134,000	91,000
Florida	846,000	42,000	391,000	414,000
Georgia	518,000	44,000	255,000	219,000
Kansas	87,000	7,000	40,000	40,000
Mississippi	186,000	16,000	100,000	70,000
Missouri	217,000	13,000	113,000	92,000
North Carolina	389,000	32,000	194,000	163,000
Oklahoma	197,000	20,000	95,000	82,000
South Carolina	214,000	20,000	101,000	93,000
South Dakota	35,000	5,000	14,000	16,000
Tennessee	260,000	39,000	117,000	103,000
Texas	1,553,000	99,000	761,000	693,000
Wisconsin*	88,000	64,000	0	24,000
Wyoming	18,000	N/A	9,000	7,000

NOTES: * Wisconsin provides Medicaid eligibility to adults up the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. ** The "100%-138% FPL" category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap. Totals may not sum due to rounding. N/A: Sample size too small for reliable estimate.
SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

DATA AND METHODS (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-COVERAGE-GAP-UNINSURED-POOR-ADULTS-IN-STATES-THAT-DO-NOT-EXPAND-MEDICAID-DATA-AND-METHODS/) —

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Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California.*

Health Benefit Exchange Authority

coronavirus.dc.gov
Read Mayor Bowser's Presentation on DC's COVID-19 Situational Update: July 13.
Phase Two of Reopening Set to Begin on June 22

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Listen

DC Health Link to Offer Even More Opportunities for Residents to Get Covered

Tuesday, February 11, 2020

DCHBX Executive Board Votes to Allow Pre-Natal Special Enrollment Period and Four Other New Opportunities

(Washington, DC) – With Open Enrollment recently concluded, District residents and small businesses have new opportunities to sign up for health insurance coverage through DC Health Link. The DC Health Benefit Exchange Authority (DCHBX) Executive Board recently adopted recommendations from its Standing Advisory Board to create four Special Enrollment Periods (SEP) and an extended open enrollment period for DC small businesses.

The Special Enrollment Periods involve pregnancy—in which a pregnant woman and her dependents can enroll in individual market or small business coverage; reinstatement when customers were enrolled in auto-payment

and were terminated due to credit card changes or expirations; and two SEPs associated with the District of Columbia individual responsibility requirement to have health insurance—one allowing taxpayers who first learn of the local individual responsibility requirement when they file their taxes for 2019 to enroll in coverage and a second allowing taxpayers who are new DC residents to enroll in coverage. The Executive Board also voted to allow an Extended Employer Open Enrollment Period for 2020 in the small business marketplace, where small businesses can enroll without minimum participation and contribution requirements.

"We listened to District residents and small business owners who told us about these particular circumstances and hardships to obtain or maintain coverage," said Diane C. Lewis, M.P.A., Chair of the DC Health Benefit Exchange Authority Executive Board. "As an Executive Board, we want to make sure that District residents have every opportunity available to them to enroll in quality, affordable health insurance."

- Pregnancy SEP: A pregnancy is now considered a qualifying life event for enrollment throughout the year. A Special Enrollment Period is available to pregnant women, and their dependents, allowing enrollment in individual market or small business coverage. A pregnant woman and her dependents can enroll in new coverage or change their existing coverage on DC Health Link. The special enrollment period is triggered based on the date a health care practitioner confirms the pregnancy. A pregnant woman can enroll retroactively starting coverage the month that her pregnancy is confirmed. She also has up to 60 days after confirmation of pregnancy to enroll in individual coverage and 30 days to enroll in her employer's coverage if the employer offers coverage through DC Health Link's small group marketplace.

- Reinstatement Following Auto Payment SEP: A SEP is now available to residents enrolled in an individual market plan to reinstate their prior coverage if their coverage was terminated due to a declined payment through a credit card or debit card auto-payment arrangement. To be eligible for this SEP, the customer must have successfully established the auto-payment arrangement with their insurance company directly. Reinstatement will result in continuous coverage in the same plan. The SEP would not be available if the reason for the declined payment was that the individual voluntarily terminated the auto-payment arrangement or there were insufficient funds for the payment.

- Individual Responsibility Requirement SEPs: The District of Columbia enacted a local individual responsibility requirement, modeled after the previous federal requirement, which became effective January 1, 2019. A SEP will be available to residents who learn about the individual responsibility requirement during the tax filing season this year, giving those residents a 60-day window to enroll in individual market coverage from when they learn of the individual responsibility requirement or based on their tax filing deadline. A separate SEP will be available to new District residents, giving them a 60-day window to enroll in coverage upon becoming a District resident.

- Small Business Open Enrollment 2020: SHOP Open Enrollment is extended through 2020 to allow small businesses to offer coverage even if they can't meet the minimum contribution and participation requirements. This is the first time that small businesses can enroll anytime during the year without having to contribute at least 50% toward employees' premiums and without having participation by two-thirds of their employees who don't have coverage elsewhere.

View more information on these four new enrollment opportunities.

Background

The most recent Open Enrollment Period for individuals and families in the District of Columbia concluded February 5, 2020. For District residents eligible for any of these new enrollment opportunities, there are 25 private health insurance options from CareFirst Blue Cross Blue Shield and Kaiser Permanente for individuals and families. Small businesses have 156 different options from three United Health Companies, two Aetna companies, Kaiser Permanente and Care First Blue Cross Blue Shield. Residents eligible for Medicaid can enroll year round.

The Affordable Care Act provides individuals, families, and small businesses in the District of Columbia with affordable options for quality health insurance. DC Health Link is the District's online health insurance marketplace which allows visitors to shop, compare, and enroll in coverage that fits their needs and budgets.

In 2019, DC Health Link provided health insurance to almost 23,000 residents through the individual marketplace and more than 101,000 people through the small business marketplace. Washington, DC has the second lowest uninsured rate among all states in the nation, with almost 97 percent of District residents covered. Since opening for business in 2013, DC Health Link has helped cut the District's uninsured rate in half.

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For Immediate Release: March 10, 2020

Washington Healthplanfinder Announces Special Enrollment Period in Response to Growing Coronavirus Outbreak

OLYMPIA, Wash.

In response to the potential growth of Coronavirus (COVID-19) cases, the Washington Health Benefit Exchange (Exchange) today announced a limited-time special enrollment period for qualified individuals who are currently without insurance. This special enrollment period (SEP), that runs through April 8, 2020, will allow uninsured individuals 30 days to enroll in health insurance coverage through *Washington Healthplanfinder*.

Until April 8, individuals seeking a special enrollment must contact the Customer Support Center between 7:30 a.m. to 5:30 p.m. Monday-Friday at 1-855-923-4633; TTY: 1-855-627-9604, or a local certified broker or navigator, request the SEP, *and select a plan* by April 8 for coverage start date beginning April 1, 2020. Language assistance and disability accommodations are provided at no cost.

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shawna.bruce@wahbexchange.org

"It is apparent that many in our state have been exposed to this virus and that health insurance will be critical to those seeking treatment," said Exchange Chief Executive Officer Pam MacEwan. "Individuals need to have peace of mind to take care of all health needs, especially if they are at a high risk. Given today's exceptional circumstances we are enabling those who are uninsured to enroll and gain access to the vital services they may need."

Customers who experience another qualifying event (such as marriage, birth of a child or a move) are also eligible to shop for coverage and/or those who qualify for Medicaid through Washington Apple Health is available year round on *Washington Healthplanfinder*.

Reminders: *Enrollment is offered year-round to individuals and families through Washington Apple Health (Medicaid). Customers enrolled in Apple Health will receive a notice of 60 days before the month they enrolled in or renewed their coverage last year.*

About *Washington Healthplanfinder*

Washington Healthplanfinder is an online marketplace for individuals and families in Washington to compare and enroll in health insurance coverage and gain access to tax credits, reduced cost sharing and public programs such as Medicaid. The next qualified health and dental plans open enrollment period for *Washington Healthplanfinder* begins on Nov. 1, 2020.

About Washington Apple Health

In Washington, Medicaid is called Washington Apple Health. Free or low-cost coverage is available year-round for those who qualify. Since the Affordable Care Act launched in October 2013, more people have access to preventive care, such as cancer screenings, treatment for diabetes and high blood pressure, and many other health care services they need to stay healthy. Apple Health clients enroll and renew online using *Washington Healthplanfinder*. Apple Health is administered by the Washington State Health Care Authority: www.hca.wa.gov.

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benefit

Toll-free support is available:
7:30 a.m. to 5:30 p.m. Monday – Friday
1-855-923-4633;
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Language assistance and disability accommodations are provided at no cost.

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Massachusetts Health Connector offers extended enrollment for uninsured individuals to ease coronavirus fears

×

On March 30, the special enrollment deadline was extended an additional month to May 25, 2020. Learn more →

BOSTON – March 11, 2020 – To ensure everyone who wants access to covered coronavirus services has it, the Massachusetts Health Connector announced today that uninsured residents can apply and get into coverage through a 45-day window running until April 25.

On March 6, the Division of Insurance announced that Massachusetts health insurers are now required to cover the cost of testing and treatment for members who may be affected by the Coronavirus (COVID-19), including not charging co-pays or deductibles for those services. The Health Connector's decision to open enrollment to anyone without coverage ensures Massachusetts residents concerned about contracting coronavirus can access necessary services without cost barriers.

Additionally, the Health Connector will be delivering to current members information about the Division of Insurance guidance, reassuring members that coronavirus-related services are available at no cost.

"The coronavirus represents a significant and growing public health threat, and the Massachusetts Health Connector is committed to making sure residents have access to testing, treatment and other related services as necessary," said Louis Gutierrez, the Executive Director of the Massachusetts Health Connector. "With 97 percent of residents covered, almost everyone in

Massachusetts understands the ongoing value and need for coverage, but if anyone is considering signing up now, we encourage them to do."

Typically, the only time of year anyone can newly access coverage is during Open Enrollment, which runs from November through January. However, because of the public health threat created by the coronavirus and the increased public interest in prevention and treatment, the Health Connector is opening enrollment for uninsured residents through April 25. For people wanting coverage starting April 1, the deadline to apply, pick a plan and pay the first month's premium is March 23.

Residents who need health insurance can call 1-877-MA-ENROLL (1-877-623-6765) to gain access to the enrollment period, and go to MAhealthconnector.org to complete an application. From the website, people who qualify for Health Connector coverage may be in the ConnectorCare program, which offers subsidized plans with low premiums and co-pays, and no deductibles for all services. Those who do not qualify for ConnectorCare can pick plans from nine carriers, with as many as 50 plans available. Applicants can also seek out assistance from local Navigator organizations or Certified Application Counselors.

About the Massachusetts Health Connector

The Massachusetts Health Connector is the Commonwealth's health insurance exchange, and currently serves 325,000 individuals and small-employer members with health and dental insurance. Massachusetts residents who do not have health insurance from an employer or other entity can use the exchange to gain coverage. Through the ConnectorCare program, income-qualifying residents

can access coverage that includes low-cost premiums and co-pays, and no deductibles. Access to health coverage for individuals and small businesses can be found at the Health Connector's website, MAhealthconnector.org.

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Wednesday, March 11th, 2020

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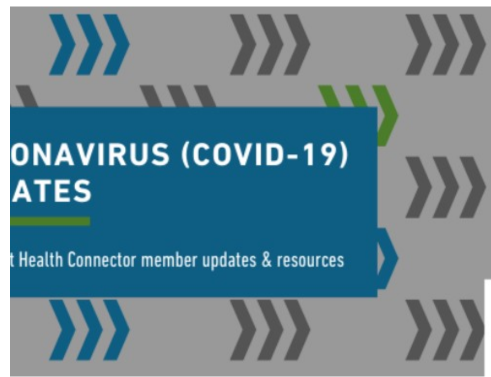

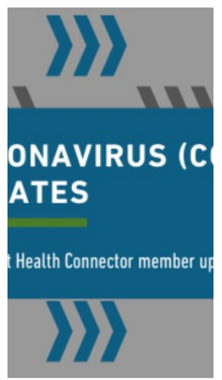

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Administrative Information Bulletin 02-20

Guidance Regarding Special Enrollment Periods Due to the Emergence of the Novel Coronavirus SARS-Cov-2, Which Causes the Disease COVID-19

March 11, 2020

Pursuant to federal regulations at 45 C.F.R. § 155.100 et seq. and state authority at M.G.L. c.176Q, s.2, the Commonwealth Health Insurance Connector Authority (the "Health Connector") is issuing this Administrative Information Bulletin ("Bulletin") to provide guidance in connection with the closed enrollment period for enrolling in non-group Health Connector plans. This Bulletin provides (a) administrative information regarding an additional circumstance that would allow a person to enroll in a Health Connector plan during closed enrollment, which for 2020 is between January 24, 2020 and December 31, 2020, and (b) clarification on the parameters of this special enrollment period. Once open enrollment closes, a person may only enroll in or make changes to their health insurance plan if they experience a triggering event. See 45 C.F.R. § 155.410. Triggering events include, but are not limited to, the following: birth or adoption of a child, marriage, loss of insurance through a job, recently moved to Massachusetts, certain changes in income, or gained an eligible immigration status. See 45 C.F.R. § 155.420; 956 CMR 12.10(5).

The novel coronavirus SARS-CoV-2, which causes the disease COVID-19, poses a clear and acute threat to the health and welfare of Massachusetts residents. Responding to this threat requires adequate access to the resources necessary to receive appropriate testing and treatment. Given that health insurance coverage increases the likelihood that residents will seek out those tests and treatments, the Health Connector is designating a temporary special enrollment period beginning on March 11, 2020 and ending 45 days thereafter on April 25, 2020 for currently uninsured Massachusetts residents. The Health Connector is designating this temporary triggering event in accordance with its authority pursuant to federal regulations at 45 C.F.R. § 155.420(d). To access this special enrollment period, individuals must be otherwise eligible for a Health Connector plan and must not already be enrolled in health insurance coverage through the Health Connector.

The Health Connector reserves the right to verify that individuals meet the requirement of being a new enrollee before granting individuals access to this special enrollment period.

This Bulletin takes effect immediately.

AHIP

AHIP Tracking: State Activities on the Coronavirus

Updated 3.12.2020

ST	Resources	Date	Statements / Activity
AL	Dept of Health resource page Dept of Insurance info page		
AK	Dept of Health & Social Services resource page	3.11.20 3.8.20 3.3.20	Gov. Dunleavy issues public health disaster emergency declaration. DOI Bulletin 20-04: Carriers should waive any cost-sharing for lab testing for respiratory syncytial virus (RSV), influenza, respiratory panel tests, and COVID-19 for enrollees meeting CDC criteria; utilization of telehealth; assess preparedness plans. DOI Bulletin 20-03: Encourages insurers to be proactive – allowing access to drug refills during quarantine, align with CDC guidance, utilizing telemedicine, review all preparedness plans are up to date, etc. Gov. Dunleavy
AZ	Dept of Health Services resource page	3.11.20 3.11.20 3.4.20	Gov. Ducey Executive Order 2020-07: Carriers to cover diagnostic testing regardless if in-network; waive cost sharing on testing; encourage telemedicine; regulatory boards shall prohibit price gouging; AG to investigate consumer fraud. Gov. Ducey proclaims a state of emergency. ADHS webinar series (9 webinars) for: schools, health plans (March 4), providers, healthcare facilities.
AR	Dept of Health resource page	3.11.20	Gov. Hutchinson Executive Order 20-03 declares a state of emergency. Waives professional licensure requirements to maintain robust healthcare workforce… other clinical issues.
CA	Dept of Public Health resource page	3.12.20 3.5.20 3.4.20 3.2.30	DMHC All Plan Letter APL-20-007: To assist with "social distancing" carriers should expand and waive cost sharing on telehealth; allow 90 refill on drugs or suspend limitations and waive delivery charges. DMHC All Plan Letter APL-20-006: Commercial and Medi-Cal plans to reduce cost sharing to zero on testing, ER and office visits; notify providers, educated customer service; display no cost sharing on website. Utilize telehealth when appropriate and waive prior auth/step therapy if shortage of prescriptions drugs. Reminder of timely access, balance billing and network adequacy regs. Gov. Newsom proclaims a State of Emergency (overview of medical providers, prohibits price gouging, hospital quarantines, consumer education, medical transportation.) Does not touch on carriers. Gov. Newsom activated the State Operations Center to 2nd highest level and requesting $20mil

AHIP Tracking: State Activities on the Coronavirus
Updated 3.12.2020

		2.28.20	Gov. Newsom answering to press questions – CA has received many new testing kits and pushing for more testing - people shouldn't panic.
CO	Dept of Public Health & Environment resource page	3.12.20 3.10.20 3.9.20 3.3.20	DOI Emergency Regulation 20-E-01 which formalizes their Bulletin B-4.104. Gov. Polis declares a state of emergency. DOI Bulletin B-4.104: Carriers to waive cost sharing on telehealth visits, testing, office & ER visits, OON visits that are necessary; 1 time early refill of prescriptions; and lists each carrier's telehealth service link. Gov. Polis press statement: implementing State Emergency Operations Plan; they have their own state lab providing testing.
CT	Dept of Public Health resource page	3.10.20 3.9.10 3.2.20 2.26.20	Gov. Lamont – declaration of public health and civil preparedness emergencies. CID Bulletin IC-39: encourages carriers to waive cost sharing on testing, visits, telemedicine; educate consumers; adequate networks with OON when appropriate; allow 90 day refill; leniency related to UR; extend filing deadlines. CID (DOI) has forwarded questions to carriers on: their outreach to enrollees, opening of networks, waiving certain cost sharing, and drug coverage. Gov. Lamont's update: no cases and continue with outreach on prevention.
DE	Department of Public Health resource page	3.12.20 3.9.20	Gov John Carney declares state of emergency DOI applauds carriers voluntarily waive cost sharing and has issued Bulletin 115: Encourages carriers to waive cost sharing on testing, treatment and telemedicine; increase member communications; update contingency plans. Carriers are currently required to cover testing, ER visits, and prescription drugs as an EHB; encourage robust telehealth network; coverage of OON visits when necessary; claim denials should be within UR timeframes; should not use prior auth; formulary exceptions may need to be considered; access to refills.
DC	Health Department resource page	3.11.20 2.28.20	Mayor Bowser declares public health emergency: Order 2020-046 and Order 2020-045; and health advisory warning on public gatherings. Mayor Bowser's Orders on District Preparations (Order 2020-035). Coordination between Dept of Health and Emergency Management Agency, with the activation to "Enhanced Watch".
FL	Department of Health resource page	3.11.20 3.9.20	OIR Informational Memo 20-02M: Carriers are to waive time restrictions on prescription refills and authorize payments to pharmacies for 30 day supply with exceptions (similar to hurricane disasters). Gov. DeSantis declares state of emergency.

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		3.2.20	Executive Order 20-51 directing a Public Health Emergency and statewide response protocol.
GA	Dept of Public Health resource page	3.2.20	Gov. Kemp Names Coronavirus Task Force to assess preparations and procedures.
HI	Dept of Health resource page and daily updates	3.10.20 3.4.20	House Select Committee convened a task force. Gov. Ige declares a State of Emergency
ID	Dept of Health & Welfare resource page	3.11.20 3.4.20	DOI News Release: ID carriers (listed) are voluntarily waive on cost sharing on testing and encourages providers to refrain from balance billing. Gov. Little Press Statement: Creation of a new Working Group to increase state coordination and communication. Actively working with legislative leaders on making state funds available.
IL	Dept of Public Health resource page	3.9.20 3.3.20 3.2.20	Gov. Pritzker has issued a disaster proclamation. DOI FAQ on Coverage: State covers testing, no higher cost sharing on OON providers, ER coverage, drug refills, travel coverage, etc. DOI Bulletin 2020-2: CDC and IDPH will cover the cost of testing; surprise billing reminder on ER visits and utilizing specialists which may be OON but necessary. Encourages carriers to reduce barriers of cost-sharing for those in HDHPs, be flexible in filling prescriptions in the event of quarantine and provide education of treatment coverage.
IN	Dept of Health resource page	3.6.20	Gov. Holcomb issued Executive Order 20-02: declaring a public health emergency.
IA	Dept of Public Health resource page; DOI resource page	3.9.20	Gov. Reynolds has issued a disaster proclamation.
KS	Dept of Health & Environment resource page	3.12.20 3.4.20	Gov. Kelly issues an emergency declaration. Gov. Kelly Press Release: state agencies and stakeholders are coordinated and ready.
KY	Cabinet for Health & Family Services resource page	3.11.20 3.7.20 3.6.20 3.6.20	Gov. Beshear Executive Order 2020-0224: Ordered that Pharmacists may disperse emergency refills of up to a 30 day supply of any non-controlled medications. Gov. Beshear Executive Order 2020-216: prohibiting price gouging of goods and services. Gov. Beshear Executive Order 2020-220: All insurers shall waive all cost sharing and prior auth on testing, visits, lavs, telehealth and immunizations; ensure adequate networks; contact providers; educate enrollees; prescription refills. Gov. Beshear Executive Order 2020-215: declaring a state of emergency.
LA	Dept of Health resource page	3.11.20	Gov. Edwards declares a state of emergency

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		3.2.20 2.14.20	Gov. Edwards forms Coronavirus Task Force to lead Louisiana's planning for different scenarios relating to the spread of coronavirus. Dept of Health Blog post on COVID-19 myth v fact
ME	Division of Disease Surveillance resource page		
MD	Dept of Health resource page	3.10.20 3.6.20 3.5.20 2.27.20	MIA (DOI) Bulletin 20-05 & Press Release: Carriers are encouraged to educate enrollees on benefits; waive cost-sharing for testing, ER/office visits, vaccination; allow OON visits; limiting prior auth; expedited appeals. Gov announced a state of emergency. Carriers to waive cost sharing on testing, visits, immunizations; limit prior auth; reimbursement of OON to in-network; expedite reviews of adverse determinations. Gov. Hogan announces state of emergency. Gov. Hogan announcement of $10mil emergency funding from supplemental budget by passing emergency SB 1079.
MA	Dept of Public Health resource page	3.11.20 3.10.20 2.28.20 1.31.20	State Exchange (Health Connector) Administrative Bulletin 02-20: adds a temporary SEP beginning March 11, ending April 25 for those that are uninsured Gov. Baker Declares state of emergency DPH announces the start of testing for coronavirus. DPH announces coronavirus preparation measures.
MI	Dept of Health & Human Services resource page	3.12.20 3.10.20 3.6.20 2.28.20	Gov. Whitmer announced the allowance of access to telemedicine for Medicaid. Asks for consideration of SEPs. Gov. Whitmer declares a state of emergency. Gov Whitmer states Medicaid will waive all cost sharing and lists carriers that have agreed to do the same. Gov. Whitmer activates state emergency operations center to coordinate response to CONVID-19
MN	Dept of Health resource page	3.10.20	Gov. Walz signs SF3813 authorizing $21mil in funding
MS	Dept of Health resource page		
MO	Dept of Health & Senior Services resource page	3.3.20	DOCI (DOI) Insurance Bulletin 20-03: Asking carriers to assess their readiness plans; streamline education; requests the waive of cost-sharing for testing, ER and office visits; encourages robust telehealth services; OON provider visits should be covered at in-network; UR timeframes; cover immunization w/o cost sharing; expedited drug refill access; DOI requests responses.

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MT	Dept of Public Health & Human Services resource page	3.12.20	Gov. Bullock declares a state of emergency.
NE	Dept of Health & Human Services resource page	3.9.20	Gov. Rickets Press Release: Clinical updates.
NV	Div. of Public & Behavioral Health resource page	3.5.20	DOI Emergency Regulation: Carriers must have no cost sharing for testing, ER and office visits; cover the costs of immunizations; educate on the benefits and telehealth; refills of prescription drugs. Consumer Alert on the reg.
NH	Dept of Health & Human Services resource page	3.11.20	NHID (DOI) released Order requiring carriers: timely information and access to services; waive cost sharing on testing (OON if needed) and visits, waive prior auth on testing; reimburse at any testing site; encourage coverage and robust telehealth; meet network adequacy or cover OON; timely UM decisions; permit 90 day supply of drugs.
NJ	Dept of Health resource page	3.10.20	DOBI (DOI) Bulletin 20-03: Advises carriers to take action on: educating consumers; covering OON necessary visits; timely UM determinations; develop robust telehealth programs; waive cost sharing on immunizations; treatment drugs should be at a preferred level of cost-sharing; (reminder of ER and surprise billing regs).
		3.9.20	Gov. Murphy Executive Order 103 declare a state of emergency & public health emergency
		3.3.20	Gov. Murphy hosts press release on Exec Order 102 creating a Task Force to coordinate state efforts.
		2.28.20	Gov. Murphy calls Vice President Pence on coronavirus preparedness.
NM	Dept of Health resource page	3.11.20	Gov. Grisham issues a public health emergency.
		3.6.20	DOI Bulletin 2020-004: Carriers should educate enrollees and providers on CDC guidelines; systems should adapt to new billing codes; encourage telehealth, ensure preparedness policy is ready; respond affirmatively to the AHIP statement.
NY	Dept of Health resource page	3.11.20	DFS (DOI) Circular Letter 5: Carriers are to respond how their preparedness plans address operation and financial risks-lists specific items. Due April 9
		3.7.20	Gov. Cuomo declares a state of emergency.
		3.3.20	DFS Circular Letter 3: putting in place Governor's announcement on coverage.
		3.2.20	Gov. Cuomo announces requiring NY insurers to waive cost sharing associated with testing (including ER and office visits), and any surprise billing. Medicaid recipients will not pay a co-pay. Carriers must also educate on availability of benefits, including telehealth treatment. Insurers should also prepare to cover the cost of prescription drugs & immunization when available.
		3.2.20	Gov. Cuomo announces expansion for coronavirus testing capacity.

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		3.3.20	A9953 / S7919 Permits the governor to issue by executive order any directive necessary to respond to a state disaster emergency; and makes a $40,000,000 appropriation from the state purposes account of the general fund for responding to the outbreak of coronavirus disease 2019 (COVID-19).
NC	Dept of Health & Human Services resource page	3.10.20 3.10.20 3.5.20 2.11.20 2.26.20	DOI Bulletin 20-B-04: Reminds carriers of state of emergency regs authorizing extra prescriptions. Gov. Cooper Executive Order 116: declares state of emergency and asks the DOI to work with insurers to identify burdens for testing and access to drugs and telehealth services, in order to eliminate cost-sharing for medically necessary screening and testing. DOI Press Release: Engaged with stakeholders. Mentions work with Blue Cross NC – virtual access to providers, expedite of approvals re hospitalization, medical supplies and post-acute care. Governor's Task Force established. Task force to provide response proposals. Task Force recommendations include outline of precautions for all business and education sectors.
ND	Dept of Health resource page	3.11.20	NDID (DOI) Bulletin 2020-1: Requires carriers and STLDI to review preparedness plans, communication with enrollees; waive cost sharing on testing and visits, immunizations; abide by state telehealth guidance; verify adequate networks, cover OON; waive prior auth; expedite formulary exceptions. Requests OON providers to accept the highest of in-network reimbursement as full payment and use the carrier's in-network labs.
OH	Dept of Health resource page; Consumers page	3.11.20 3.9.20 3.5.20 2.27.20	ODI (DOI) Bulletin 2020-02: Reminds carriers of coverage they are already required to provide on ER, UM, telemedicine, appeals, access, prescriptions, keep members informed of benefits. STLDI are not included. Gov. DeWine declares a state of emergency Gov. DeWine Summit (video) for local health departments; state can provide targeted testing. Gov. DeWine announced preparations on addressing CONVID-19 and scheduled a summit on March 5 to discuss the state's further steps.
OK	Dept of Health resource page	3.5.20	OHA will host a call briefing CCOs & insurers at 9am PT. Register Here.
OR	Health Authority resource page	3.8.20 3.5.20	Gov. Brown Exec Order 20-03: declares a state of emergency. Gov. Brown announced (8) insurers have partnered with the state to offer no cost sharing on testing and immunization. Pursuing the same arrangement with self-insured plans.

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PA	Dept of Health resource page	3.10.20 3.9.20 3.6.20	DOI Notice 2020-03: review preparedness plans; educate enrollees on their benefits, waive cost sharing on testing, OON visit, office/ER visits; assist enrollees with in-network services to avoid surprise billing; cover telehealth services; expedite UR and appeal procedures; cover refills; coordinate with self-funded employers; provide steps on carriers activities to the DOI. Gov. Wolf Press Release: Listed 10 carriers who have agreed on waiving costs on testing. Explains limitations of non-insurance products. Included is a FAQ on insurance coverage related to medically necessity services and ER visits. Gov. Wolf declares a state of emergency.
RI	Dept of Health resource page	3.9.20	Gov. Raimondo Executive Order 20-02: declaration of disaster emergency.
SC	Dept of Health & Environmental Control resource page		
SD	Dept of Health resource page		
TN	Dept of Health resource page	3.12.20 3.11.20 2.28.20	Gov. Lee Executive Order 14: emergency order. TDCI (DO) Bulletin 20-02: requesting carriers review preparedness plans; educate enrollees; waive cost sharing on testing, visits, immunizations; review telehealth reg; review for adequate networks; timely UR; expedite formulary excepetions; report back to agency. Statement from Health Commissioner that the state is prepared.
TX	Dept of State Health Services resource page	3.10.20 3.4.20 2.27.20	Gov. Abbott & TDI (DOI) announced they have requested carriers: waive cost sharing on testing, telehealth, related supplies, necessary OON visits; waive prior auth; allow extra time for filing claims; allowing refills. TDI resource page requesting carriers: monitor CDC guidelines (i.e. denials), consider communication with enrollees on your options of telemedicine, ascertain your contingency plans are up to date. Gov. Abbot briefing on monitoring and preparation.
UT	Dept of Health resource page DOI Coronavirus & Your Insurance	3.11.20 3.6.20	DOI Payer Forum Gov. Herbert declares a state of emergency.
VT	Dept of Health resource page	3.6.20 3.5.20	DOH Health Advisory: Guidance to hospitals, health care facilities and emergency medical services to support personal protective equipment needs. DOH Health Advisory: Guidance to providers and facilities - be able to triage, consider rescheduling elective surgeries, revisit quarantine procedures, etc.

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		2.28.20	DOH press release on preparation efforts and safety tips.
VA	Dept of Health resource page	3.12.20	Gov. Northam Executive Order 51(2020): declaring a state of emergency.
WA	Dept of Health resource page OIC – Insurance & Coronavirus Health Care Authority (regulator of Medicaid, school, public employee plans) resource page	3.11.20 3.10.20 3.5.20 3.1.20 2.29.20 2.28.20	OIC (DOI) Asks labs to honor their unique role in supporting the common good. While the DOI does not have authority, they will be monitoring for excessive charges. State Exchange announced an SEP through April 8 with coverage effective April 1 for individuals who are currently uninsured. OIC Emergency Order 20-01: Health plans & STLDI must cover testing and office visits w/o copay; suspend prior authorization to testing; modify prescription refills and OON reimbursement for insufficient network adequacy areas. HCA is working with their carriers to ensure testing and treatment will be covered when determined necessary by a provider. Gov. Inslee issues a state of emergency proclamation, which directs the Washington State Comprehensive Emergency Management Plan to be implemented. $8.6mil included in appropriations waiting on Gov. signature (not confirmed.) Office of Insurance Com: blog post stating coverage is required by insurers of medically necessary treatments.
WV	Dept of Health & Human Resources resource page	3.9.20 3.4.20	OIC (DOI) Bulletin 2020-01: Insurers to review their preparedness plans; inform enrollees on related benefits; waive cost sharing on testing, office/ER visits, OON necessary visits, immunizations; encourage telehealth; reminder of UR timelines; exceptions on prescription refills; alert OIC on carrier's current steps. Gov. Justice declares a state of preparedness.
WI	Dept of Health Services resource page	3.12.20 3.6.20	Gov. Evers Executive Order 72: declares a state of emergency. OCI (DOI) Bulletin: Directs carrier to – have preparedness plans ready; education for enrollees; no cost sharing on testing and office visits or immunizations; encourages telehealth; adequate networks or in-network payments; expedite prior auth, refill of prescriptions, etc.
WY	Dept of Health resource page		
CMS	Medicaid resource page	3.12.20	(CMS) released an FAQ on COVID-19 for state Medicaid and CHIP agencies.
NGA	*Coronavirus: What You Need to Know*. A webpage tracking state activities and government announcements.	3.19.20 3.11.20 3.3.20	NGA Partners COVID-19 Webinar Call on Congress to expand liability protections to ensure a supply of respirators are available, coverage under the PREP Act.

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			NGA Gov. Hogan & Cuomo (leadership) Joint Statement: Governors spoke with VP Pence to discuss fed-state coordination and called on federal leaders to reject partisanship and work together on appropriations and a united national response. Governors will be hosting weekly calls.
NAIC	NAIC Coronavirus Resource Center: Links to govt websites and news on impact to businesses and insurance.	3.20.20	Will host a full day meeting at upcoming Spring National Meeting
NCSL		3.3.20	Blog Post: providing a summary of resources and state activities
ASHTO			Emergency Declarations & Authorities Fact Sheet (not specific to COVID-19)

Notes:

- Highlighted dates are specific to health insurance providers. This document does not include occasional updates from state agencies unless they impact insurers directly.
- This is working document with additions and corrections made daily.

Contact:
Kris Hathaway - Vice President, State Affairs
America's Health Insurance Plans – Coronavirus Webpage
Cell [redacted] (NJ & DC) | [redacted]

Acronyms:

DOI	Department of Insurance
ER	Emergency Room (Emergency Services)
OON	Out of Network
SEP	Special Enrollment Period
UM	Utilization Management
UR	Utilization Review

Writer is seeking health insurance

March 12, 2020

Secretary Mr. Azar/ Assistant Secretary Mr. Lance Robertson,

I need urgent help with the health insurance. I am [redacted] years old. I never had any illness. I am fit. Because of the Coronavirus fear I want to take a health insurance. I do not have enough credits for medicare. The insurance company Ambetter or others are not allowing me to enroll just now because they say the enrollment period is in November. I would appreciate if you and other lawmakers make the insurance companies to enroll people like me even though the enrollment period is over because Coronavirus is a national emergency. I do not want to go bankrupt if I get coronavirus through no fault of mine. I would appreciate your urgent help. I live in [redacted], OH

Sincerely,

[redacted]

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Health Care Priorities For A COVID-19 Stimulus Bill: Recommendations To The Administration, Congress, And Other Federal, State And Local Leaders From Public Health, Medical, Policy And Legal Experts

Howard P. Forman, Elizabeth Fowler, Megan L. Ranney, Ruth J. Katz, Sara Rosenbaum, Kavita Patel, Abbe R. Gluck, Christen Linke Young, Brendan G. Carr, Erica Turret, Suhas Gondi, Timothy Jost, Adam L. Beckman

MARCH 12, 2020 10.1377/hblog20200312.363618

With nationwide community-spread of the novel coronavirus COVID-19 and extreme volatility in the economic markets, Congressional action is necessary and appropriate to help keep the United States healthy and to avoid financial calamity. Doing so will require significant financial investment, legislative and executive action, and the full participation of all segments of American society — government, the private sector, and individual citizens.

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"Health Care Priorities For A COVID-19 Stimulus Bill: Recommendations To The Administration, Congress, And Other

As experts in public health, medicine, policy and law, and with prior expertise in developing federal health legislation and public health initiatives, we hereby present a framework designed to protect the health of all Americans in the face of this unprecedented epidemic. Because this framework is directed at Congress, we do not detail critical efforts that must be undertaken, and in some cases already are being undertaken at the state level. States have broad emergency powers to regulate insurance and health care access. If asked, the President should immediately invoke the Stafford Act to trigger an influx of federal funds and support state, tribal, and local government response efforts. An additional Presidential declaration via the National Emergencies Act would empower multiple federal agencies to waive or relax current legal restrictions.

Four basic principles guided the development of the framework offered here:

* Ensuring health security is the fundamental duty and responsibility of government at all levels — federal, state, and local.

* Protecting Americans' health in this time of crisis should be a unifying effort; it should not be and cannot be divisive.

* Immediate and targeted action is required to address the current coronavirus epidemic.

* Sustained investments in public health are needed to respond to this acute crisis and to prepare the nation for future epidemics.

We also note that while this framework is focused on a health care response, this crisis also requires action in many other policy areas. We recognize that there can be substantial harm to vulnerable populations from recession and other economic, workplace, and family disruptions. The federal government should expand access to programs like WIC, TANF, and SNAP, as well as increase the social services block grant in order to help families financially affected. We also urge Congress to require paid sick leave for employees so that they can stay home from work in order to prevent transmission. This should include paid leave to care for sick relatives including dependents and the elderly. We will defer to other proposals to address broader economic effects within the context of a stimulus/bailout package.

Affordable, Accessible Testing & Treatment

Privately Insured Individuals And Families Should Be Protected From High Out-of-pocket Costs That Threaten Financial Well-being And Represent Barriers To Timely Testing And Treatment For The Novel Coronavirus.

- *No cost-sharing for COVID-19 related preventive services.* All private insurance coverage should be required to cover preventive and diagnostic services related to COVID-19 with no cost-sharing, immediately. The ACA's preventive services coverage mandate should be expanded to include services that HHS determines are necessary for mitigating the spread of COVID-19, including screening and diagnostic testing, and any eventual vaccine. Insurers should be required to cover these services immediately.
- *Coverage for treatment, recovery, and complications arising from COVID-19 or suspected infection.* All individual and group market insurance coverage and employer group health plans should be required to cover all medically necessary care related to suspected COVID-19, including testing, treatment, and recovery, and treatment for complications arising from COVID-19 or suspected infection. Plans must cover services regardless of whether covered services are obtained from in-network providers, with payment at the plan's median in-network rate for out-of-network care, and regardless of whether the patient receives a COVID-19 test or whether the test is negative, and providers may not balance bill for these services.
- *Extending these requirements to otherwise unregulated plans.*
    - *Association health plans and short-term limited duration health plans.* Require all AHPs and short term limited duration health plans (STLDI) to cover all testing, treatment and recovery services for COVID -19, including treatment for

Federal, State And Local Leaders From Public Health, Medical, Policy And Legal Experts, " Health Affairs Blog, March 12, 2020.
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complications arising from COVID 19. Bar such plans from cancelling or refusing to renew coverage based on a policyholder's COVID-19 status.
    - *Student health plans*. Require self-insured student health plans to cover all testing, treatment and recovery services for COVID -19, including treatment for complications arising from COVID 19. Require student health plans (whether insured or self-insured) to cover testing and treatment services for any diagnosis or condition relating to COVID-19 delivered away from campus, and prohibit providers from balance billing for services delivered to students covered under a student health plan.
- *Special enrollment period for Marketplace health plans.* Create a sixty-day special enrollment period for individuals seeking coverage through the health insurance Marketplace.

Strengthen State Medicaid Capacity To Respond To COVID-19.

- *Medicaid expansion.* Reinstate the 100 percent federal medical assistance percentage (FMAP) rate for any state that elects to adopt the ACA Medicaid expansion to encourage any state that has not already done so to expand eligibility on a long-term basis.
- *State option for COVID-related care*. Building on the precedent set by the Breast and Cervical Cancer Prevention and Treatment Act, amend Medicaid to add a state option to extend Medicaid eligibility for the duration of the COVID-19 outbreak, to any state resident who is uninsured for all medically necessary services in connection with COVID-related testing, treatment, and recovery, including treatment for complications and other health conditions arising from COVID-19 or that could be worsened by COVID-19. Set federal financial participation rates for this eligibility option at 100 percent. This option would be in place until the end of the quarter in which the HHS-declared public health emergency ends.
- *Federal matching dollars for Medicaid*. For the duration of the COVID-19 outbreak, increase the federal medical assistance percentage (FMAP) nationwide by 10 percentage points over each participating state's otherwise applicable FMAP rate for both traditional and ACA expansion Medicaid beneficiary populations, through the end of the quarter in which the HHS-declared public health emergency ends. Condition enhanced federal Medicaid funding on maintenance of state effort in terms of eligibility, benefits, cost sharing, and premiums.
- *Enrollment and renewal.* Enhance the federal financial participation rate for states that seek to expand enrollment and renewal capabilities, including outstationed enrollment at hospitals and clinics and the addition of eligibility determination and enrollment staff.
- Increase Medicaid funding to Puerto Rico, the Virgin Islands, other U.S. territories, and sovereign states covered by the Compact of Free Association (COFA)
- *Public charge rule.* Suspend the operation of the public charge rule for the duration of the crisis and ensure that no medical services utilized during the crisis apply to any reinstated rule.

Protect Medicare Beneficiaries From Out-Of-Pocket Costs.

- *COVID-related care.* Clarify Medicare coverage (whether through original Medicare or Medicare Advantage) of all diagnosis, treatment, and recovery care related to COVID-19, including care for complications arising from COVID-19, without cost-sharing. In the case of Medicare Advantage plans, require plans to provide coverage at no out-of-pocket cost to patients, and regardless of whether treatment is obtained from in-network providers, with payment at a plan's median in-network rate in the case of out-of-network care.

Ensure Hospitals Are Meeting Their Community Obligations.

- Clarify that hospitals with specialized treatment capabilities must accept transfers (unless capacity has been reached) in the case of inpatients at hospitals that lack such capabilities and that request such a transfer for patients who require specialized care in order to be stabilized.

- *Financial assistance to patients and bar against extraordinary collection practices.* Clarify the obligation of all hospitals that seek tax-exempt status under § 501(c)(3) of the Internal Revenue Code (and are thus, subject to community benefit obligations) to offer financial assistance to all patients at the time services are furnished and not to pursue extraordinary collection efforts (including liens, garnishment of wages, or seizure of real or personal property) in connection with claims related to COVID-19 or conditions related to complications arising from COVID-19.

Vulnerable Populations

Implement Specific Protections For Especially Vulnerable Groups.

- *Vulnerable population-centered policy.* Craft all programs with vulnerable populations in mind, including homeless and undocumented individuals. Communicate with tailored messaging to these and other populations around the urgency of seeking care and provide assurances they will be held harmless when they do seek care with respect to both cost and immigration status.
- *Institutionalized populations.* Additional attention is needed for institutionalized populations (e.g., group home residents, nursing home or long-term care facility residents and incarcerated individuals) who are at high risk of quick transmission of COVID-19.
- *Undocumented patients.* Prohibit immigration enforcement in health care facilities so immigration status does not prevent care-seeking for undocumented individuals.
- *Low-income families.* Increase funding for the Social Services Block Grant (SSBG) by $1 billion for the remainder of FY20 to provide funding for states to assist low-income families negatively impacted by COVID-19. Services provided by states would be specifically tied to the following SSBG statutory goals:
  - Prevent or reduce inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
  - Secure referral or admission for institutional care when other forms of care are not appropriate.
- *Community health centers and Medicaid Disproportionate Share Hospital (DSH) Payments*.
  - Increase funding for community health centers by 25% through the end of FY20 to allow these providers to extend their COVID19 response, particularly to uninsured individuals.
  - Delay scheduled Medicaid DSH cuts beyond the May 22 expiration (when cuts are currently scheduled to be imposed) through the end of 2020.
- *Access to care for incarcerated individuals*. Expand Medicaid coverage for hospitalization of incarcerated individuals. Eliminate the 24-hour waiting period before Medicaid can provide payment for care provided in an inpatient setting outside of the correctional institution.
- *Insurance barriers*. For patients with chronic health conditions who require ongoing prescription medications, require insurers to waive refill limits and prior authorization requirements.
- *Nutritional services.* Access to food is a critical part of health for vulnerable populations under quarantine; consider funding existing visiting nurses or home health providers to provide nutritional services to quarantined vulnerable populations.

Frontline Health Care Workers

Institute Protections For Health Care Workers Of All Professions On The Frontlines In The Epidemic.

- *Ensuring frontline workers are properly equipped.* Increase manufacturing of personal protective equipment (e.g. masks), ventilator equipment, IV saline, and other medically critical supplies to ensure our frontline providers can safely and appropriately care for patients with infection, with government decree if necessary. The Strategic National Stockpile and other similar resources should be mobilized.
- *Financial protection for frontline health care workers.* Establish a health care worker fund similar to the James Zadroga fund established for 9/11 first responders to

protect frontline health care providers including but not limited to physicians, nurses, respiratory therapists, radiology technicians, emergency medical service providers and other first responders, advanced practice providers (e.g., physician assistants, nurse practitioners), certified nursing assistants, and nursing home staff, and their families from financial harm resulting from exposure or infection.
- *Child and elder care for health care workers working extra or unscheduled shifts.* Allow for child care and elder care expenses to be tax exempt and consider how to create tax-deferred funding pools to compensate for emergency childcare for healthcare workers and public health workers called to work outside of expected scheduling due to increased COVID-related demand.
- *Facilitate sharing of best practices among healthcare providers.* Use a multimedia approach to reach as many health care personnel as possible with a goal of sharing best practices (how to set up COVID-19 wards most efficiently, how to consider an alternate staffing model, facilitating testing during a surge demand, etc.).
- *Continuity of funding.* The Centers for Medicare and Medicaid services should not deny residency funding to hospitals if residents are sent home for safety or quarantine related to COVID-19.

Healthcare Delivery Capacity

Strengthen The Capacity Of Health Care Delivery Organizations To Respond To Escalating Demand.

- *Funding and capacity of hospitals and clinics.*
  - Provide emergency subsidies to support under-resourced hospitals and clinics, particularly in rural areas, to support re-purposing clinical units, quarantines, and the cost of additional labor to meet increased demand.
  - Increase funding flexibility for states so they can deploy funds from various sources (Medicaid, CDC transfer funds, emergency supplemental funding) to address shortages.
  - Mobilize Public Health Service to fill staff shortages in local and regional health structures and charge the Surgeon General to be able to quickly add personnel to the Public Health Service if necessary, particularly for vulnerable populations which might lack appropriate staffing, such as border and rural populations.
- Build on emergency expansions in Medicare telemedicine coverage by encouraging states to waive telemedicine requirements that a provider be licensed in the state where care is delivered. Collaborate with national telehealth delivery systems to enhance use of telehealth triage across the country, to efficiently identify patients with suspected COVID-19 infection and refer for testing.
- *Regulatory flexibility*.
  - Allow off site treatment under all federal programs.
  - Allow licensed health care facilities to establish temporary locations to provide care based on need to limit exposures or treat large volumes of patients without waiting for state or local regulatory approval of those locations.
  - Allow emergency departments to divert patients meeting certain criteria (e.g. mild symptoms not requiring urgent stabilization or hospitalization), only during declared public health emergencies, to alternative facilities without fear of EMTALA violations.
  - Approve lab applications to the Food and Drug Administration for emergency use authorization so commercial lab companies to offer testing to meet the need.
  - Exempt clinical laboratories from certain Clinical Laboratory Improvement Amendments (CLIA) regulations for local testing protocols to enable hospitals with capability to enhance testing by mobilizing local PCR lab resources to do so.
- *Establish temporary COVID-specific clinics*. Establish drive-through testing in community areas (e.g. parking lots) to increase capacity to evaluate patients with concerning symptoms and to offset the burden on hospitals. The deployment of pallets to set up tents for evaluation and treatment may accelerate this process.

- *Mental health care.* Provide support to boost mental health workforce capacity beyond the period of a declared public health emergency in order to allow for care related to the consequences of COVID-19.

Public Health Infrastructure

Invest And Improve The Operations Of The Nation's Key Public Health Institutions To Enhance Their Capacity To Respond To The Current Epidemic And To Address The Next One (Which Is Inevitable).

- Deploy federal resources, including appropriate medical and public health personnel to states which request assistance.
- Provide funding directly to state and local governments to hire additional public health personnel, enhance laboratory capacity, and support data collection efforts.
- Reimburse state and local governments for their resources already expended in carrying out these activities.
- Increase funding immediately for CDC and FDA to bolster their containment, monitoring, and mitigation functions, including those related to testing for the coronavirus and COVID-19.
- Establish a dedicated CDC public health emergency fund that (1) is not subject to the annual appropriations process; (2) cannot be used for purposes other than to address public health emergencies, and (3) is automatically replenished when monies from the fund are drawn down. A portion of the fund would be designated for use by state and local health departments, as appropriate, and at CDC's discretion.
- Renovate and otherwise improve outdated CDC buildings and laboratories.
- Undertake a major CDC data modernization initiative designed to allow the agency to collect, analyze, produce, and release relevant information quicker and more efficiently to state and local health departments as well as the public.
- Exempt CDC (and other appropriate HHS agencies) from Paperwork Reduction Act requirements regarding the collection of information during the conduct of research and appropriate public health interventions.
- Revisit Office of Personnel Management (OPM) waiver authority to allow greater direct hire flexibility to CDC (and HHS more broadly), especially in times of public health emergencies.
- Increase funding for the CDC Foundation, an independent, non-profit organization created by Congress to mobilize philanthropic and private sector resources to support CDC health protection work. Because it is an independent organization (and therefore, not subject to government bureaucratic procedures), the Foundation can act quickly in assisting CDC and state and local governments in addressing public health emergencies.
- *Data sharing for tracking and monitoring.*
  - Require all labs to report testing data to the CDC (can be accomplished via presidential emergency declaration).
  - Direct the Department of Health and Human Services (HHS) to establish a national monitoring mechanism of test kit availability with the ability to facilitate just in time testing capacity by having specimens sent to labs with supply.
  - Leverage the recent HHS Interoperability Rule to facilitate rapid sharing of patient-centered data. Consider tasking the US Digital Service and the HHS Office of the Chief Technology Officer to work in partnership with the private sector to create real time information sharing related to lab testing, supplies, access issues, and hotspots.
- *Providing timely, factual information to the public.* Establish both a national hotline and a dedicated Medicare hotline for the public whose purpose, in each instance, is to provide information, answer questions, offer guidance, and triage patients. Such hotlines could be linked to existing call lines such as 211 or 911 or tie into regional poison control hotlines.

Vaccine, Treatments, & Research

Support Research And Discovery Related To A COVID-19 Vaccine, Development Of Novel Pharmaceutical Treatments, And Research On Epidemiology, Risk Factors, Outcomes, And Response To Existing Therapies.

- Development of vaccines, treatments, and methods to better protect health care workers. Provide incentives for both the public and private sector to develop, test, and produce new vaccines and treatment modalities, as well as novel or more efficient methods to sanitize health care facilities and equipment and to otherwise protect health care workers from COVID19 transmission.
- Rapid, equitable access to new vaccines/therapies. Ensure mechanisms are in place to expedite access to vaccination and/or treatments as soon as they are available. This includes expedited processes for FDA review and approval, and potentially the authority to purchase intellectual property for a vaccine or treatment if price gouging occurs.
- New single-mission entity to develop a universal influenza vaccine. Provide support for the establishment of a new, independent, single-mission entity focused on accelerating the development of a universal influenza vaccine, to achieve global protection.
- *Dedicated fund at National Institutes of Health (NIH)*. Provide a dedicated NIH fund to support both basic and applied research on COVID-19. Funded research should include elucidation of basic epidemiology (e.g. incubation period, R0, etc), description of risk factors for infection and for mortality, description of the normal course of and co-occurring disorders (e.g., myocarditis, acute respiratory distress syndrome) with COVID19 infection, development and validation of novel biomarkers of infection and of severe infection, development and validation of improved diagnostic tests, trials of treatments, trials of containment/mitigation strategies, and dissemination and implementation studies. This work should additionally include trials of electronic health record or other data monitoring and experimentation, to speed learning and provide better estimates of risk, outcomes, and strategies to best mitigate the risk.
- *Health services research.* Direct and fund health services, implementation, and comparative effectiveness research through directed mandates to PCORI, AHRQ, and CDC.
- *Health communication.* Direct and fund research on effective health communications strategies for all aspects of COVID19 response including communication with the public, with vulnerable populations, and with health care providers.

The letter will be sent to federal officials on March 12, 2020, but it will remain open for sign-ons at this link. The online version of the letter will be updated as new endorsements come in. Please email covid19stimulus@gmail.com with questions.

Signed

(All individuals speaking on their own and not on behalf of their institutions; affiliations are for identification purposes only.)

Howard P. Forman, Professor of Public Health, Radiology, and Management, Yale University. (Founding member and lead of the group.)

Elizabeth Fowler, Executive Vice President for Programs, The Commonwealth Fund; former special assistant to the president on health care and economic policy at the National Economic Council

Megan L. Ranney, Associate Professor of Emergency Medicine and Health Services, Policy, & Practice, Brown University

Ruth J. Katz, Vice President and the Executive Director of the Health, Medicine and Society (HMS) Program at the Aspen Institute; former Chief Public Health Counsel (Democratic Staff) with the Committee on Energy and Commerce in the U.S. House of Representatives

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Adam Beckman, student, Harvard Medical School

Additional experts who express support:

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Seth Trueger, Assistant Professor of Emergency Medicine, Northwestern University; Digital Media Editor, JAMA Network Open

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Benjamin K. Chu, Former President of NYC Health + Hospitals; Former Acting Commissioner of Health for the New York City Department of Health; Senior Advisor, Manatt Health

Bruce Lesley, Former Senior Health Policy Advisor on the Senate Finance and Health, Education, Labor, and Pensions Committees; President, First Focus

Alice Chen, Co-Founder and Former Executive Director, Doctors for America

Aaron Kesselheim, Professor of Medicine and Director, Program On Regulation, Therapeutics, And Law, Division of Pharmacoepidemiology and Pharmacoeconomics of Harvard Medical School and Brigham and Women's Hospital

Neel Shah, Founder, Costs of Care; Director, Delivery Decisions Initiative at Ariadne Labs; Assistant Professor of Obstetrics and Gynecology, Harvard Medical School

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Gretchen Berland, MacArthur Fellow; Associate Professor of Medicine, Yale School of Medicine

Helen Burstin, Executive Vice President and Chief Executive Officer, Council of Medical Specialty Societies

Jeremiah Schuur, Chair and Physician-in-Chief, Department of Emergency Medicine,The Warren Alpert Medical School of Brown University; Founding Chief, Division of Health Policy Translation, Department of Emergency Medicine, Brigham and Women's Hospital

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Laurie Zephyrin, Vice President, Delivery System Reform, The Commonwealth Fund; Former Acting Deputy Under Secretary for Health for Community Care and National Director of the Reproductive Health Program at the Department of Veterans Affairs

Eric Topol, Founder and Director, Scripps Research Translational Institute

Asaf Bitton, Executive Director, Ariadne Labs; Former Senior Advisor to Centers for Medicare and Medicaid Innovation

Saad Omer, Director, Yale Institute for Global Health; Associate Dean (Global Health Research), Yale School of Medicine; Professor of Medicine (Infectious Diseases), Yale School of Medicine; Susan Dwight Bliss Professor of Epidemiology of Microbial Diseases, Yale School of Public Health

Complete and growing list of supporters is being updated here.

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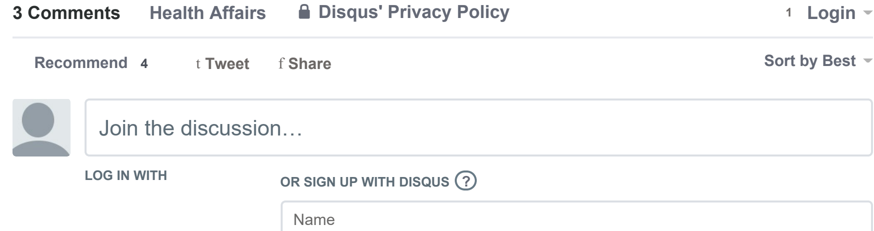

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Name

Daryl Diamond • 4 months ago

This is great, to handle the problems once they occur.
However, we need to post-track the whereabouts of infected individuals, and inform exposed persons.

The government must start publishing the cell phone MAC addresses of infected persons.

A cell phone app can capture a list of cell phone MAC address a person encounters.
This can be compared to the government list to see if exposure might have occurred.
This will allow users of the app to self-isolate and get tested ASAP.

We must act NOW.

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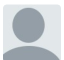

Robert Wolfson • 4 months ago

Excellent, clearly-stated, comprehensive recommendations. Agree with the "Four Basic Principles". "Affordable, Accessible Testing & Treatment" is properly listed as the group of recommendations with the highest priority.

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PBT2013 • 3 months ago

Since most will get the stimulus check it would be nice if our Medical workers etc that are having to be at work facing this virus could get something for having to treat us!! I would gladly donate mine to someone (I know who it will be) that is working with others that have this virus to show we do appreciate them.

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Coronavirus

CORONAVIRUS

Whitmer Administration Expands Telemedicine, Urges President Trump to Permit ACA Special Enrollment Period During COVID-19

FOR IMMEDIATE RELEASE

March 12, 2020

Whitmer Administration Expands Telemedicine, Urges President Trump to Permit ACA Special Enrollment Period During COVID-19

LANSING, Mich. -- Today, Governor Gretchen Whitmer announced that her administration will expand access to telemedicine for Michiganders by immediately allowing Medicaid beneficiaries to receive services in their home while the state combats the spread of Novel Coronavirus (COVID-19). In addition, insurance plans like Blue Cross Blue Shield of Michigan, Blue Care Network of Michigan, Priority Health, Meridian, CVS Health, McLaren, and Health Alliance Plan also announced that they will cover and encourage the use of virtual care and telemedicine, as well as waive cost-sharing for COVID-19 testing.

Governor Whitmer and Michigan Department of Insurance and Financial Services (DIFS) Director Anita Fox also called on the Trump administration to allow for a special enrollment period under the Affordable Care Act (**www.healthcare.gov**) to allow more Americans, including Michiganders, to sign up for coverage and help mitigate the spread of COVID-19.

“During this crisis, we must do everything we can to ensure access to quality, affordable health care,” said **Governor Whitmer.** “That’s why we’re calling on the president to al[illegible] for a special enrollment period, and why we’re taking action today in Michigan to expand

opportunities for safe, quality care through telemedicine. We will continue to work with our partners across both state and federal government, as well as those in the private sector, to ensure Michiganders everywhere can access the care they need."

"When we expand access through telemedicine, we can help reduce the number of Michiganders who need to visit their health care provider in person, which will help slow the spread of disease and ensure our health facilities have adequate staff and resources to care for those who are sick," said Michigan Department of Health and Human services (MDHHS) **Director Robert Gordon.** "And when we expand coverage through a special enrollment period, we can ensure access to quality, affordable care to more Michiganders. This is about keeping the people of Michigan safe and combatting the spread of COVID-19."

After Hurricanes Harvey, Irma, and Maria devastated communities across the Southern United States, the Centers for Medicare and Medicaid Services announced a special enrollment period for those impacted by the hurricanes. Special enrollment periods have also been used to respond to more personal situations such as house fires or domestic violence.

"The president should do what's best for Americans and allow for a special enrollment period while we combat the spread of COVID-19," said DIFS **Director Anita Fox**. "Michiganders need leaders who will do everything they can to ensure quality, affordable care during times like this. It's the smart thing to do, and it's the right thing to do."

Michigan currently has two presumptive positive cases of COVID-19. Patients with confirmed infection have reportedly had mild to severe respiratory illness with symptoms of:

- Fever
- Cough
- Shortness of breath

The best prevention for viruses, such as influenza, the common cold or COVID-19 is to:

- Wash your hands often with soap and warm water for 20 seconds. If not available, use hand sanitizer.
- Avoid touching your eyes, nose, or mouth with unwashed hands.
- Cover your mouth and nose with a tissue or upper sleeve when coughing or sneezing.
- Avoid contact with people who are sick.
- If you are sick, stay home, and avoid contact with others.

Information around this outbreak is changing rapidly. The latest information is available at **Michigan.gov/Coronavirus** and **CDC.gov/Coronavirus**.

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United States Senate
WASHINGTON, DC 20510

March 12, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

In light of the ongoing outbreak of novel coronavirus (COVID-19) in the United States, we write to express our concern regarding the increasing rates of individuals and families who are uninsured or underinsured. We ask that the Department of Health and Human Services and the Centers for Medicare and Medicaid Services allow individuals who are at-risk for COVID-19 to access affordable health care options through the health insurance marketplaces with a special enrollment period. We must do everything in our power to improve access to health care at a time when we are encouraging people who may have been exposed to COVID-19 to come forward, get tested, and seek treatment to help prevent further spread of the disease.

As you know, the U.S. Census Bureau released new data in November 2019 showing that the uninsured rate increased from 7.9 percent in 2017 to 8.5 percent in 2018. This amounts to nearly 2 million more people, bringing the total to 27.5 million uninsured Americans. Many more people likely have insufficient insurance coverage through short-term limited duration insurance or "junk" plans, which could still leave someone facing expensive medical bills if hospitalized for treatment for COVID-19 or seasonal flu.

We are deeply concerned that individuals and families will be forced to choose between getting tested and seeking care for COVID-19 to protect themselves, their families, and communities from further spread and being left with thousands of dollars in bills that they are unable to pay. In addition, when the uninsured or underinsured are unable to pay their medical bills, it is health care providers who are left to make up the shortfall. Health care providers are already relying on emergency resources to pay for increased capacity and medical supplies in order to be prepared for further spread of COVID-19.

As such, and given the ongoing unprecedented public health crisis, we ask that HHS and CMS work to establish special enrollment periods for anyone seeking individual or family coverage through the health exchanges. Having comprehensive, affordable coverage is essential to ensure the health and well-being of the American people, particularly given the lack of access to testing for the COVID-19 and the uncertain trajectory of the outbreak. It is imperative for

patients to receive covered care, regardless of whether they test positive or negative for the virus. Patients should not feel the need to avoid care out of fear of incurring medical bills they cannot afford.

Patients must have access to affordable health insurance that will cover needed health care services for testing and treatment, especially now, when the broader public health is at risk. While there are many unknowns about how this outbreak will progress in the United States, we can certainly all agree that increasing the rate of insurance coverage will be critical to managing this outbreak and the expenses associated with increased need for health care services, such as costly hospitalizations. Thank you for your attention to this critical issue and we look forward to your response.

Sincerely,

Jack Reed
United States Senator

Debbie Stabenow
United States Senator

Kirsten Gillibrand
United States Senator

Tammy Baldwin
United States Senator

Jeanne Shaheen
United States Senator

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United States Senator

Sheldon Whitehouse
United States Senator

Robert Menendez
United States Senator

Congress of the United States
Washington, DC 20515

March 13, 2020

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Azar:

We write to urge you to establish a Special Enrollment Period to be applicable to all Affordable Care Act Marketplace coverage, including those using healthcare.gov as well as state-based marketplaces, during the COVID-19 pandemic. Many among the close to 30 million Americans living without insurance[1] and estimated 44 million who are underinsured[2] would benefit from such a declaration. As outbreaks emerge and community spread continues in the United States, our most vulnerable neighbors are those who lack comprehensive health coverage. Without that coverage, they are unlikely to seek treatment for COVID-19, leaving all in our community at risk.

You declared COVID-19 a public health emergency on January 31st. Responding to that emergency must include ensuring access to insurance coverage so patients can seek treatment for COVID-19. There is precedent for HHS declaring a Special Enrollment Period during an emergency. In 2017, HHS established a Special Enrollment Period for patients living in areas FEMA deemed eligible for assistance following Hurricanes Irma, Maria, Nate, and Harvey. Similarly, a Special Enrollment Period was established in 2019 for areas affected by Hurricane Dorian.

Providing an opportunity for more Americans to seek health coverage is an important step in assuring public health during this crisis. Without effective action, we are concerned that Americans will not be adequately protected against current and future coronavirus outbreaks. We look forward to your response.

Sincerely,

Lloyd Doggett

Ted W. Lieu

Chris Pappas

[1] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[2] https://www.advisory.com/daily-briefing/2019/02/08/underinsured

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Media Release **March 13, 2020**

SPECIAL ENROLLMENT OPENS NEXT WEEK DURING MARYLAND'S CORONAVIRUS STATE OF EMERGENCY

New availability complements the Easy Enrollment Health Insurance Program. Both will continue through mid-April.

BALTIMORE, MD – The Maryland Health Benefit Exchange today announced a new special enrollment period open to all Marylanders in need of health insurance during the State of Emergency for Coronavirus (COVID-19) declared by Gov. Larry Hogan this week. Uninsured Marylanders may enroll through MarylandHealthConnection.gov, the state's health insurance marketplace.

To ensure residents of the state receive access to affordable ACA-compliant insurance coverage during this emergency, individuals can visit MarylandHealthConnection.gov or download the free "Enroll MHC" mobile app. Request or select "Coronavirus Emergency Special Enrollment Period." Free consumer assistance is available by calling 1-855-642-8572 from 8 a.m. to 6 p.m. on weekdays.

Individuals can enroll starting Monday, March 16, through Wednesday, April 15. Coverage selected during this time will have a start date of April 1, 2020, regardless of when a consumer enrolls during this period.

"Health concerns are heightened for many families, and Maryland is in a state of emergency. We are grateful for the support of our insurance companies in opening this additional special enrollment for uninsured residents," said Michele Eberle, executive director of the Maryland Health Benefit Exchange, which administers Maryland Health Connection.

Assistance is available in more than 200 languages through the call center, and relay services also are available for the deaf and hard of hearing. Hundreds of trained insurance brokers and navigators statewide will offer free in-person help. You can find their locations and contact information at MarylandHealthConnection.gov or through the mobile app.

Additional details about Maryland's response to the ongoing pandemic can be found at governor.maryland.gov/coronavirus. And health resource information is at health.maryland.gov/coronavirus.

This special enrollment will run concurrent with the new Maryland Easy Enrollment Health Insurance Program that also ends on Wednesday, April 15. When tax filers check the box on their 502 and 502B tax forms seeking information about health coverage, they will be able to enroll.

###

About the Maryland Health Benefit Exchange: The Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of the state government. It was established in 2011 in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA) and is responsible for the administration of Maryland Health Connection.

About Maryland Health Connection: One of every six Marylanders receive their health coverage through Maryland Health Connection (MHC), the state-based health insurance marketplace. Residents can compare and enroll in health insurance as well as determine eligibility for Medicaid or financial help with private plans.

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Betsy Plunkett, Director, Marketing & Web Strategies, 410-547-6324
betsy.plunkett@maryland.gov

CONGRESS

States reopen insurance enrollment as coronavirus spreads

Maryland, Massachusetts and Washington state all announced special enrollment periods this week

Affordable Care Act supporters wave signs outside the Supreme Court. Maryland, Massachusetts and Washington state all announced special enrollment periods for uninsured individuals. (Bill Clark/CQ Roll Call file photo)

By **Mary Ellen McIntire and Lauren Clason**
Posted March 13, 2020 at 4:00pm

At least three states are reopening their health insurance exchanges amid the coronavirus outbreak in an effort to boost coverage and expand treatment for the uninsured.

Maryland, Massachusetts and Washington state all announced special enrollment periods for uninsured individuals this week as the outbreak worsens and governors declare emergencies. The World Health Organization officially labeled the virus a pandemic on Wednesday, and President Donald Trump declared a nationwide emergency Friday.

[***Hospitals want to kill a policy shielding nurses from COVID-19 because there aren't enough masks***]

Twelve states and the District of Columbia operate their own health insurance exchanges, which give local leaders the authority to reopen enrollment on their own in the face of an emergency like the coronavirus.

Maryland's enrollment window will run from March 16 through April 15. Massachusetts' sign-up period will run for 45 days from March 11 through April 25. Washington's will run from March 10 through April 8.

States like Rhode Island are also considering initiating a special enrollment period. The District of Columbia, meanwhile, is already operating an enrollment period through tax filing season for individuals unaware of the district's new penalty for forgoing health insurance.

Insurance companies are on board with the opportunity to enroll more people, according to exchange officials, with some requesting assurances that the period would be restricted to a specific timeframe and effective coverage date.

"Surprisingly, I think the carriers understand that this is a pretty big deal, and based on the state of emergency, this is really a unique situation that we've never encountered at this level here in our state," Washington Health Benefit Exchange Chief Marketing Officer Michael Marchand told CQ Roll Call.

Insurance and medical care costs are a top concern for lawmakers who want to encourage potentially infected people to seek treatment. Leaders in many states have been requiring plans to cover testing or treatments related to the virus, while multiple insurance plans said they would waive out-of-pocket costs for testing and related doctors' visits.

Washington was the first to announce a special period Wednesday following Democratic Gov. Jay Inslee's emergency declaration last month. The state has been hit hard by the outbreak, with more than 450 cases and 31 deaths. Marchand said the exchange has already fielded around 200 to 300 new applications.

Maryland Health Benefit Exchange Executive Director Michele Eberle said she looked to Washington as Maryland decided to open its own enrollment period. Exchange leaders hold a conference call every two weeks where issues like coronavirus are discussed.

Eberle also urged young and healthy people — a notoriously difficult demographic to enroll — to reconsider purchasing insurance coverage.

"This is a time to reevaluate," she said.

A spokeswoman for the Centers for Medicare and Medicaid Services, which oversees the federal exchange, said the agency is not currently offering a special enrollment period for COVID-19.

"We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time," the spokeswoman said.

Democrats in the House and Senate appealed to Health and Human Service Secretary Alex Azar to launch a special enrollment period to allow anyone who doesn't have an insurance plan or who are underinsured to select a plan.

"As outbreaks emerge and community spread continues in the United States, our most vulnerable neighbors are those who lack comprehensive health coverage," a letter signed by more than 100 House Democrats read. "Without that coverage, they are unlikely to seek treatment for COVID-19, leaving all in our community at risk."

In a separate letter to Azar and CMS Administrator Seema Verma, 25 Democratic senators wrote that the uninsured rate has gone up in recent years and said that people may choose not to get tested for COVID-19 or seek treatment because of affordability concerns.

"In addition, when the uninsured or underinsured are unable to pay their medical bills, it is health care providers who are left to make up the shortfall," they wrote. "Health care providers are already relying on emergency resources to pay for increased capacity and medical supplies in order to be prepared for further spread of COVID-19."

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Customers

Application Quick Tips

Coverage Basics

Who Can Sign Up

Individuals & Families

Tribal Members

Businesses

Self-Employed People

Immigrants

Special Enrollment Period

Financial Help

Special Enrollment Period

In response to the potential growth of Coronavirus (COVID-19) cases, the Washington Health Benefit Exchange (Exchange) announced a limited-time special enrollment period for qualified individuals who are currently without insurance. This special enrollment period (SEP), that runs through April 8, 2020, will allow uninsured individuals to enroll in health insurance coverage through *Washington Healthplanfinder*.

Until April 8, individuals seeking a special enrollment must contact the Customer Support Center between 7:30 a.m. to 5:30 p.m. Monday-Friday at 1-855-923-4633; TTY: 1-855-627-9604, or a local certified broker or navigator, request the SEP, *and select a plan* by April 8 for coverage start date beginning April 1, 2020. Language assistance and disability accommodations are provided at no cost.

Additional information and resources

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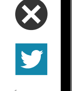

Decision

Insurance Company Payment Options

Manage Your Coverage

Appeal a Decision

Your 1095-A Statement

A special enrollment period is a time outside the open enrollment period when you can sign up for coverage or shop for a new plan. Certain life changes or special circumstances may qualify you for a special enrollment period. For events that don't qualify for a special enrollment period, you'll need to wait for the next open enrollment period to sign up or shop for a new plan. When you apply or report a change through Washington Healthplanfinder, your health plan shopping experience will depend on your qualifying life event.

Washington Apple Health enrollment is year-round and you don't need a special enrollment period to apply.

Qualifying Life Events

Once you've had a qualifying life event, your household has 60 days to sign up for coverage or shop for a new plan. Your new coverage will be effective depending on the type of event you report.

Examples of qualifying life events:

- Adding a dependent or becoming a dependent
- Losing a dependent or dependent status*
- Filed or reconciled taxes for a year that you received health insurance premium tax credits
- Change in program eligibility or amount of financial help*
- Losing other health coverage (i.e., job loss, divorce, loss of Washington Apple Health or WSHIP coverage, etc.)
- Permanently moving from a location in the United States to Washington, or to a new county within Washington, only if you

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- Permanently moving from a location outside the United States to Washington
- A change in citizenship or lawful presence status
- Getting released from jail or prison
- Tribal membership
- Gaining access to a Health Reimbursement Arrangement (HRA) through your employer. More information about HRAs can be found here

**This is for currently enrolled customers only.*

View the full list of qualifying life events.

These changes do not count as a qualifying life event:

- Choosing to stop other health coverage
- Being terminated for not paying your premiums
- Finding out your doctor isn't covered through your plan

Special Circumstances

Certain special circumstances may also qualify you for a special enrollment period.

Examples of special circumstances:

- Survivors of domestic abuse/violence or spousal/domestic abandonment. Read more about survivors of domestic violence applying for coverage.
- Errors of *Washington Healthplanfinder* (includes system errors that prevented you from getting coverage)

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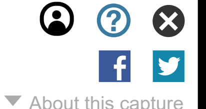
About this capture

open enrollment

- Contract violation by the Qualified Health Plan
- Additional exceptional circumstances as defined and approved by the Washington Health Benefit Exchange

View the full list of qualifying special circumstances.

Applying for a Special Enrollment Period

If you're a new customer:

1. Visit www.wahealthplanfinder.org and create an account
2. Fill out an application
3. If you're eligible for a Qualified Health Plan, fill out the Special Enrollment Questionnaire
4. If you qualify, select and confirm your plan

If you're an existing customer:

1. Visit www.wahealthplanfinder.org and sign in to your account
2. Click the quick link "Report a Change in Income or Household"
3. Fill out the Special Enrollment Questionnaire
4. If you qualify, select and confirm your plan

If you are approved for a special enrollment period, your insurance company may ask for records that prove you qualify. Make sure you have these papers ready in case you need to show proof.

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7:30 a.m. to 5:30 p.m.
Monday – Friday
1-855-923-4633; TTY: 1-855-627-9604

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Other

Partner Sign In © 2020 Washington Health Benefit Exchange
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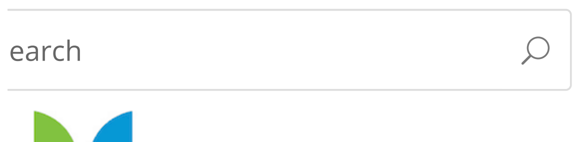
Account Sign-in Español

Account Sign-in Español

Individuals & Families: 1-855-840-4774
Employers & Employees: 1-855-683-6757



What type of coverage is available?

- Coverage through HealthSource RI
- Medicaid
- Dental coverage through HealthSource RI
- Other programs
- RI Health Insurance Mandate

Can I get financial help?

When can I enroll??

How do I apply?

Current Customers

Get Help

About Us

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Employers & Employees

Coverage through HealthSource RI

*** Special Enrollment due to COVID-19: Due to the potential spread of COVID-19, a special enrollment period is now available until April 15 for Rhode Islanders seeking health coverage.**

HealthSource RI was created because buying health insurance coverage is complicated. It's our job to help Rhode Islanders cut through the confusion and choose the best, most affordable health insurance plan possible.

Click here to compare plans and get a quick quote. You might even qualify for financial help.

HealthSource RI offers health insurance coverage through these companies:

Whatever plan you choose, you'll get comprehensive health benefits for things like doctor visits, hospitalizations, maternity care, Emergency Room visits, and prescriptions.

We also offer dental coverage from these companies:

2020 Health and Dental Plans:

2020 Health Plans and Benefits for Individuals and Families

2020 Cost Share Reduction Plans for Individuals and Families

2020 Dental Plans for Individuals and Families

2020 Age-based Medical Rate Sheet

2019 Health and Dental Plans:

2019 Plan Comparison and Savings Tool

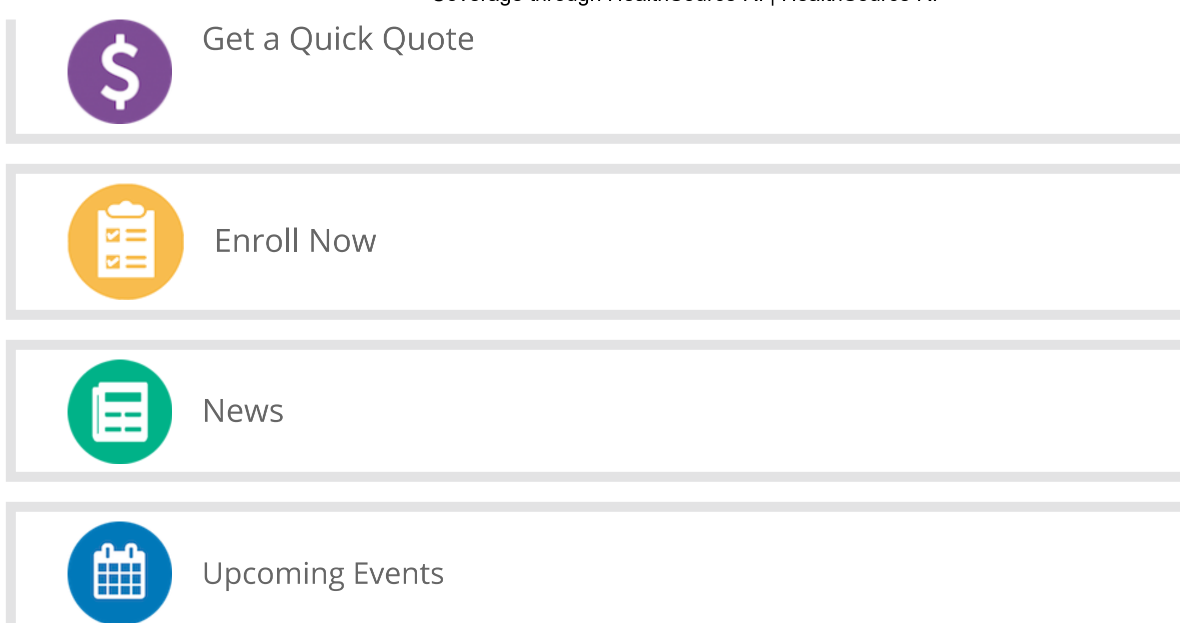
2019 Health Plans and Benefits for Individuals and Families

2019 Cost Share Reduction Plans for Individuals and Families

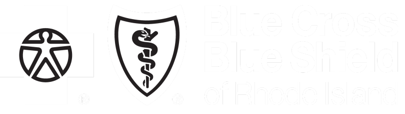
2019 Age-based Medical Rate Sheet

2019 Dental Plans and Benefits for Individuals and Families

Compare Plans &



HealthSource RI connects you with health and dental insurance from these companies:



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1332 Waiver - June 2020 Public Meeting Notice

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RI Insurance Mandate

INDIVIDUALS AND FAMILIES

Walk-in Center

1-855-840-4774
TTY: 1-888-657-3173
Fax: 1-401-223-6317

401 Wampanoag Trail
East Providence, RI 02915

Hours:
Mon-Fri 8:00 a.m. – 6:00 p.m.

EMPLOYERS AND EMPLOYEES

Business Engagement Team

1-855-683-6757

20 Newman Ave, Suite 1000
Rumford, RI 02916

Hours:
Mon-Fri 8:30 a.m. – 5:00 p.m.

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March 15, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: COVID-19 Special Enrollment Period

Dear Secretary Azar:

The New Mexico Health Insurance Exchange (NMHIX), also known as beWellnm, respectfully requests that the federal government open an Enrollment Period in response to the COVID-19 emergency. Doing so would be consistent with the Public Health Emergency declared by Governor Michelle Lujan Grisham on March 11 and the National Emergency declared by President Donald Trump on March 13.

The importance of providing access to health care during this emergency cannot be overstated. Individuals deserve every effort from policymakers to eliminate barriers. This is especially important among those who are uninsured and under-insured. Giving individuals a new opportunity to enroll in health coverage is another tool to help stem the tide of COVID-19. The states of Washington and Maryland have already announced enrollment periods, and the federal exchange must quickly follow their lead.

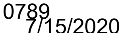
We recognize that protecting the integrity of the health system, from insurance carriers to hospitals, is critical. Having an enrollment period does not have to undermine that priority, and opportunities will emerge through collaboration to accomplish all goals.

Please do not hesitate to contact our Exchange if we may be of assistance. We look forward to your support of our request.

Sincerely,

Jeffery Bustamante
Chief Executive Officer
beWellnm, New Mexico's Health Insurance Exchange

cc: Administrator Seema Verma



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Governor Phil Murphy

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Governor Murphy Requests Federal Government Re-Open Affordable Care Act Enrollment in New Jersey in Response to COVID-19

03/15/2020

TRENTON – Responding to the global COVID-19 pandemic, Governor Phil Murphy today requested the federal government open a Special Enrollment Period (SEP) in New Jersey to allow uninsured and underinsured residents to enroll in health coverage through the federal health insurance exchange.

The Governor's request was issued in a letter sent to U.S. Department Health and Human Services Secretary Alex Azar and U.S. Centers for Medicare and Medicaid Services Administrator Seema Verma.

(https://twitter.com/GovMurphy)
(https://www.facebook.com/governorphilmurphy)
(https://www.youtube.com/njgovernorsoffice)

"With COVID-19 now a pandemic and confirmed cases increasing in New Jersey and across the country, it is imperative that we take all appropriate actions to increase access to screening, testing, and treatment related to COVID-19. While I have coordinated across state agencies to take emergency action to facilitate access to screening, testing and access to care for the residents of New Jersey, more can be done to ensure every individual has access to appropriate health care during this crisis," **Governor Murphy wrote.** "Therefore, as New Jersey transitions from a State Based Exchange on the Federal Platform to a State Based Exchange, I respectfully urge the Administrator of the Centers for Medicare & Medicaid Services to authorize a Special Enrollment Period in New Jersey to allow individuals to access affordable health insurance options through the federal platform."

Several states that operate a State-Based Exchange have already established a Special Enrollment Period in response to COVID-19. However, federal action is required for the establishment of an SEP in states that operate on the federal platform, Healthcare.gov. Governor Murphy is calling for a special enrollment period of at least 60 days for all eligible uninsured and underinsured persons to purchase health coverage through the federal platform, and for that coverage to be in place as soon as possible.

"With no vaccine in place and a high degree of uncertainty about the direction that the virus will take, increasing access to health coverage will play a role in managing this outbreak. Similar to actions CMS has taken in the past during major weather events such as hurricanes, creating a SEP is a responsible action that will benefit individuals, as well as contribute to the management of this public health crisis," **added Governor Murphy.**

"As the state responds to the COVID-19 situation, we want to ensure that residents have the coverage they need to access testing and treatment if necessary. We have taken action to require carriers regulated by the state to waive cost sharing for COVID-19 testing. However we can do more and, in this case, we need the federal government's assistance," **said Department of Banking and Insurance Commissioner Marlene Caride.** "Clearly, we do not want residents to be apprehensive about seeking treatment because they are not insured or concerned about medical bills. We are asking the federal government to establish a special enrollment period for our residents, and for that coverage to be in place as soon as possible."

U.S. Senator Bob Menendez and 24 of his colleagues recently sent a letter requesting a Special Enrollment Period for consumers in response to COVID-19. Senator Menendez and U.S. Senator Cory Booker also introduced legislation to support the response to the pandemic including to create a special enrollment period for individuals impacted by COVID-19, among other initiatives. The Governor's letter may be found here (http://d31hzlhk6di2h5.cloudfront.net/20200315/8f/63/22/fb/f333ac94f2e2ebf477b14898/Governor_Murphy_Letter_to_Secretary_Azar_and_Administrator_Verma_03152020.pc

For the latest information on novel coronavirus, please visit www.nj.gov/health (https://www.nj.gov/health/) or call 1-800-222-1222 or 1-800-962-1253 (if using out-of-state phone line).

Governor Phil Murphy

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(https://tech.nj.gov/)

State of New Jersey
OFFICE OF THE GOVERNOR
PO BOX 001
TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

March 15, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

With COVID-19 now a pandemic and confirmed cases increasing in New Jersey and across the country, it is imperative that we take all appropriate actions to increase access to screening, testing, and treatment related to COVID-19. While I have coordinated across state agencies to take emergency action to facilitate access to screening, testing and access to care for the uninsured or underinsured in New Jersey, more can be done to ensure every individual has access to appropriate health care during this crisis. Therefore, as New Jersey transitions from a State Based Exchange on the Federal Platform to a State Based Exchange, I respectfully urge the Administrator of the Centers for Medicare & Medicaid Services to authorize a Special Enrollment Period (SEP) in New Jersey to allow individuals to access affordable health insurance options through the federal platform.

On March 9, 2020, I declared a State of Emergency and a Public Health Emergency across all 21 counties in New Jersey, allowing state agencies and departments to utilize state resources to assist affected communities responding to and recovering from COVID-19 cases. At my direction, several state departments acted to mitigate the spread of the virus and increase access to screening, testing, and testing-related services related to COVID-19, including requiring the waiver of consumer cost sharing for all medically necessary COVID-19 testing. In order to remove any potential remaining barriers to testing and treatment, it is imperative for New Jersey residents to have access to an SEP so uninsured and underinsured individuals can enroll in health insurance.

I urge you to provide for a SEP of at least 60 days for all eligible uninsured and underinsured persons to purchase health coverage through the federal platform, and for that coverage to be in place as soon as possible.
With no vaccine in place and a high degree of uncertainty about the direction that the virus will take, increasing access to health coverage will play a role in managing this outbreak. Similar to actions CMS has taken in the past during major weather events such as hurricanes, creating a SEP is a responsible action that will benefit individuals, as well as, contribute to the management

of a public health crisis. Thank you for your attention to this important and emergent issue as we work to secure the health and safety of all New Jersey residents.

Sincerely,

Philip D. Murphy
Governor

From: Handelman, Justine [redacted]
Sent: Monday, March 16, 2020 6:33 PM
To: Parker, Jim (HHS/IOS)
Cc: [redacted]
Subject: AHIP-BCBSA COVID-19 Recommendations
Attachments: Draft COVID Stability Package 031620 530PM.docx; Covid19 Policy Recommendations.docx

Jim –

Attached are the latest joint COVID-19 recommendations from BCBSA & AHIP. We'd love the opportunity to discuss with you.

Justine & Matt

Assuring Access to Affordable Coverage in Response to COVID-19

Health plans are working to respond to the emerging COVID-19 emergency by providing expanded access to care during the pandemic. The ultimate costs of responding to this pandemic is uncertain across all markets given the potential dimensions of the health care crisis and its impact on the economy. In addition, we understand that more people may be interested in purchasing insurance in light of the crisis and need to have affordable options for comprehensive coverage.

In light of the unprecedented nature of this crisis, we recommend the following:

1. **CMS should allow a one-time special enrollment period for the individual market.** This special enrollment period should be time limited (30 days) with either a prospective effective date or a uniform date in the middle of the period that limits the number of people having a retroactive effective date. The SEP should be available to all persons regardless of whether they are currently uninsured. Under no circumstances should the SEP be focused only on those diagnosed with COVID-19 as this would significantly increases adverse selection.

2. **Congress should establish a risk mitigation program that would be applicable across the individual, small employer, Medicare and Medicaid markets.** The program will provide protection against possible catastrophic losses due to the emergency and the additional risk being assumed by insurers. Given the uncertainty regarding the costs of the epidemic, we recommend that the program be structured as follows:
    a. This program should apply to both 2020 and 2021 given the uncertainty regarding the length of the emergency and the impact on 2021 rates.
    b. The program would only apply if overall claims in a market exceed the amount assumed in premiums by an amount greater than a threshold. If claims exceed the threshold, the government would share in the losses in excess of the threshold.
    c. A retrospective calculation would compare the issuer's actual allowed costs in total by market for individual, Medicare Advantage, and Medicaid against a target amount representing the claims component built into the premiums. The allowed costs calculation begins with total claims. Adjustments for risk adjustment and federal or state reinsurance programs are applied as applicable by market to the allowed cost or the target amount.
        i. For 2020, the Covid-19 catastrophic protection program would provide for federal funding when the issuer's allowed costs are 105% or greater than the target amount. The federal funding would cover 80% of the costs above the 105% threshold.
        ii. For 2021, the parameters would be set differently due to the ability of issuers to re-price. The program would provide for funding if the issuer's allowed costs are 103% or greater than the target amount. If the issuer's allowed costs are between 103% and 108%, the federal funding will cover 50% of the amount over 103%. If the issuer's allowed costs are over 108%, the federal funding will cover 2.5% of the target amount plus 80% of the amount over 108%.
    d. For Medicaid, require that states incorporate payments received under the federal risk mitigation program into payments to managed care plans.

DRAFT

March 16, 2020

Health insurance providers are fully committed to help America's powerful health care system meet the challenges posed by this pandemic. As this public health emergency progresses, Health Insurance Providers are taking decisive action to help prevent the spread of this disease, to ensure that people have coverage for and access to needed testing, and to help patients who are infected receive the care and treatment they need.

We are collaborating with federal, state and local officials, our provider community and community organizations to proactively engage the American people on common-sense steps that everyone can take to stay healthy, particularly those who are most at-risk for infection, such as seniors and patients with chronic diseases.

Addressing COVID-19 will be an ongoing process that will require close coordination with all levels of government. We appreciate the steps that Congress and the Administration have taken to date to address the crisis and welcome the opportunity to continue to work collaboratively with policymakers to assure that we are doing our part to ensure the health and safety of Americans. We hope the door will be open to ongoing evaluation of the situation, and to considering steps that will be necessary to assure everyone receives the care they need during this critical time.

In the spirit of that partnership, we offer the following legislative policy recommendations which we believe are necessary at this time.

Market	Summary
All	**Affordability of Care:** As Congress looks to take legislative action to address and mitigate challenges posed by COVID-19 we recommend that Congress: • Establish an excess loss protection program that would be applicable across the individual, small group, Medicare and Medicaid markets. The program will provide protection against possible catastrophic losses due to the emergency and the additional risk being assumed by insurers and apply for 2020 and 2021. For Medicaid, require that states incorporate payments received under the federal risk mitigation program into payments to managed care plans. • Ensure transparency on pricing for COVID-19 testing, vaccines and antivirals (when available) • Take additional steps to prevent fraud, waste, abuse, and price gouging in this time of crisis.
All	**Telehealth:** During a national public health emergency, the flexibility to shift the health care work force from areas of low need to areas of high need is paramount. Existing clinician licensure rules limit the ability to quickly move staff from one state to another, as licensure is regulated at the State level, and licenses are often not transferable to another State. Friday's Declaration of a National Health Emergency by the President allows Medicare and Medicaid to relax licensure requirements for providers practicing

Market	Summary
	across State lines serving Medicare and Medicaid beneficiaries, but the flexibility does not extend to clinicians treating commercial patients or other health care providers. Federal Legislative Action Waiving Licensure Requirements or Requiring Reciprocity Congress should enact legislation providing specific authority under Section 319 of the Public Health Service Act (42 CFR § 247d) to the Secretary of Health and Human Services to pre-empt State licensure laws and State Boards during a national public health emergency, allowing any clinician in good standing in the State in which she is licensed to practice in any other State during the public health emergency. The legislation should adopt key provisions of the Uniform Emergency Volunteer Health Practitioners Act related creating a single uniform registration system and providing practice liability protections. The legislation should clarify that clinicians deploying out-of-state may be paid by their employer for their service. Elimination of State Barriers to Telehealth (Eliminates barriers to licensure to allow broad access to Telehealth) For Medicare, we recommend that first sentence of section 1135(b) of the Social Security Act (42 21 U.S.C. 1320b–5(b)) be amended as follows: A. in paragraph (7), by striking ‘‘and’’ B. in paragraph (8), by striking the period at the end and inserting ‘‘; and’’; and C. by inserting after paragraph (8) the following new paragraph: ‘‘(9) any State licensure or other requirements, in addition to those waived under paragraph (b)(2), that restrict access to telehealth services described in paragraph (8). Insofar as the Secretary exercises the authority under this paragraph (9), the waiver will preempt any contrary state law.
Commercial / Marketplace	Health insurers are committed to minimize the instances in which health plan enrollees receive surprise medical bills from their providers. However, health insurers cannot prevent a provider from balance billing their patients. For this reason we ask Congress to take swift action to prevent surprise medical billing for testing and treatment of COVID-19. We ask that Congress set a benchmark payment for out-of-network providers, of the median in-network rate or the Medicare rate for any item or service for which an insurer does not have an in-network rate for plans in the individual market, small group market and large group market (both fully insured and self-funded plans).
Medicaid	**Medicaid Telehealth:** In order to assure that Medicaid beneficiaries in all states have access to telehealth services during this crisis we recommend that the first sentence of section 1135(b) of the Social Security Act (42 21 U.S.C. 1320b–5(b)) is amended— B. in paragraph (8), by striking ‘‘and’’ C. in paragraph (9), by striking the period at the end and inserting ‘‘; and’’; and D. by inserting after paragraph (8) the following new paragraph: ‘‘(10) mandatory State coverage of telehealth services that are no less than the telehealth services covered under section 1834, as waived under paragraph (8) above.

Market	Summary
	Medicaid Eligibility Renewals In order to assure that Medicaid beneficiaries in all states maintain coverage during this crisis we recommend that the first sentence of section 1135(b) of the Social Security Act (42 21 U.S.C. 1320b–5(b)) is amended— D. in paragraph (9), by striking ''and'' E. in paragraph (10), by striking the period at the end and inserting ''; and''; and F. by inserting after paragraph (8) the following new paragraph: ''(11) mandating extended deadlines under section 1902(e)(8).
Medicare Advantage/ Part D	Consistent with the theme of flexibility, we ask that Congress update the Medicare statute to: **Medicare Telehealth Issue** (Strikes the three-year rule for Medicare FFS and Medicare Advantage which limits telemedicine visits for people without an pre-existing provider relationship) Paragraph (3) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) is amended by striking subparagraphs (A) and (B). **All MA Bid Timeline Flexibility:** The first parenthetical in Section 1854(a)(1)(A) of the Social Security Act (42 USC 1395w-24(a)(1)(A)) is amended to read as follows: "(or the first Monday in June of each subsequent year, or such later date as the Secretary determines is appropriate due to an emergency period as defined in section 1135(g)(1))" **Modify Star Ratings to Address COVID 19:** Section 1853(o) of the Social Security Act (42 USC 1395w-23(o)) is amended by adding the following paragraph (8): "(8) Special Rule for Emergency Periods.—CMS shall make adjustments so that an MA plan's star ratings for 2019 and later measurement periods are not adversely impacted due to an emergency or disaster for which the Secretary exercises authority under section 1135." **Allow Telehealth Visits to Count as Encounters under MA Risk Adjustment** Section 1853(a)(1) of the Social Security Act (42 USC 1395w-23(a)(1)) is amended by adding the following paragraph: (J) Improvements to risk adjustment to encourage use of telehealth in emergencies. — The Secretary shall adjust a Medicare Advantage plan enrollee's risk score to take into account diagnosis data obtained through telehealth services covered by the plan that are telehealth benefits under the original Medicare fee-for-service program or additional telehealth benefits under section 1852(m) [for any emergency area in an emergency period as defined in section 1135(g)(1)].

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Advancing Health in America

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March 16, 2020

Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks **the Secretary of Health and Human Services (HHS) to consider additional actions to temporarily suspend certain requirements in order for health care providers to better respond to the novel coronavirus (COVID-19) outbreak.**

On Jan. 31, 2020, your office declared a public health emergency in the U.S. for COVID-19, representing an important first step in combatting this virus. The public health emergency together with the President's recent national emergency declaration enabled your office to make several critical waivers consistent with section 1135 of the Social Security Act. We appreciate your swift action in making these waivers, including removing the critical access hospitals (CAH) limitation of 25 inpatient beds and 96-hour average length of stay, the long-term care hospital (LTCH) 25-day length of stay requirement, the inpatient rehabilitation facility (IRF) 60% Rule, and certain physician licensing requirements. However, much more flexibility is required to allow hospitals and health systems to most effectively respond to this emergency and provide the best care possible to patients. For example, we ask you to:

1. Waive the CAH 96-hour condition of payment in addition to the 96-hour average length of stay. This is crucial for rural areas that may not have other options for inpatient beds.
2. Waive the requirement that an LTCH patient have a prior hospital stay that includes three or more days in the intensive care unit (ICU) in order to qualify for the full payment rate. Doing so would help ensure these hospitals are able to add capacity to the health care system by caring for more appropriate patients, without penalty.

3. Waive the IRF 3-hour rule, which requires that IRF patients receive at least three hours of therapy a day, the "preponderance" of which must be one-on-one. This is critical to enabling them to add capacity to the health care system.

A list of our specific suggested actions are attached.

Other important waiver flexibilities that we urge you to consider cover conditions of participation or other certification requirements, program participation, preapproval requirements and performance deadlines and timetable delays. The HHS Secretary should also immediately implement unique codes for COVID-19 disease, exposure to COVID-19 and screening for the virus. Such codes are essential to tracking COVID-19 patients or patients without the disease that require health care services. While there are codes existing for coronaviruses, they are not unique to COVID-19. For all waivers, including those already made, the HHS Secretary should also consider creating a code for providers to use to identify patients *without* COVID-19 who are receiving care under a waiver – those who are, for example, transferred to a post-acute care hospital solely in order to meet the demands of the emergency. This is much less resource intensive than documentation in the medical record.

In addition, while a number of actions require the use of section 1135 waiver authority, there also are additional steps that HHS can take without such authority. For example, we encourage the agency to require that health plans reduce access barriers, such as limiting utilization management techniques that could delay access to COVID-19 testing and treatment, and require that coverage decisions be based on presenting symptoms, not final diagnosis.

Finally, we must acknowledge and accept the unknowns we face when combatting COVID-19. Our requests today represent actions we know are necessary at this moment. If taken, these steps will help care for patients, while keeping hospital workers and the public as safe as possible. As more information becomes available, we anticipate the need for additional assistance from HHS, and ask that the agency remain flexible as our hospitals and health systems continue to care for patients during this national emergency.

Communities rely on America's hospitals and health systems to be there for them in the face of an emergency. Whether that emergency develops in the form of a natural disaster, like a hurricane or tornado, or as a virus, like COVID-19, hospitals and health systems are prepared to fulfill their commitment to patients. While our members continue to do everything they can to address COVID-19 cases, the additional action we request would help them continue to put the health and safety of patients first by removing barriers that threaten to impede decisive and quick action by providers at a time when agility and flexibility are of utmost importance.

We appreciate your leadership and the ongoing work of the White House Coronavirus Task Force. We look forward to continuing to work with you during this critical time to protect the health of our nation.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Cc: Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Stephen M. Hahn, M.D., Commissioner, Food and Drug Administration
Robert R. Redfield, M.D., Director, Centers for Disease Control and Prevention

ASSISTANCE MANAGING THE SURGE

Medicare Outpatient Observation Notice (MOON). In addition to the Centers for Medicare & Medicaid Services' (CMS) waiver of the skilled nursing facility (SNF) 3-day rule, waiving the MOON written and oral notification requirements is appropriate since undergoing observation care will have no implications for SNF eligibility.
Home Health (HH) Homebound Requirement. Waiving the requirement that a beneficiary must be "home-bound" in order to receive HH services would allow beneficiaries to obtain care while minimizing the risk to themselves or others.
Critical Access Hospital (CAH) 96-hour Condition of Payment. Waiving the requirement that a physician certify a patient can reasonably be expected to be discharged within 96 hours would provide critical flexibility for care in rural areas that may not have other options for inpatient care.
Medical Review Audits. Pausing all audits during the emergency, including additional documentation requests and other audit work, would help free capacity in the health care system.
HH Face-to-Face Requirement. Waiving the requirement that the certifying physician or nonphysician practitioner document a face-to-face encounter with the patient prior to certifying a patient's eligibility for the HH benefit would allow beneficiaries to obtain care while minimizing the risk to themselves or others. In these situations, a telephonic or telehealth visit may fulfill the requirements of the face-to-face requirement.
Transfer of Mechanically Ventilated Patients. Suspending the restrictions of Medicare Managed Care organizations surrounding transfer of mechanically ventilated patients to long-term care hospitals (LTCHs) would allow patients to be transferred as soon as they are physiologically stable enough. This would facilitate appropriate transfer of patients that benefit from the specialized care LTCHs provide and also add capacity to the health care system.
Federal Audits. Delaying all federal audits during the emergency, such as Medicaid disproportionate share hospital (DSH) and Payment Error Rate Measurement (PERM), would help free capacity in the health care system.
Waiving certain CMS certification requirements. If a nonprofit entity that holds multiple certificates to operate hospitals in that jurisdiction from the appropriate state licensing entity, a certificate of participation from CMS, a license from a state licensing authority to operate a new or refurnished hospital and has applied for accreditation to operate a new or refurbished hospital that facility may be deemed certified for billing by CMS and private insurance entities. The nonprofit entity would receive certification for no more than 90 days or until accreditation is received or the national emergency has ended. Entities may renew this temporary certification every 90 days for up to one year.
Physical Environment. Waiving physical environment requirements at 482.41; would allow non-hospital buildings and spaces to be used for patient care, provided sufficient safety and comfort is provided for patients and staff, thus adding capacity to the health care system.

HH Review Choice Demonstration. Suspend expansion of the HH Review Choice Demonstration project to allow clinical staff to focus on accommodating coronavirus patients and those transferred to home health due to the disaster. Also, suspend ongoing demonstration activities in Illinois, Ohio and Texas.

ENSURING STAFF CAN FOCUS ON CARE DELIVERY

Additional EMTALA Sanctions Waiver. In addition to waivers issued on March 15, 2020, waiving the following EMTALA sanction would assist hospitals in most effectively managing patient care and health care system capacity: 1. Permit the medical screening examination to be conducted by other qualified staff authorized by the hospital and acting within their state scope of practice and licensure, who are not formally designated to perform medical screening examinations in the hospital by-laws or in the rules and regulations.
Practice Limitations. Waiving specific practice limitations on nurse practitioners that are more restrictive under CMS than under state licensure would help address workforce shortages.
Waiving standard death reporting requirements at 482.13(g), which would allow the reporting of the death of patients who were in seclusion or restraint to occur later than currently required. This would keep the requirement where any death where restraint may have contributed is reported within standard time limits.
Medical Record Timing. Waiving medical records timing requirements at 482.24 would allow medical records to be fully completed later than 30 days following discharge, providing flexibility to the health care system.
Verbal Orders. Waiving verbal order requirements at 482.24 would allow verbal orders to be used more frequently and authentication may occur later than 48 hours, thus providing flexibility to the health care system.
Physician Privileging. Waiving certain physician privileging requirements at 482.22(a) would allow physicians whose privileges will expire and new physicians to begin practice before full medical staff/governing body review and approval, adding capacity to the health care system.
Discharge Planning Requirements. Waiving hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services is necessary because the capacity and/or capabilities of available facilities to care for COVID-19 patients may be severely limited, effectively restricting patient choice, and this is a time consuming task that draws nurses away from direct patient care.
HH Assessments. Waiving HH requirements at 484.55 would remove a series of requirements around initial and comprehensive assessments. For example, it would allow HH agencies to perform initial assessments and determine patients' homebound status remotely or by record review, so that beneficiaries can obtain care while minimizing the risk to themselves or others. It also would grant greater flexibility with the timing of and information included in patient assessments.

Expanded Use of Telehealth. Insurers should support management of scarce resources, such as personal protective equipment, and efforts to reduce community transmission by expanding access to services delivered via telehealth.
Credentialing. Requiring expedited or presumptive credentialing, such as requiring health plans to establish a process to recognize and credential community physicians who offer to work at hospitals and health systems, would help to ease workforce shortages during this time.
Patient Assessments. Granting relief to all providers on the timeframes related to pre- and post-admission patient assessment and evaluation criteria would help ensure patients are treated in a timely manner.
CMS Survey of 340B Hospitals. CMS should suspend its scheduled survey of all hospitals that participate in the 340B Drug Pricing Program collecting actual acquisition costs for specified covered outpatient drugs (SCODs). While AHA has significant issues with the survey design, our paramount concern is the significant reporting burden this survey would place on 340B hospitals during the COVID-19 national health emergency.
Administrative Timeframes. Allowing leniency in administrative timeframes, including for billing and the submission of Medicare Cost Reports, for hospitals/health systems that experience business disruptions, e.g., as a result of workforce shortages.

HELP US GET THE TOOLS WE NEED

Sterile Compounding. Waiving sterile compounding requirements at 482.25(b)(1) and USP 797 would allow face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift only to conserve scarce face mask supplies.
340B Eligibility. Providing for a limited waiver of the 340B Hospital Medicare DSH eligibility threshold for current 340B hospitals responding to the COVID-19 national health emergency and experiencing a significant change in patient mix would help ensure that hospitals do not lose their 340B status in the future as a result of a time-limited change in patient mix.
Prior Authorization for Post-acute Care (PAC). Requiring that plans waive prior authorization requirements for PAC placement would enable hospitals to free up inpatient bed capacity.
Restrictions on Telehealth Technology. Waive the restrictions on the type of technology that may be used to provide telehealth would allow patients to use the technology they have on hand, such as FaceTime and Skype, providing critical flexibility that will allow them to remain in their homes while still obtaining services. These waivers must be made in conjunction with those above on geographic and originating sites and below on HIPAA privacy requirements in order to be meaningful.
HIPAA Privacy Requirements. Waiving HIPAA privacy requirements and permitting a similar waiver of applicable security rule requirements would allow patients to use technologies such as FaceTime and Skype, as specified above. These waivers must be made in conjunction with those above on geographic and originating sites and telehealth technology in order to be meaningful.

IRF 3-hour Rule. Waiver of the 3-hour rule, which requires that inpatient rehabilitation facility (IRF) patients receive at least three hours of therapy a day, the "preponderance" of which must be one-on-one, would help ensure that IRFs are able to add capacity to the health care system, without penalty.
LTCH 50% Rule. Waiving both the numerator and denominator of the requirement that LTCHs have no more than 50% of Medicare cases paid at the site-neutral rate would help ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty.
Emergency Use Authorizations (EUAs). Expediting the approval of EUAs for hospital laboratory developed tests (LDTs), including the approval of licensed automated testing systems and rapid response testing, would assist hospitals in expeditiously testing and confirming COVID-19 infection in patients and thus responding to the emergency.
Access to Coronavirus. Access to the virus and its genomic RNA would allow hospitals to validate their LDTs. Some hospitals with laboratories certified for high complexity testing under CLIA are having difficulty obtaining this material

ENSURE COVERAGE SO ALL PATIENTS CAN SEEK HELP WHEN NECESSARY

Presumptive Authorization. Requiring plans to accept presumptive authorization in instances where health plans, due to business disruption such as reduced workforce capacity, cannot adjudicate requests within a timely manner, would help ensure patients are treated in a timely manner.
Presenting Symptoms as Basis for Coverage. Generally, insurers make coverage decisions in part by assessing whether care was medically necessary, and many insurers adjudicate medical necessity using information that becomes available during the course of treatment or testing. This approach could result in many coverage denials for individuals who were originally suspected to have coronavirus but who ultimately are found to have the flu. The government should clarify that coverage decisions must be made on the presenting symptoms, not the final diagnosis.
Cost-sharing. Mandating that all forms of cost-sharing (co-pays, co-insurance, deductibles) be waived not only for testing, but also for treatment of coronavirus would help eliminate cost as a barrier to care. CMS should also require plans to reimburse providers for the full contracted amount.
Out-of-network Care. We urge the government to direct health plans to hold the patient harmless for out-of-network care, such as laboratory services, and negotiate reimbursement with the provider.
Utilization Management Requirements. Requiring health plans to ease utilization management requirements during the emergency period to account for reduced workforce would help ensure there are not bottlenecks and unnecessary delays in care. Specifically, hospitals and health systems are expected to experience staff reductions and diversions and health plans should not be permitted to deny reimbursement for care for which providers were unable to complete prior authorization or other utilization management functions due solely to workforce constraints.

Ensuring Adequate Coverage and Resources. Refraining from implementing policies that would reduce Medicaid coverage and/or resources would help ensure patients get the care they need. Specifically, we ask that the Administration withdraw the proposed Medicaid Fiscal Accountability Rule, which could have a negative impact on coverage and health care system resources just as we seek to manage COVID-19 patients.
Automatic Eligibility Renewal. Allowing states six month automatic eligibility renewal would help ensure continuity of coverage.
Increase Access to Presumptive Eligibility. The Administration should remove administrative barriers to Medicaid hospital presumptive eligibility during the COVID-19 emergency to increase access to coverage.
Children's Health Insurance Program (CHIP) Eligibility Limits. Federal law restricts states from increasing their CHIP eligibility limits. We urge flexibility to states seeking to expand CHIP eligibility within their current CHIP grants to enable access to testing and treatment for uninsured children.
Uncompensated Care Pools. Allow states to reestablish or create time-limited Medicaid-funded uncompensated care pools through Medicaid Section 1115 demonstration waivers to cover the costs of the uninsured.
Special Enrollment Period. Creating a special period enrollment for the Health Insurance Marketplaces would increase access to coverage and care.
Direct Provider Reimbursement. Establishing a federal program to directly reimburse providers for costs associated with caring for the uninsured would help ensure hospital have adequate resources for addressing the emergency. While federal law now provides a mechanism for reimbursement for testing and testing-related services, this must be expanded to treatment costs as well.
Medicaid DSH. Delaying Medicaid DSH cuts and establishing a temporary Medicaid DSH allotment increase would help cover COVID-19 related testing and treatment, including equipment.

ENSURE PAYMENT FLOWS APPROPRIATELY

Telehealth Geographic and Originating Site Requirements. Waiving the geographic site requirements that limit telehealth payment to services furnished within certain geographic areas, as well as the originating site requirements that specify the particular sites at which the eligible telehealth individual must be located would provide critical flexibility to allow patients to remain in their homes while still obtaining services. These waivers must be made in conjunction with those below on telehealth technology and HIPAA privacy requirements in order to be meaningful.
LTCH 50% Rule. Waiving both the numerator and denominator of the requirement that LTCHs have no more than 50% of Medicare cases paid at the site-neutral rate would help ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty.

LTCH ICU Requirement. Waiving the requirement that an LTCH patient have a prior hospital stay that includes three days or more in the intensive care unit (ICU) in order to qualify for the full payment rate would ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty.
Alternative Payment Model (APM) Flexibility. Deeming coronavirus an 'extreme and uncontrollable circumstance' for APMs that have significant hardship policies would allow the agency flexibility in making adjustments to the APM specifications, such as for episode spending or quality measurement. This would help ensure that providers are not penalized for circumstances beyond their control.
Supplemental Payments. Allow states to create new time-limited supplemental hospital payment mechanisms (fee for service and managed care) to address COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents program.
Temporary Waiver of Certain Payment Caps. Allow states to suspend any Upper Payment Limit restrictions or Medicaid DSH hospital-specific caps to address hospital payments for COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents such payments.
Site-neutral Payment Cuts. Immediately cease paying claims for clinic visits provided at excepted off-campus provider-based departments at the reduced payment rate implemented with the 2020 Medicare final rule governing the hospital outpatient prospective payment system. Instead such clinic visit claims should be paid at the rate that would have been in effect absent the payment reduction. Refraining from reducing resources in this manner would help ensure patients get the care they need.

From: McGlamery, Gabriel [redacted]
Sent: Monday, March 16, 2020 5:50 PM
To: O'Brien, Kelly P. (CMS/CCIIO)
Subject: FW: Demand response in pandemics
Attachments: Braithwaite_et_al-2013-Health_Services_Research.pdf; Matheny et al 2007 Financial effects.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Kelly,

If you wanted sources about medical utilization in an epidemic, the attached docs might at least suggest the financial situation for issuers and providers might not be as straight forward as claims volume growing as the epidemic grows. Both look at it from the hospital's perspective and look a little more at losses from differing elective care v. increased volume from the epidemic. When you shift to the insurer's perspective there are some other considerations:

- How will the distribution of risk across age impact issuer claims? If hospitals fill up, will Medicare push out ACA-aged enrollees?
- While the attached consider hospitals, I'd expect inpatient treatment centers would have all the negative impact, like delaying elective care or sick providers, without any of the epidemic-related admissions to offset the lost revenue.
- The impact will not be evenly distributed. I would love to have a risk adjustment conversation about this (which won't surprise Beth and Erin) and will be talking to my risk adjustment SMEs tomorrow.

Health care economics isn't easy, intuitive, or straight forward. If there are adverse selection risks, that might be mitigated through risk adjustment, but there will be time to figure that out later (next week?). From a market-wide 2021 rating perspective or from a macro-economic impact perspective, the cost of delaying action and leaving people uninsured seems higher than any adverse selection risk from a SEP. Another way of looking at it is that contagion means the risk of leaving someone

I'm happy to say the testing rate is growing very quickly (https://covidtracking.com/data/). At some point, it will reach a capacity that will loosen testing criteria, allow more proactive testing, and we might be able to mimic Korea's aggressively preventive approach that gave them their low COVID-19 growth rate and low mortality rate. But getting people to be comfortable with protective testing requires them to have insurance. So, right now, the protective benefit of insurance likely outweighs the adverse selection risk. Lots of good stuff at https://protect2.fireeye.com/url?k=d4cf5618-889b4f64-d4cf6727-0cc47adc5fa2-cc27f5fa57acc011&u=http://covid19dashboards.com/, and to illustrate why I'm pointing to Korea - check out https://protect2.fireeye.com/url?k=ba88783e-e6dc6142-ba884901-0cc47adc5fa2-f1d2748dc77cadc9&u=http://covid19dashboards.com/growth-bayes/.

- Gabe

J. Gabriel McGlamery J.D. | Florida Blue
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(c) [redacted] | (o) [redacted] | [redacted]

From: David Anderson
Sent: Monday, March 16, 2020 4:04 PM
To: McGlamery, Gabriel
Subject: Demand response in pandemics

Gabe –
I am attaching a few papers of relevance to your theory that non-pandemic utilization goes down in times of an epidemic.

1) Braithwaite et al 2013 looks at the financial impact of H1N1 on hospital finances and found hospitals came out ahead due to massive increase in admissions for the pandemic that outweighed lost income from postponed elective surgery. I think COVID19 will have larger magnitude but directionally similar results from this same simulation model
2) Matheny et al simulated a 1918 Flu pandemic and found healthcare costs would go down as elective surgeries postponed brought in more revenue than flu care

I think that your assumption that all other non-pandemic utilization goes down is defensible. If your claims teams could look at how many knee replacements occurred during H1N1 vs previous year and forward year, that could be helpful as well.

Dave

David Anderson, MSPPM
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O |
C

Pronouns: He/Him/HIs

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NY State of Health and New York State Department of Financial Services Announce Special Enrollment Period for Uninsured New Yorkers, as Novel Coronavirus Cases Climb

Remind New Yorkers That There is No Cost Sharing for COVID-19 Testing Across Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans

ALBANY, N.Y. (March 16, 2020) - NY State of Health, together with the New York State Department of Financial Services (DFS), today announced that New York will make a Special Enrollment Period available to New Yorkers during which eligible individuals will be able to enroll in insurance coverage through NY State of Health, New York's official health plan Marketplace, and directly through insurers. This step is being taken in light of the COVID-19 public health emergency to further protect the public health of New Yorkers. NY State of Health, DFS, and New York State health insurers are taking this action due to the exceptional nature of the public health emergency posed by the COVID-19 so that individuals do not avoid seeking testing or medical care for fear of cost. The open enrollment period for coverage in 2020 had previously ended on February 7, 2020.

Individuals who enroll in Qualified Health Plans through NY State of Health or directly through insurers between March 16 and April 15, 2020 will have coverage effective starting April 1, 2020. Individuals who are eligible for other NY State of Health programs – Medicaid, Essential Plan and Child Health Plus – can enroll year-round. As always, consumers can apply for coverage through NY State of Health on-line at nystateofhealth.ny.gov, by phone at 855-355-5777, and working with enrollment assistors.

As directed by Governor Cuomo, all New York insurers will have waived cost-sharing for a COVID-19 testing,

"With a pandemic spreading through the U.S., it's important to ensure that healthcare is available to everyone who needs it," **said NY State of Health Executive Director, Donna Frescatore**. "This special enrollment period will provide New Yorkers with another opportunity to sign up for high-quality, affordable health insurance."

"Ensuring access to affordable and quality medical care for all New Yorkers is a top priority during this state of emergency," **said Superintendent of Financial Services Linda A. Lacewell.** "Under Governor Cuomo's leadership, we have established a special enrollment period, providing uninsured New Yorkers an opportunity to select a New York State health insurance provider to access diagnostic testing and care they may need."

For additional information on COVID-19:

- The Department of Health provides public health information and guidance here: https://www.health.ny.gov/diseases/communicable/coronavirus/, and has implemented a Novel Coronavirus Hotline at 1-888-364-3065.
- The Centers for Disease Control's website offers up to date information at: https://www.cdc.gov/coronavirus/2019-ncov/
- Governor Cuomo has issued a directive regarding access and cost sharing for COVID-19 testing and treatment available at: https://www.governor.ny.gov/news/governor-cuomo-announces-new-directive-requiring-new-york-insurers-waive-cost-sharing
- The Department of Financial Services has issued a circular letter on COVID-19 for health insurers here: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_03

From: O'Brien, Kelly P. (CMS/CCIIO)
Sent: Monday, March 16, 2020 10:13 AM
To: McGlamery, Gabriel
Cc: Bellsdale, Amber J. (CMS/CCIIO); Miller, Daniel J. (CMS/CCIIO); Kraemer, Carolyn M. (CMS/CCIIO)
Subject: RE: Covid-19 SEP

+ Carolyn

Thanks for reaching out, Gabe. I'll give you a call as soon as I can (likely early afternoon).

Stay safe!

-Kelly O'Brien
CCIIO/CMS/HHS
Cell: [redacted]
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From: McGlamery, Gabriel [redacted]
Sent: Monday, March 16, 2020 8:20 AM
To: O'Brien, Kelly P. (CMS/CCIIO) [redacted]
Cc: Bellsdale, Amber J. (CMS/CCIIO) [redacted]; Miller, Daniel J. (CMS/CCIIO) [redacted]
Subject: Covid-19 SEP
Importance: High

Kelly,

Do you have a chance to talk this morning about getting a Covid-19 SEP for Florida? I can be reached at 860-808-8294. The short version is that we want to do what we can to reduce the number of uninsured, and an "open the gates" SEP makes sense from a public health perspective. Before I call Randy or before Gov. DeSantos calls Admin. Verma, I wanted to touch base with you or Dan about this, especially to understand operational limitations.

Thank you,

Gabe

J. Gabriel McGlamery J.D. | Florida Blue
Sr. Health Policy Consultant | Government Relations
4800 Deerwood Campus Parkway, DCC8-2, Jacksonville, FL 32246
(c) [redacted] | (o) [redacted] | [redacted]

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COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR

March 16, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma;

Due to the national emergency declared by President Trump in light of the COVID-19 pandemic, I am writing to request that the Centers for Medicare & Medicaid Services (CMS) immediately issue a Special Enrollment Period (SEP) through HealthCare.gov for uninsured Pennsylvanians who may be unable to access testing and treatment. As of midday on Sunday, March 15, 2020, there have been 63 confirmed cases of COVID-19 in Pennsylvania. Nearly 450 Pennsylvanians have been tested for the novel coronavirus and we are expecting to identify more cases for testing in the coming days. We are urging everyone exhibiting symptoms to get tested and fear those without health insurance might forgo necessary testing and treatment due to the associated costs.

On March 6, I signed an emergency disaster declaration requiring my administration to initiate a statewide effort to protect the public health and safety of all Pennsylvanians. Our Insurance Department has worked with Pennsylvania's major health insurers to confirm they will cover medically appropriate COVID-19 testing without any cost-sharing for consumers. Our Department of Human Services has announced the state's Medicaid program and the Children's Health Insurance Program (CHIP) will cover COVID-19 testing treatment and that prior authorization will not be required in certain cases. These are steps being taken to protect our residents, but more can be done, particularly for those currently uninsured and in need of testing and treatment.

The prevalence and proliferation of COVID-19 outside of the annual Open Enrollment Period clearly meets the threshold for an exceptional circumstance and provides the justification necessary to issue a SEP for those without comprehensive insurance who may be impacted. We urge you to make the SEP available immediately and to keep it open for at least 60 days. Many state-based exchanges, to which Pennsylvania is transitioning for 2021, are considering or have already taken this action as a means to protect residents and facilitate access to COVID-19 testing. CMS recently released guidance clarifying that the diagnosis and treatment of COVID-19 is generally covered by Qualified Health Plans as an Essential Health Benefit (EHB). While we appreciate this clarification, we believe it is prudent to make Qualified

Health Plans, and their coverage of EHBs, available to everyone through an SEP. For these reasons, I urge you to make the SEP available immediately and keep it open for at least 60 days.

Thank you for your consideration and your efforts to ensure barriers to coverage are broken down for all Pennsylvanians during this vulnerable time.

Sincerely,

TOM WOLF
Governor

FOR IMMEDIATE RELEASE
March 17, 2020

Media Contacts:
Janel Davis, Silver State Health Insurance Exchange, 775-687-9934, j-davis@exchange.nv.gov
Cherryl Kaopua, Faiss Foley Warren, 702-408-8334, cherryl@ffwpr.com
Marissa Schwartz, Faiss Foley Warren, 925-595-8363, marissa@ffwpr.com

Silver State Health Insurance Exchange Announces Exceptional Circumstance Special Enrollment Period on Nevada Health Link

Carson City, Nev. – In response to Governor Sisolak's March 12th Emergency Declaration, the Silver State Health Insurance Exchange (Exchange), the state agency that connects Nevadans to qualified health plans through the online State Based Exchange (SBE), known as Nevada Health Link, announces a limited-time Exceptional Circumstance Special Enrollment Period (SEP) for qualified Nevadans who missed the Open Enrollment Period (OEP). The SEP runs from March 17, 2020 through April 15, 2020, and will allow eligible individuals to enroll in a qualified health plan through the SBE platform, Nevada Health Link.

Individuals seeking a special enrollment are encouraged to contact the Customer Assistance Call Center between 9:00 a.m. to 5:00 p.m. Monday-Friday at 1-800-547-2927; TTY: 711. The Call Center will extend its hours on Saturday's and Sunday's (except for Easter Sunday) from March 21 through April 15 from 10:00 a.m. to 2:00 p.m. PST. The Exchange recommends working with a certified broker or navigator to enroll in the SEP. Nevada Health Link offers language assistance and if you are deaf, hard of hearing, or have a disability, accommodations are provided at no cost.

"I am calling on all uninsured Nevadans, even if you are healthy, to take advantage of this special opportunity to gain access to health insurance coverage through the Exchange," said Nevada Governor Steve Sisolak." The COVID-19 virus is an unfortunate but important reminder that our health and wellbeing should be top priority and gaining access to insurance is a critical step in that process."

"The comprehensive insurance plans on Nevada Health Link are designed to protect you and your family from financial ruin if a medical issue or accident occurs, and they cover the ten essential health benefits mandated by the Affordable Care Act, including but not limited to pre-existing conditions. This is an incredibly important time to ensure you and your family are covered," said Exchange Executive Director, Heather Korbulic. "Nevadans deserve to have peace of mind to take care of all their health needs, and given today's exceptional circumstances, we are enabling those who are qualified to enroll and gain access to the vital services they may need."

Nevada Health Link wants to clarify that insurance is NOT required to be tested for COVID-19; and the emergency regulation signed by the Governor provides that there is no cost to consumers for medical services related to testing for COVID-19.

Nevada Health Link reminds Nevada residents who experience other qualifying events, such as marriage, birth of a child, moving, loss of health insurance, or Medicaid denial are also eligible to shop for a qualified health plan. Learn more on our website: https://www.nevadahealthlink.com/sep or in Spanish: https://www.nevadahealthlink.com/sepes.

About Nevada Health Link

Nevada Health Link is the online insurance marketplace operated by the Silver State Health Insurance Exchange (Exchange), which was established per *Nevada Revised Statutes* (NRS) in 2011 by the State of Nevada and began operations in 2013 on the belief that all Nevadans deserve access to health insurance. In 2019, the Exchange transitioned away from the federal marketplace, HealthCare.gov and became a fully operational State Based Exchange (SBE), in time for its seventh Open Enrollment Period (OEP). Nevada Health Link connects eligible Nevada residents to budget-appropriate health and dental coverage and is the only place where qualifying consumers can receive federal tax credits to help cover premium costs. Open Enrollment has concluded; for more information or to see if you're eligible for a Special Enrollment Period, visit our website. Subscribe to Nevada Health Link's Blog and YouTube channel, like them on Facebook or follow on Twitter and Instagram. Nevada Health Link always encourages consumers to use the free assistance of a licensed enrollment professional by calling 1-800-547-2927 or by visiting NevadaHealthLink.com.

From: Pate, Randy (CMS/CCIIO)
Sent: Tuesday, March 17, 2020 6:18 PM
To: Thornton, Jeanette
Subject: Re: Re: SEP Chart

Thanks Jeanette!

Sent from my iPhone

On Mar 17, 2020, at 5:54 PM, Thornton, Jeanette [redacted] wrote:

Please pass along to Peter. I don't have his email. Please note this includes where we've had outreach from the DOI. NE and CT are not on the chart, but based on plan or DOI outreach, we believe they are also evaluating an SEP.

Jeanette Thornton | Senior Vice President, Product, Employer, and Commercial Policy
America's Health Insurance Plans

[redacted] (office) | [redacted] (mobile)

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<COVID SEP Tracking Chart.docx>

(https://agency.accesshealthct.com)

Access Health CT Announces A New Special Enrollment Period For Uninsured Connecticut Residents

AS COVID-19 THREATENS PUBLIC HEALTH, ACCESS HEALTH CT ANNOUNCES A NEW SPECIAL ENROLLMENT PERIOD FOR UNINSURED CONNECTICUT RESIDENTS

New Special Enrollment Period starts Thursday, March 19 and ends Thursday, April 2

- Uninsured individuals can sign up for health insurance coverage through Access Health CT during the **NEW Special Enrollment Period** from Thursday, March 19 – Thursday, April 2, 2020.
- The effective date of coverage for all enrollments during the **NEW Special Enrollment Period** will be April 1, 2020.
- The only way to sign up for this **NEW Special Enrollment Period** is by calling 855-365-2428.
- Individuals who experience a Qualifying Life Event (e.g. loss of coverage due to job change or unemployment) or qualify for Medicaid/Children's Health Program (CHIP), can **ALWAYS** enroll online, in-person or over the phone and all help is free.

HARTFORD, Conn. (March 18, 2020)—With the exceptional circumstances due to the spread of the coronavirus, COVID-19, Access Health CT (https://u7061146.ct.sendgrid.net/ls/click?upn=4tNED-2FM8iDZJQyQ53jATUSHJhSm-2Fr-2FnNowogc6OL23P1pVGN2J-2BHd5jkADlzYdhXd27QaNy4ez-2FINLfPL2IpVw-3D-3DXQxq_W0niMUizrFlEwafZ43ePznnkKv2F5FVXi8l9u1uH5vGzYW31-2BpvLxSQ2C7U9C79aJFuh0VcZ3LwEFoxhs6FJ8bqF-2FdnubEKmjR4S3I6GahYC7LXOi6DjxKSZfTwdaale6oBCTqroQdEct4-2B4B2FgEtd2sKolRsdSGUKhMDbM0GWF5fiulukZsy-2BWCDkx8w3WBz2jYH29gG-2FXMPXEKfFHHANTybNunduBTXT-2BPM3BLbmymeHsevZVGrOa-2FU8blqaKzAmdcGhKnOsNorDoGHOI3DqoUqxgQtwEj0A49GQxKj0szptGgtRTuDaC6J6aZY-2FJYd4Xcv2w-2FTr06iCBOHii1v14IBM8VYkb-2Bx4QnqZNSDM-3D) (AHCT) today announced that a **NEW Special Enrollment Period** will be available to uninsured Connecticut residents to sign up for a health insurance plan offered by either of AHCT's two insurance carriers. There are other carriers who do not participate in the exchange who are working to provide reinsurance to make this special enrollment period possible.

The New Special Enrollment Period starts Thursday, March 19 and ends on Thursday, April 2, 2020. Connecticut residents must be lawfully present in the United States, and not incarcerated to be eligible. The coverage for those who enroll during this New Special Enrollment Period will start on April 1, 2020.

"No Connecticut resident should worry that testing or treatment will compromise their financial security. I thank each of Connecticut's health insurance carriers on the exchange, Anthem and ConnectiCare, and Access Health CT CEO James Michel for working with our administration to again offer health insurance to the uninsured during this new Special Enrollment Period," **Governor Lamont said**. "I thank Commissioner Mais and his team at the Insurance Department for their leadership working with our partners in the health insurance industry to assure that we are doing everything we can to provide access to health insurance coverage."

"We are experiencing a moment in history that requires flexibility and innovative ways to access healthcare," **said Chief Executive Officer at Access Health CT, James Michel.** "Since inception, Access Health CT offers year-round enrollment opportunities through Special Enrollments to individuals who experience a Qualifying Life Event, like loss of coverage due to job change. By implementing this new Special Enrollment, we are focusing on the uninsured so they can get covered and stay healthy."

"The goal is to slow the spread of the virus and reduce its cost to all Connecticut residents. That means everyone who needs it should get access to covered services and be tested and treated if necessary," **said Insurance Commissioner Andrew N. Mais.** "Insurance will help make that possible. It will also help those who need treatment avoid burdensome medical bills."

"ConnectiCare continues to step up to serve the people of Connecticut," **said Eric Galvin, President of ConnectiCare.** "This is an opportunity for Connecticut to lead the nation by bringing the entire health ecosystem together to focus on what's best for our people."

"As our communities continue to implement measures to help prevent the spread of COVID-19 and care for those impacted, we remain committed to providing greater access to care for more people in Connecticut. It is very important that those who are uninsured take advantage of this special enrollment period. Having health coverage will be important for those seeking treatment for this virus," **said Jill Hummel, President of Anthem Blue Cross and Blue Shield in Connecticut.** "We will continue to be a partner with the state and public officials as we work together to protect public health and provide both access to care and peace of mind for Connecticut residents."

New Special Enrollment Period

Who's Eligible?	**ONLY** qualified individuals who are **Uninsured**, lawfully present (https://u7061146.ct.sendgrid.net/ls/click?upn=4tNED-2FM8iDZJQyQ53jATUSI5RfCWZdg0qryUSuTC4dIYOPL49oaY96xfcLMRcNrY3KpWW7YQf7MAnHf3Jpnt7eaLjqcoHQ-2FJae-2BSiUt-2F36HFBPl7U5yxgdqCKkx9upYgArWVMkLvTXF7SvPAcyapVfskoWhdgJpPAoCJCx-2BIZT0-3DwEXF_W0niMUizrFlEwafZ43ePznnkKv2F5FVXi8l9u1uH5vGzYW31-2BpvLxSQ2C7U9C79aJFuh0VcZ3LwEFoxhs6FJ8bqF-2FdnubEKmjR4S3I6GahYC7LXOi6DjxKSZfTwdaale6oBCTqroQdEct4-2B4B2FgEtd2sKolRsdSGUKhMDbM0GWF5fiulukZsy-2BWCDkx8w3W14maJNNhrU6BuNT5U9VoDnY-2FTEb68eOnuow8lDo9FUqoPof-2BtvOSBj5rO1McKes90uSVrHt-2BBX-2BDknCattblXMDo1SkILpdHG0iv2dLsnjZtZJa7L9IiyL6AuGZa-2FEDLctZeBFqoUkLjFYUjiGVULs-2BGOYQRsOq9wzTQKL6nVDA-3D) and not incarcerated.
When can I enroll?	From March 19, 2020 through April 2, 2020.
When will my coverage start?	The effective date of coverage for all enrollments during the **NEW Special Enrollment Period** will be April 1, 2020.
How can I enroll?	**PHONE ONLY: 1-855-365-2428 (TTY: 1-855-789-2428)** **8AM – 5PM | Monday – Friday**

Other information about this **New Special Enrollment Period** is available at: Learn.AccessHealthCT.com (http://www.Learn.AccessHealthCT.com).

Access Health CT reminds residents of the importance of maintaining their coverage throughout the year, and not just during this public health crisis. It is critical that uninsured individuals take advantage of this opportunity to protect themselves financially and ensure they have access to necessary services.

(https://eregulations.ct.gov/eRegsPortal/)

State of Connecticut Disclaimer (http://portal.ct.gov/Policies/Disclaimer), Privacy Policy (http://portal.ct.gov/Policies/State-Privacy-Policy), and Web Site Accessibilty Policy (http://www.access.state.ct.us/policies/accesspolicy40.html)

Community (http://learn.accesshealthct.com/community/) Press Releases (https://agency.accesshealthct.com/press-releases)

Meeting Updates (https://agency.accesshealthct.com/meetings)

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STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

The Honorable Alex Azar
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator,

As states continue to act and find innovative solutions to help our citizens combat the COVID-19 outbreak, I ask that the United States Department of Health and Human Services allow for a special open-enrollment period for a 60-90-day period.

This action would allow individuals, especially those who are potentially most at-risk for COVID-19 to access affordable health care coverage through the federally facilitated individual insurance market place. Individuals who believe they are demonstrating symptoms of the virus will have greater confidence to get tested, seek treatment and guard against further spread if they know they have a health care plan that will cover them.

We have taken proactive steps to ensure Granite Staters are safe, healthy, and have access to health care. Earlier this month, my administration directed insurance companies to provide testing for COVID-19 without cost-sharing.

In light of this outbreak, we must take every opportunity possible to expand health care options and coverage. As such, allowing for a special open-enrollment period is a simple step that increases access to quality, affordable healthcare at a time when it is critically needed.

Sincerely,

Christopher T. Sununu
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.governor.nh.gov/ • Email: governorsununu@nh.gov
TDD Access: Relay NH 1-800-735-2964

From: McGlamery, Gabriel [redacted]
Sent: Wednesday, March 18, 2020 4:24 PM
To: O'Brien, Kelly P. (CMS/CCIIO)
Subject: RE: SEP Update?

Kelly,

If you have a chance to call, it would be great to calibrate how the SEP conversation is going. I'm working from home and reachable at any time at [redacted].

Stay safe and healthy!

- Gabe

From: McGlamery, Gabriel
Sent: Wednesday, March 18, 2020 11:11 AM
To: 'O'Brien, Kelly P. (CMS/CCIIO)'
Subject: SEP Update?

Kelly,

I understand things are probably crazy and have changed since we spoke. I've reached out to Randy and I'm checking in on DeSantos' outreach effort, but it sounds like there are a lot of stakeholders are asking for a SEP at this point. Please let me know if we can help.

Gabe

J. Gabriel McGlamery J.D. | Florida Blue
Sr. Health Policy Consultant | Government Relations
4800 Deerwood Campus Parkway, DCC8-2, Jacksonville, FL 32246
(c) [redacted] | (o) [redacted] | [redacted]

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March 19, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Special Enrollment Period during COVID-19 National Emergency

Dear Administrator Verma:

We appreciate the Center for Medicare and Medicaid Services (CMS) working with the Alliance of Community Health Plans (ACHP) and our member organizations at this time of national emergency. Our member plans have deep roots in the communities they serve giving them insight into immediate needs and concerns.

Given increasing and urgent demand on our health care infrastructure, ACHP urges the Administration to establish a Special Enrollment Period during the COVID-19 National Emergency to be applicable to all Affordable Care Act Marketplace coverage. The nearly 30 million uninsured Americans and estimated 44 million underinsured should have the ability to enroll in health care coverage during a time of high anxiety and uncertainty. These individuals face two options: go untreated and risk spreading the virus or face unmanageable medical bills. As we see small businesses temporarily – or permanently – shuttering, the need for a health care safety net will be even more necessary in the coming weeks and months. Already, our members are hearing from small businesses contemplating dropping employee coverage as they face drastic reductions in revenue.

ACHP believes that a Special Enrollment Period during the COVID-19 National Emergency is an appropriate next step following the declaration of COVID-19 as a National Emergency on March 13, 2020. Maryland, Washington, New York, Connecticut and Massachusetts have already declared Special Enrollment Periods to address coverage needs within their states. Individuals nationwide should be afforded the same opportunity. There is precedent for HHS declaring a Special Enrollment Period during an emergency: In both 2017 and 2019, HHS established a Special Enrollment Period for affected individuals following devastating hurricanes (Irma, Maria, Nate, Harvey and Dorian).

A Special Enrollment Period would offer much needed coverage to millions of Americans and mitigate the potential impact on providers and hospitals which will be forced to rely on emergency funding, an especially dire scenario for rural providers and hospitals.

1825 Eye Street, NW, Suite 401 | Washington, DC 20006 | p: 202.785.2247 | f: 202.785.4060 | www.achp.org

ACHP appreciates the Administration's recent flexibilities around telehealth benefits and services. Given these flexibilities, increased health care coverage would mean fewer people seeking care in brick and mortar institutions and more people being directed to telehealth services. ACHP strongly recommends the Administration move forward with this proposal to augment the progress already made, continue our national efforts to flatten the curve and ensure all American's have access to care and coverage in this uncertain time. We look forward to closely collaborating with the Administration and responding to this crisis.

If you have questions or require additional information, please contact Michael Bagel, ACHP Director of Public Policy, at mbagel@achp.org or (202) 897-6121.

Sincerely,

Ceci Connolly
President and CEO

March 19, 2020

The Honorable Mitch McConnell
Senate Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Charles Schumer
Senate Democratic Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
House Republican Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Speaker Pelosi, Leader McConnell, Leader McCarthy, and Leader Schumer:

We are committed to working with you in every possible way to help America through the COVID-19 emergency. Our mission has always been to cover and care for the people we serve. That mission is more important now than ever before. We have their back – and they have our support.

One of the most important things we can do together is to deliver as much certainty as we can in these uncertain times. The American people need the peace of mind of knowing that their health and financial future are secure. That means knowing that they can count on their health care coverage when they need it most. It also means knowing that their doctors, hospitals, nurses, and other health care professionals have the resources they need to care for them.

This is especially important for Americans working in sectors of the economy facing the biggest hardships from COVID-19. As businesses of all sizes wrestle with mounting economic challenges and make hard decisions about their future, we must do everything we can to ensure that employees do not lose health coverage – which would make the harms and risks of COVID-19 much worse for hundreds of millions of people. We must also ensure that Americans who buy coverage on their own can continue to afford their coverage.

Helping Businesses and Families Get and Maintain Coverage

We believe the following actions will deliver more certainty and support for all Americans – now and long term. We also believe they will provide greater flexibility to respond to evolving economic and health care circumstances:

- Support businesses in their goal to continue providing health coverage to their employees. There are many options for how this support could be provided. It could take the form of

payroll tax relief, or a refundable credit against employment tax withholdings, for firms providing coverage. It could include direct subsidies of the employer's premium obligation for each person covered under the employer's plan beginning on the day the crisis was declared.

- Establish robust new funding to support Americans who lose their jobs to allow them to maintain coverage. Congress should create new funding to support coverage for those who lose their jobs due to the crisis, by providing a 90% subsidy for COBRA or other insurance coverage.

- Establish a temporary, emergency risk mitigation program to ensure that health care premiums do not spike, and that benefits are stable in the future. Health insurance providers are covering COVID-19 tests and needed treatments. As more people seek coverage and care due to this pandemic, this temporary, emergency program would protect Americans from the consequences of potential catastrophic costs. This should be structured as a backstop contingency program that is triggered only if real-world health insurer costs are significantly higher than expected. Given the enormous uncertainty regarding the costs of the epidemic, we recommend that the program cover a portion of related costs for 2020 and 2021 and apply to the individual, employer, Medicare and Medicaid markets.

- Allow a one-time special enrollment period (SEP) for the individual market – regardless of an individual's current health status or whether they have coverage today. Given the risk posed by COVID-19, it is more important than ever for people to have health coverage. This will give people the opportunity to get the security and peace of mind that health care coverage provides.

- Enhance current financial assistance to lower the cost of premiums for those who rely on the individual market. Tax credits for those with incomes over 400% of the federal poverty level should be made available, and adjustments to the tax credit formula by age to would encourage more younger people to get covered.

Meeting the Needs of the Health Care Delivery System

We must also take action to support the doctors, hospitals, nurses, and other health care professionals who treat patients every day by ensuring that our front-line, health care heroes have the resources they need to confront this pandemic. Specifically, we urge the Congress to:

- Provide emergency funding to hospitals to assist the surge in patient needs. This emergency funding can help secure critical supplies and future vaccines, re-purpose treatment units, and expand staffing. Funding could also help build temporary COVID-specific clinics that enable drive-through testing in communities that can help identify those in critical need and alleviate burden on hospitals.

- Support independent health care providers with direct financial support. Small and independent practices are struggling with a wave of cancelations, a dramatic shift from

elective procedures to urgent COVID-19 tests and treatment, and their own staffing strains as parents stay home with children. Congress should make Small Business Administration loans and grants available so that practices can remain open, reduce the need to lay off staff, support personnel that must take leave, and shift resources to telehealth services.

- Enhance funding for testing and treatment of COVID-19-related conditions for those who remain uninsured. Congress should expand the new state option through Medicaid to ensure the uninsured are covered for treatment of COVID-19-related illnesses beyond the coverage of the diagnostic test and related visit recently enacted in HR 6201. Similarly, Congress should increase the funding allocation for the National Disaster Medical System (NDMS) to cover treatment of COVID-19-related illnesses for anyone who remains uninsured. This NDMS funding would be in addition to the $1 billion allowance Congress appropriated for coverage of the diagnostic test and related visit in HR 6201.

These changes are critical to help stabilize the coverage and care that hundreds of millions of Americans are depending on right now. Knowing that businesses and employees are supported, and that their care providers have the resources they need, are essential actions to help and support the people we serve. Thank you for the opportunity to work with you as our nation tackles the enormous economic and health care challenges created by COVID-19.

Sincerely,

Matthew Eyles

Scott P. Serota

President and Chief Executive Officer
America's Health Insurance Plans

President and Chief Executive Officer
Blue Cross Blue Shield Association

If you've recently experienced a job loss or loss of income, you might qualify for a 60-day Special Enrollment period, which will allow you to sign up for a new health insurance plan or to change your current plan. Visit the When Can I Buy Insurance Page under Get Started to learn more.

Uninsured Coloradans Can Enroll during a Special Enrollment Period in Response to COVID-19 Outbreak

Uninsured Coloradans Can Enroll during a Special Enrollment Period in Response to COVID-19 Outbreak

03/19/2020

DENVER – To help as many people as possible protect their health and safety during the COVID-19 outbreak, Connect for Health Colorado® announces a new Special Enrollment period that starts **Friday, March 20, 2020 and ends Friday, April 3, 2020**. **Coloradans who are uninsured qualify to enroll in a health insurance plan for coverage that starts April 1, 2020.**

To sign up for coverage through the Marketplace- the only place where residents can qualify for financial help to lower costs- Coloradans can complete an application and select a health insurance plan:

- Online at ConnectforHealthCO.com.
- Over the phone at **855-752-6749**, Monday through Friday from 8 a.m. to 6 p.m. We're also extending Customer Service Center hours this weekend and next, from 9 a.m. to 5 p.m. Saturday and Sunday.
- Working with a certified enrollment expert. Many local experts continue to provide virtual and/or phone appointments.

Applicants should select the enrollment reason as, **"Will lose or lost health insurance and/or have no other health coverage during the COVID-19 outbreak"** and input the application date as the qualifying life change event date. Residents who take these steps will not be asked by health insurance companies to provide documentation to verify their eligibility for the Special Enrollment period.

As always, Coloradans can sign up for a plan if they experience other qualifying life change events, including loss of job-based and Health First Colorado (Medicaid) coverage. Coloradans may be eligible to enroll in a new plan if they experience changes or losses in income, which should be reported to Connect for Health Colorado. Residents who qualify for Health First Colorado (Medicaid) or the Child Health Plan *Plus* program can enroll online through the PEAK application any time during the year.

###

About Connect for Health Colorado

Connect for Health Colorado is a public, non-profit entity established by the Colorado General Assembly in 2011 to create a health insurance Marketplace. Since 2013, we've been helping individuals, families and small employers compare plans, apply for financial help and buy health insurance. As Colorado's official health insurance marketplace, we are the only place to apply for financial help to lower the monthly cost of premiums. Customers can shop online; get help by phone or online chat from Customer Service Center representatives; and access expert, in-person help from a statewide network of certified Brokers and community-based Assisters. For more information: ConnectforHealthCO.com

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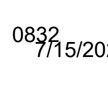

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From:
Sent: Thursday, March 19, 2020 9:46 PM
To:
Subject: FW: AHIP/BCBSA COVID-19 Stability Recommendations
Attachments: AHIP-BCBSA COVID Stability Package_031920.pdf

From: Goodman, Elizabeth
Sent: Thursday, March 19, 2020 8:38 PM
To: Arbes, Sarah (HHS/ASL) ; Morse, Sara (HHS/ASL)
Cc: Griffin, Aron ;
Subject: AHIP/BCBSA COVID-19 Stability Recommendations

Hi Sarah and Sara - I hope you are well and weathering this crisis as well as can be expected. I'm emailing to share some additional information which we forwarded to the Hill this evening.

As the COVID-19 outbreak has progressed, we along with BCBSA, have shared several sets recommendations with the relevant committees in Congress regarding flexibilities we believe to be necessary to meet the needs of our members at this crucial time.

Since submitting our last set of recommendations, and with passage of the Families First Coronavirus Response Act, the challenges faced by individuals, states, large and small employers, and the health care system have become increasingly clear. We are committed to working with you in every way possible, and at this moment one of the most important things we can do is ensure that those already facing economic hardships do not lose health coverage.

As such, AHIP & BCBSA developed the attached recommendations, including a refinement of a few recommendations from our earlier list, which are focused health care coverage and ensuring a stable health care system.

We believe the fuller list is critical to enact, however, given recent developments and focus of the developing package, we believe the attached are the most critical in the short-term.

Please don't hesitate to reach out if you have any questions, or would like to discuss in greater detail.

Thanks so very much,

Liz

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Assuring Access to Coverage and Care during the COVID-19 Crisis

As we all urgently work to address this unprecedented national emergency, America's health insurance providers are focused on meeting the needs of our members and our communities. A critical component of assuring that people receive the care they need in response to COVID-19 is ensuring that Americans who currently have coverage maintain it and enabling those who are uninsured to have a pathway to access coverage.

As we respond to the COVID-19 emergency, we urge Congress to address several critical priorities to assure that consumers can get the care they need, employers and individuals have resources to continue their critical health insurance coverage, and the health care system has the resources it needs to address this crisis and remain strong to meet future needs.

In light of the unprecedented nature of this crisis, the critical need to ensure the health care system and our communities are prepared moving forward, and the enormous uncertainty around the health and economic impacts of COVID-19, we recommend the following:

1. Meeting the Needs of Consumers Who Today Have Coverage:

Consumers and businesses should receive assistance to maintain coverage so people can get the care they need: According to a recent report, more than 24 million Americans work in five high-risk sectors facing a sharp slowdown because of the COVID-19 crisis. We ask Congress to act to support employers negatively impacted by the economic effects of the virus so that they are able to continue offering coverage to their employees and to provide additional assistance to individuals who buy coverage on their own but whose livelihoods have been negatively impacted by COVID-19:

a. Providing support for employers to continue coverage (e.g., payroll tax relief, refundable credit against employment tax withholdings for firms providing coverage, or direct subsidies of the employer's premium obligation for each person on the employer's sponsored plan beginning on the day the crisis was declared).

b. Establishing new funding to support coverage for those who lose their jobs by providing a 90% subsidy for COBRA or other insurance coverage.

c. Enhancing current financial assistance to lower the cost of premiums for those in the individual market by providing tax credits for those with incomes over 400% FPL and adjusting the tax credit formula by age to encourage younger people to purchase coverage.

To assure coverage for people is there when they need it, Congress should establish a risk mitigation program that would be applicable across the individual, employer, Medicare Advantage and Medicaid markets. The new program is needed to provide protection against possible catastrophic costs due to the emergency and the additional risk assumed by insurers as COVID-19 spreads and people seek coverage and care. Given the uncertainty regarding the costs of the epidemic, we recommend that the program be triggered if costs are higher than expected and structured to cover a portion of related costs for 2020 and 2021.

2. Meeting the Needs of Consumers Who Lack Coverage Today

Given the risk posed by COVID-19, it is more important than ever that people have health insurance coverage. To assure that coverage is available to everyone who needs it, we recommend that Congress take the following additional steps to ensure they can easily access coverage and that it is affordable:

CMS should allow a one-time special enrollment period (SEP) for the individual market. This SEP should be time limited (30 days) with a prospective effective date(s) on the first of the month. The SEP should be available to all persons who are not eligible for Medicare or Medicaid. Given the uncertainty about the cost of treating those who would enroll through an SEP, this option should be coupled with risk mitigation funding as outlined above.

Congress should enhance funding for testing and treatment of COVID-19-related conditions for the uninsured. Congress should expand the new state option through Medicaid to ensure the uninsured are covered for treatment of COVID-19-related illnesses beyond the coverage of the diagnostic test and related visit recently enacted in HR 6201. Similarly, Congress should increase the funding allocation for the National Disaster Medical System (NDMS) to cover treatment of COVID-19-related illnesses for anyone who remains uninsured or cannot access coverage through exchanges. This NDMS funding would be in addition to the $1 billion allowance Congress appropriated for coverage of the diagnostic test and related visit in HR 6201.

3. Meeting the Needs of the Health Care Delivery System

It is essential for a coordinated government response to leverage the full force of the President's national emergency declaration. Specifically, we recommend the following mission-critical, time-sensitive actions to ensure that necessary resources are delivered to the communities most in need:

Hospitals should receive direct federal funding to support relief efforts. Congress should provide new direct federal funding to ensure hospitals can handle surge/capacity issues and that public health investments are made to secure needed supplies and coverage of vaccines and potential treatments. Emergency subsidies should be made available to support rural hospitals and other clinics that need assistance re-purposing units or adding labor to meet increased demand. Additional investments should be made in the creation of temporary COVID-specific clinics that enable drive-through testing in communities that can help identify those in critical need and alleviate burden on hospitals.

Independent providers should be given the necessary resources to maintain their practices: Congress should provide direct financial support for small and independent practices who are struggling with cancelations, stoppage of elective procedures and workforce strain as parents stay home with children, as well as other unprecedented challenges during this time. Congress should make Small Business Administration loans and grants available to these providers so practices can remain open, reduce the need to lay-off non-physician providers and other staff, and support staff that need to take leave. Congress should also fund grants for these providers to administer telehealth services to maintain safe access points of care for patients as well as short-term revenue streams for providers.

From: Neil Heller [redacted]
Sent: Thursday, March 19, 2020 11:00 AM
To: Reed Ferguson [redacted]; Mathis, Greg (Warner) [redacted]; Wright, Katie (Kaine) [redacted]
Cc: Richard Tugman [redacted]; David Cook [redacted]; Phillip Miller [redacted]
Subject: Urgent Request to Assist Virginia Health Insurer to Expand Coverage

Mr. Ferguson for Representative Cline:
Mr. Mathis for Senator Warner:
Ms. Wright for Senator Kaine:

Piedmont Community Health Plan is a health insurer based in Lynchburg, Virginia.

We believe that access to affordable health insurance is critically important during these troubled times, for both the protection it offers and the peace-of-mind it provides.

Currently, uninsured Virginians cannot use the risk of COVID-19 as an approved "qualifying event" if they wish to purchase insurance on the Federal Marketplace. In contrast, some of the State Based Marketplaces (SBMs) such as Massachusetts, Maryland, Washington and now Nevada have all reopened their Individual Markets with specific Special Enrollment (SEP) opportunities for anyone seeking individual insurance through the marketplace as a result of COVID-19: details are available at https://www.rollcall.com/2020/03/13/states-reopen-insurance-enrollment-as-coronavirus-spreads/.

We have questioned CMS about their position on opening an SEP opportunity at the federal level for Federally Facilitated Marketplace (FFM) states like Virginia as a result of COVID-19. So far, there has been no response. We strongly agree with the SBM states' actions, and that providing health insurance to our communities is essential during times such as this. We would hope that CMS would understand that enrolling additional uninsured individuals would help ensure people are covered in the event they need medical coverage through the end of 2020. There is a great deal of uncertainty coming these next few weeks and months, and we believe the Virginia uninsured should have an opportunity to purchase a plan mid-year if they want to.

Would your offices be willing to support our request and contact the CMS/CCIIO offices to inquire about their position on this topic? You may have a different channel of communication that we do not have access to. Additionally, if you have other recommendations on how best to proceed, any assistance would be greatly appreciated.

Thank you for your help. To state the obvious, time is of the essence.

Kind regards,

Neil A. Heller
Chief Marketing Officer

Piedmont Community Health Plan
2316 Atherholt Road, Lynchburg, VA 24501
P: [redacted] | **C:** [redacted] | **E:** [redacted]

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From: McGlamery, Gabriel [redacted]
Sent: Thursday, March 19, 2020 2:02 PM
To: O'Brien, Kelly P. (CMS/CCIIO)
Subject: Uninsured in Florida

Follow Up Flag: Follow up
Flag Status: Flagged

Kelly,

You wanted hard facts about what the impact of a SEP might be and I happened to get some projections of the number of uninsured and the cost of coverage that illustrate the issue. Charts are below, but key points:

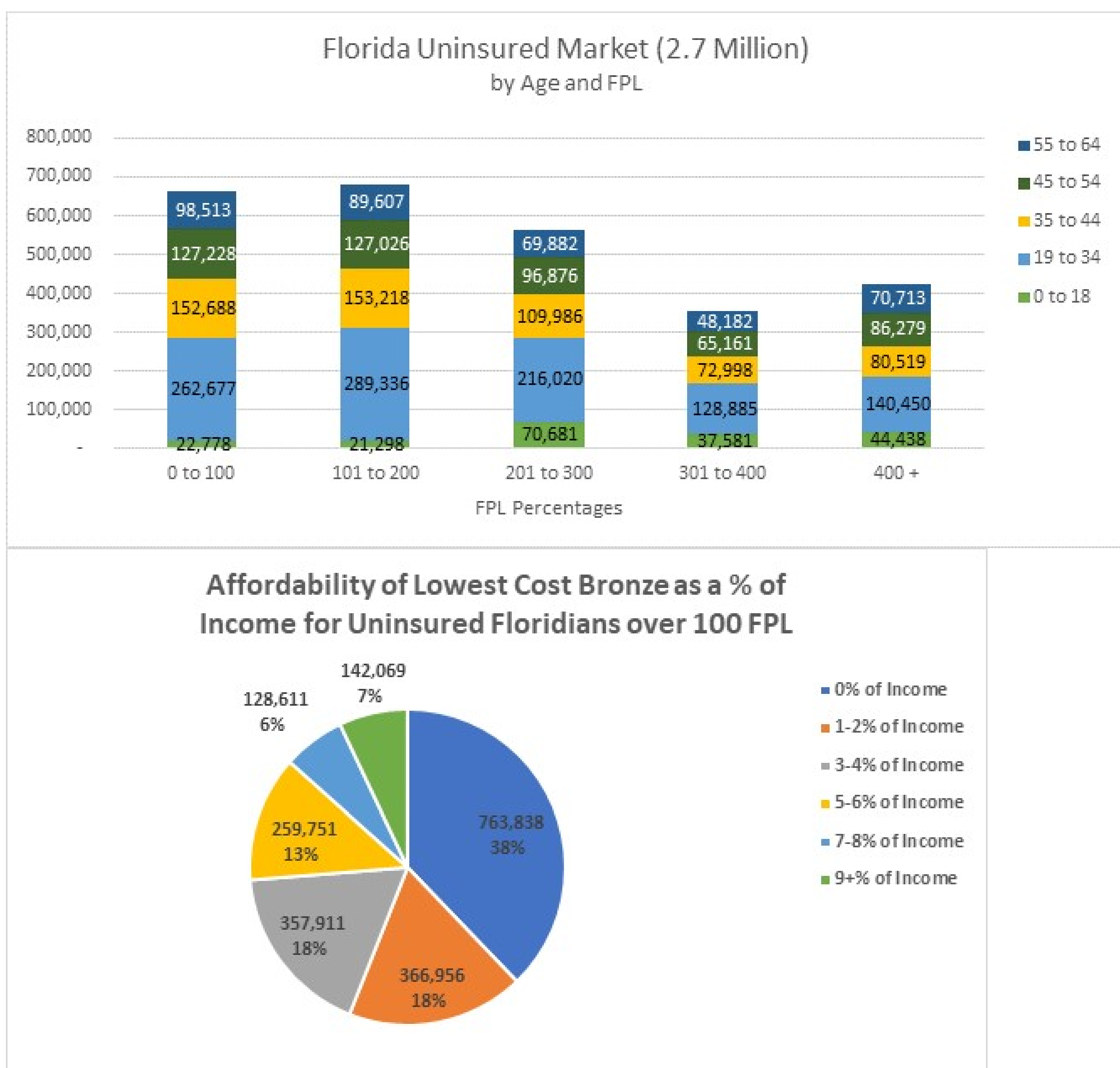
- 764k people in Florida should have access to $0 Bronze, but are uninsured (and $0 bronze is a great way to get people in the door so they buy silver CSR-eligible plans).
- 367k can get bronze for 1-2% of their income. That might have been a bad deal for a healthy person a month ago, but things are different today.
- Anyone in the high-risk age range (mid fifties and sixties) will almost always fall into one of those buckets if they're eligible for Marketplace subsidies – that includes people at 399% FPL.
- These are numbers using 2018 ACS data and 2020 premium rates. As people lose job and hours, income falls, and the number of people with access to cheap or free coverage through the Marketplace will increase.

So, **up to 1.123m Floridians could use the SEP to reconsider their decision not to buy health insurance** without worrying about financial hardship. Most of them are healthy and will be healthy (especially if they can access care safely). Many of these people might not have considered the value of insurance, might not have been aware of the size of subsidies, or might not be eligible (the model we used was very simple) but every person who forgoes testing because they're worried about their personal finances, or goes to an ED because they lack telehealth, will make it harder for us to recover from this crisis.

When I've looked, I've seen similar numbers of uninsured in the subsidy-eligible range, even in states with Medicaid expansion, like California or Colorado.

I hope this helps, but I look forward to touching base and learning if there is anything else I might do to get the SEP ASAP.

- Gabe



Notes on our model:
The data being used is from 2018.
Our uninsured count is lower than what IMI previously sent, but the numbers align with external data sources (Census/KFF).
Our population model focuses on IU65 ACA and we make two data edits to the uninsured population to account for IU65 focus:

- Individuals older than 65 are bucketed into Medicare
  - The reasoning here is that they would enroll in Medicare, and not IU65, if they were to get insurance.
- Individuals that are eligible for CHIP (0-18, <200% FPL) are moved to Medicaid
  - They are not eligible for ACA subsidies and healthcare.gov steers them towards CHIP

J. Gabriel McGlamery J.D. | Florida Blue
Sr. Health Policy Consultant | Government Relations
4800 Deerwood Campus Parkway, DCC8-2, Jacksonville, FL 32246
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News Release

Covered California Media Line: (916) 206-7777 @CoveredCANews media@covered.ca.gov
Department of Health Care Services Media Line: (916) 440-7660 @DHCS_CA DHCSPress@dhcs.ca.gov

FOR IMMEDIATE RELEASE
March 20, 2020

California Responds to COVID-19 Emergency by Providing Path to Coverage for Millions of Californians

Covered California Expands Special Enrollment and Medi-Cal Seeks Waivers to Encourage Coverage

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- *Effective immediately, anyone uninsured and eligible to enroll in health care coverage through Covered California can sign up through the end of June.*
- *The Department of Health Care Services announces new steps to help those eligible for Medi-Cal sign up easily and get immediate coverage.*
- *The moves come amid widespread disruption in the lives and livelihoods of Californians as public health officials seek to reduce the spread of COVID-19.*
- *All medically necessary screening and testing for COVID-19 are free of charge, and all health plans available through Medi-Cal and Covered California offer telehealth options.*
- *These actions build on increased state subsidies and the implementation of a state penalty, both of which took effect in January 2020.*

SACRAMENTO, Calif. — As the state of California is taking action on many fronts to respond to the COVID-19 pandemic, Covered California and the Department of Health Care Services (DHCS) joined together to make sure that those losing employment would have a ready path to coverage — whether through Medi-Cal or the plans offered through Covered California.

Effective Friday, March 20, Covered California opened the health insurance exchange to any eligible uninsured individuals who need health care coverage amid the COVID-19 national emergency. Anyone who meets Covered California's eligibility requirements, which are similar to those in place during the annual open-enrollment period, can sign up for coverage through June 30.

"We want to get as many people covered as possible to ensure they have access to the health care they need," said Peter V. Lee, executive director of Covered California. "Having more people insured is the right thing to do, and this action builds on our efforts to leave no one behind in California."

People who sign up through Covered California will have access to private health insurance plans with monthly premiums that may be lowered due to federal and new state financial help that became effective in 2020. After selecting a plan, their coverage would begin on the first of the following month — meaning individuals losing job-based coverage will not face a gap in coverage.

In addition, consumers who sign up through CoveredCA.com may find out that they are eligible for no-cost or low-cost coverage through Medi-Cal, which they can enroll in online. Those eligible for Medi-Cal can have coverage that is immediately effective.

California has put a 90-day hold on Medi-Cal renewal reviews, ensuring those already enrolled can continue their coverage and freeing up resources to quickly process the expected new enrollments. DHCS also is seeking expanded authority to expedite enrollment for seniors and other vulnerable populations, expand the use of telehealth, and take other steps to make care easier to access.

"The extraordinary challenges posed by COVID-19 demand an equally extraordinary response, and the Medi-Cal and Covered California systems are stepping up to meet the need for health coverage and ease access to services," said Dr. Bradley P. Gilbert, Director of the Department of Health Care Services.

DHCS oversees Medi-Cal, California's version of Medicaid, which provides coverage for about 13 million Californians.

The California Department of Managed Health Care (DMHC) and the California Department of Insurance will provide guidance to health plans on the special-enrollment period, which will also include off-exchange health plans. This will ensure consumers enrolling in the entire individual market in California will have access to coverage during the pandemic emergency.

"We are working together to protect the health and safety of Californians during this pandemic," said DMHC Director Shelley Rouillard. "This includes making sure that Californians are able to access health care coverage. Opening a special-enrollment period due to COVID-19 offers new coverage options to Californians when they need it most."

(more)

All Covered California and Medi-Cal Plans Offering Telehealth Options

All health plans offered through Covered California and by Medi-Cal provide telehealth options for enrollees, giving individuals the ability to connect with a health care professional by phone or video without having to personally visit a doctor's office or hospital.

All medically necessary screening and testing for COVID-19 is free of charge. This includes telehealth or doctor's office visits as well as network emergency room or urgent care visits when necessary for the purpose of screening and testing for COVID-19. In addition, Medi-Cal covers costs associated with COVID-19 in both its managed care plans and with fee for service providers. Covered California health plans will help cover costs that arise from any required treatment or hospitalization.

"A core part of our mission is improving access to high-quality health care, and that has never been more important than it is right now in California," Lee said.

New Ad Campaign to Get the Word Out

Covered California will be alerting the public about the new special enrollment period through television, radio and digital ads. Covered California is already running ads that highlight the new financial help that is available for the first time this year, the new state individual mandate penalty and ads that make the connection to the COVID-19 pandemic and the ability to get coverage.

Click here to listen to the radio ad currently airing that highlights what consumers can do in face of the COVID-19 epidemic .

Watch the new television ads focusing on the financial help and penalties in English and Spanish here.

New State Subsidies Help Californians Lower Their Health Care Costs

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people. The subsidies are already benefitting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 and 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household). The financial assistance lowers the average household monthly premium from $881 per month to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have already qualified for new state subsidies, with average state subsidy to eligible households is $504 per month, lowering their monthly premium by nearly half.

(more)

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their “off-exchange” coverage. They are also eligible to switch to Covered California and benefit from the financial help. During this special enrollment period, Covered California, its health plans and certified agents will be reaching out to these Californians to let them know how they can save money on their premiums – which will help them keep their coverage in challenging financial times.

California’s Success in Expanding Coverage Strengthens Pandemic Response

The policies announced today build on the success of the Affordable Care Act in California. Since the law was signed 10 years ago, California’s uninsured rate has dropped to a record low of 7.2 percent thanks to the expansion of Medi-Cal and the creation of Covered California.

“California’s policy makers made important choices ten years ago to build the Covered California exchange and dramatically expand the state’s Medi-Cal program. Those choices — as well as new efforts by Gov. Newsom and the Legislature to bolster financial support to buy coverage — mean many millions of people have coverage today and can get it tomorrow for this critical moment in time,” Lee said. “Our goals now must be to make sure we meet the needs of those without insurance -- whether they just lost their coverage or lost their income – while assuring those with coverage get the care they need, when then need it. The urgency of this public health crisis calls on all of us to do everything we can to help Californians.”

Staying Safe While Getting Help Enrolling

With the just announced order for Californians to stay home if they are not engaged in essential work or travel, Covered California is working with the more than 10,000 Certified Insurance Agents that help Californians sign up and understand their coverage options through phone-based service models.

“We are in a different world right now, but social distance does not mean you cannot get personal help,” Lee said. “Our agents and staff are stepping up to help people by phone and support them to enroll online.”

Consumers can easily find out if they are eligible Medi-Cal or other forms of financial help and see which plans are available in their area by using the CoveredCA.Com Shop and Compare Tool and entering their ZIP code, household income and the ages of those who need coverage.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller.

(more)

- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

About Covered California

Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

About the Department of Health Care Services

The California Department of Health Care Services (DHCS) is the backbone of California's health care safety net. It provides access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. DHCS funds health care services for about 13 million Medi-Cal beneficiaries and is the largest health care purchaser in California. It collaborates with the federal government and other state agencies, counties, and partners to invest more than $100 billion for the care of low-income families, children, pregnant women, seniors, and persons with disabilities. For more information about DHCS, please visit www.dhcs.ca.gov.

###

www.mainecahc.org

Advocating the right to quality, affordable health care for every person in Maine.

Consumer Assistance HelpLine
1-800-965-7476

March 20, 2020

Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd, Baltimore, MD 21244

Re: Request to HHS to create an emergency special enrollment period

Dear Secretary Azar and Administrator Verma,

On behalf of Consumers for Affordable Health Care, we are writing to urge the Centers for Medicare & Medicaid Services and the Department of Health and Human Services to create an emergency, 60-day special enrollment period as part of the effort to respond and combat the growing COVID-19 crisis.

Consumers for Affordable Health Care (CAHC), is a nonpartisan, nonprofit organization that advocates the right to quality, affordable health care for all people in Maine. CAHC is designated by the Maine Superintendent of Insurance and Attorney General as Maine's Health Insurance Consumer Assistance Program (CAP). The CAP provides statewide, toll-free access to certified application counselors who help Mainers understand their health coverage options and how to apply and enroll in private health insurance. Through this work, we often hear from people who have difficulty understanding their coverage options, especially when circumstances in life have resulted in a change in their health insurance status. We are hearing from many Mainers who are very concerned about losing their jobs and their health insurance. We are hearing from others who do not have coverage and are concerned about not having access to health care to prevent illness or to obtain the testing or treatment they need to identify and overcome the coronavirus. Small businesses in particular are concerned about having to lay off workers. Self-employed and sole proprietors are also struggling to make ends meet. It is important that everyone have access to the health care they need during this time of uncertainty.

Every effort should be made to maximize enrollment of the uninsured in the U.S. Ensuring access to health coverage is a critically important strategy for addressing the current pandemic. The virus is typically detected when people who are symptomatic seek care. Consumers without insurance face cost barriers and often delay necessary care until illness worsens. Even if the test for COVID-19 is made available for free, uninsured consumers may still delay care due to associated costs of screening, such as facility and provider fees for administering the test. During the current pandemic, delaying detection and treatment of COVID-19 will only accelerate the spread of the virus.

You surely are aware that many states operating their own exchanges have already created emergency special enrollment periods (SEPs) in order to eliminate barriers to accessing coverage and care during this national emergency. We urge CMS to provide an emergency SEP that will give Americans in states

served by the Federally-facilitated Exchange and State-based Exchanges on the Federal platform similar access to coverage and care.

The emergency SEP should be available to anyone who wishes to enroll in coverage. Limiting the SEP to defined groups who must verify eligibility would only delay access to care and deter enrollment by consumers who are young and healthy, potentially endangering the individual-market risk pool. Coverage should begin as soon as possible, so that medically necessary screenings and treatment can commence immediately.

Given rising unemployment and uncertainty among low-wage workers, we urge CMS to focus significant outreach and advertising efforts to employers and employees most at-risk of losing employer-based coverage. Efforts should also be made to reach vulnerable, hard to reach populations, including minorities, people with disabilities, the homeless, people struggling with mental health and substance use disorder, and others who face barriers to accessing affordable coverage and health care.

We strongly encourage additional resources be provided to navigators and certified application assisters to help consumers through the application process and in enrolling in coverage during this time. This will help make an emergency SEP more successful in reaching the goal of combating COVID-19.

Finally, we urge CMS to provide extended grace periods for late premium payments to ensure people who are unable to work or experience an economic hardship due to the pandemic do not lose their health coverage in the midst of this national emergency.

Thank you for considering the immediate creation of an emergency SEP. Doing so would take an important step towards enrolling uninsured Americans in health coverage as part of the larger effort to limit the spread of the coronavirus in the U.S.

Sincerely,

Lee Umphrey
Board Chair

Ann Woloson
Executive Director

cc: Governor Janet Mills
Commissioner Jeanne Lambrew
Senator Angus King
Senator Susan Collins
Congresswoman Chellie Pingree
Congressman Jared Golden

From: Eyles, Matt [redacted]
Sent: Friday, March 20, 2020 11:51 AM
To: Parker, Jim (HHS/IOS)
Subject: AHIP Admin Flexibility Recommendations
Attachments: Regulatory Recommendations Updated-03.19.2020.pdf

Jim – hope you are safe, well, and healthy. Working across our AHIP members who operate in MA, Medicaid, and group/individual markets, we developed an updated list of recommendations for potential administrative / regulatory actions to provide more flexibility to address COVID-19 and other related challenges/issues. You are all doing an amazing job given all the demands. Let me know if it'd be helpful to talk.

Hang in there, please let me know what else AHIP can do to help, and be well.

Matt

Matthew Eyles | President & Chief Executive Officer
America's Health Insurance Plans

601 Pennsylvania Ave, NW | South Building, Suite 500 | Washington, DC 20004
[redacted] (o) | [redacted] (c)

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Administrative Actions to Address COVID-19
March 19, 2020

Health insurance providers are fully committed to help America's powerful health care system meet the challenges posed by this pandemic. As this public health emergency progresses, health insurance providers are taking decisive action to help prevent the spread of this disease, to ensure that people have coverage for and access to needed testing and treatments, and to help patients who are infected receive the care and treatment they need.

We are collaborating with federal, state and local officials, our provider community and community organizations to proactively engage the American people on common-sense steps that everyone can take to stay healthy, particularly those who are most at-risk for infection, such as seniors and patients with chronic diseases.

Addressing COVID-19 will be an ongoing process that will require close coordination with all levels of government. We appreciate the steps that Congress and the Administration have taken to date to address the crisis and welcome the opportunity to continue to work collaboratively with federal, state, and local policymakers to assure that we are doing our part to ensure the health and safety of Americans. We hope the door will be open to ongoing evaluation of the situation, and to considering steps that will be necessary to assure everyone receives the care they need during this critical time.

In the spirit of that partnership, we offer the following administrative policy recommendations which we believe are necessary at this time.

Market	Summary
All	To assure that our members receive testing and access care in the most appropriate setting and to mitigate the spread of the virus and impact on the health care system and health care workers through direct contact, we ask that the Administration: • Encourage testing in the appropriate settings, establishing alternative testing sites outside of hospitals. To assure that our members can use telehealth to the maximum extent possible under the authority under the national emergency: • Encourage states to suspend state licensure requirements and state telehealth laws that limit capacity for telehealth visits in lieu of in-person care. • Coordinate across the government to allow flexibility to use telehealth as an alternative to face-to-face interactions for civilian and military health care-related programs. To assure the integrity of our programs during this current crisis, we ask the Administration to:

Market	Summary
	• Increase surveillance to prevent fraud, waste and abuse during the duration of the public health emergency. To allow health insurance providers to focus attention on the current health care emergency, and in recognition of the impacts on plan staff and others: • Relax non-essential program requirements and suspend non-emergency plan audits, including those relating to payments and program administrative compliance, for the remainder of the plan year. This is consistent with similar steps CMS is implementing in the fee for service Medicare program. • The Administration, working where appropriate in collaboration with states, should respond to global data collection challenges. Non-essential data collection should be eliminated and flexibility should be provided on data collection required during this period so plans can devote time and resources toward responding to the needs of members and communities, facilitate ongoing communications with enrollees and clinical providers, and respond to CMS and state-required flexibilities and mandates, which are changing on a daily basis. Compliance obligations and other measures should also be adjusted to reflect plans' lack of access to medical records, records review, vendor closings, etc. • Relax/suspend/delay requirements for purposes of HEDIS Chart review (i.e., directly accessing medical records in provider offices), CAHPS surveys, HOS surveys and other quality measurement programs through the course of the public health emergency and account for the effect of the public health emergency in assessment of quality in all programs. • Delay implementation of recent regulations regarding healthcare interoperability. • Relax any other applicable federal requirements, and work in collaboration with states as needed to relax similar state requirements, that can create unnecessary risks of transmission, such as physical signatures for delivery of medications. To assure that public health resources are appropriately leveraged to serve our communities, we ask that the Administration: • Clarify that Commercial plans outside of the ACA markets are not required to finance non-medically required quarantine at home or in a non-medical facility, as these expenses should be borne by governmental resources and/or state or local public health functions. This was recently clarified by CMS/CCIIO but the tri-agencies have not promulgated similar guidance.

Market	Summary
	• Educate the public about unnecessary drug stockpiling that could lead to drug shortages. To assure that care related to COVID-19 is appropriately identified and documented we ask that the Administration: • Permit health plans and providers to use the new diagnosis code for COVID-19 effective sooner than the 4/1/2020 effective date. • Quickly promulgate and make effective any additional codes related to the testing and treatment of individuals with COVID-19.
Commercial/ Marketplace	To assure consistency and access to the delivery of care for all Americans, we ask the Administration to: • Allow a one-time special enrollment period for the individual market. This special enrollment period should be time limited (30 days) with a prospective effective date and not be diagnosis specific. • Issue guidance related to premium payment deadlines and enforcement of the ACA 90-day grace period to avoid unnecessary loss of health insurance coverage and to avoid wide variation in state approaches, which adds unnecessary operational complexity. • Encourage states to extend filing product and pricing deadlines for plan year 2021. • Coordinate with the National Association of Insurance Commissioners (NAIC), State Departments of Insurance, and the National Governors Association (NGA) to provide more uniformity and alignment among emergency coverage requirements for commercial insurance. • Make adjustments to the Exchange Quality Ratings System (QRS) so that a QHP issuer's star ratings for 2019 and later measurement periods are not adversely impacted due to the current healthcare emergency. This includes applying NCQA guidance for Medicaid and Commercial plans which would allow plans to use the higher of this year or last year's HEDIS measure results. To assure broad access to telehealth: • Ensure state laws are not a barrier to expanded telehealth and that cost-sharing flexibility permits plans to waive co-payments for all telehealth visits and, not just those related to COVID-19 (3/17 CMS guidance only pertains to Federal programs).

Market	Summary
	• Expand recent Office of Civil Rights guidance regarding HIPAA enforcement discretion to private health insurers. OCR has released a waiver for sanctions and penalties for a covered hospital that does not comply with certain provisions of the HIPAA Privacy Rule, along with an announcement regarding Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. These are helpful but narrowly focused on health care providers. We request additional clarification that the waiver and guidance extend to health insurance plans as HIPAA covered entities. Due to the disruption of normal business practices, the delay in available standards, and the shift of resources to address the COVID-19 outbreak, and to allow for time to adequately test the new technologies to ensure appropriate privacy and security standards are met CMS should: • Delay until January 1, 2022 the effective date of the Centers for Medicare & Medicaid Services (CMS) *Interoperability and Patient Access final rule* for Issuers of Qualified Health Plans on the Federally-facilitated Exchanges.
Medicaid	To assure consistency in the delivery of care for all Medicaid enrollees during this public health crisis, we ask the Administration and CMS to: • Require all states, not just those that avail themselves of the crisis-related FMAP increase included in the Families First Coronavirus Response Act, to follow practices used during natural disasters to relax eligibility redetermination rules and extend hospital presumptive eligibility flexibility to assure that people retain coverage during the public health emergency, particularly when the disease progression of COVID is not well understood. • Coordinate with Centers for Medicare & Medicaid Services (CMS), National Association of Medicaid Directors (NAMD) and state Medicaid agencies to assure more consistency and alignment among emergency coverage requirements. • Implement one consistent policy across all states on 90-day refill, home delivery of medications and telehealth coverage. • Relax all program requirements re: face to face visits in order to limit the number of people traveling in and out of enrollee homes, allowing telephonic or virtual care visits including for continuity and care coordination. • Require states to count for purposes of rate setting certain “in lieu of” services – virtual training for providers, meal delivery, and other services.

<table>
<tr><th>Market</th><th>Summary</th></tr>
<tr><td></td><td>

Enhance the monthly minutes available to enrollees under the FCC's Lifeline program to allow for sufficient capacity to leverage lifeline phones for the delivery of telehealth.
Allow telemedicine and/or phone contacts to count as visits/encounters in the assessment of quality under HEDIS.
Suspend Medicaid experience of care surveys (Medicaid CAHPS, HCBS CAHPS, NCI-AD, NCI-DD, etc.) for the period of the emergency.
In order to assure that the Medicaid system remains stable and able to rapidly respond to the crisis, and to avoid further strains on health system capacity, withdraw the proposed Medicaid Fiscal Accountability Rule (MFAR).

Due to the disruption of normal business practices, the delay in available standards, and the shift of resources to address the COVID-19 outbreak, and to allow for time to adequately test the new technologies to ensure appropriate privacy and security standards are met CMS should:

Delay until January 1, 2022 the effective date of the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule for Medicaid Managed Care Plans.

To allow Medicaid managed care plans focus attention on the current health emergency and recognizing the impacts of COVID-19 on plan staff and the need to work safely, CMS should:

Encourage and authorize states to relieve Medicaid managed care plans from certain service level requirements that do not impact Medicaid beneficiary health. This would ensure that plan staff can work remotely at a time when states and localities are urging people to stay home or, if need be, work onsite in a safe manner. It would also enable Medicaid MCOs to remain a vital connection for beneficiaries who are vulnerable during regular conditions but who are especially vulnerable now.

</td></tr>
<tr><td>Medicare Advantage (MA) & Part D</td><td>
In times of public health challenges, plan flexibility is critical to ensure the delivery of optimal plan benefits and timely and effective communications and information flow. To achieve these goals, in the addition to addressing the issues described above affecting all programs (such as suspending non-essential program audits), CMS should:

Align CMS policies with the urgent need to enhance the use of telehealth by modifying the MA/Part D risk adjustment policy to incorporate diagnoses from telehealth encounters and allow telehealth encounters for HEDIS capture. CMS also should consider additional flexibilities that may be needed to address future encounter data collection/submission challenges.

</td></tr>
</table>

Market	Summary
	• Provide flexibility to MA plans in marketing/communications rules to allow plans to quickly send communications to members about coverage, cost sharing, or educational information. • Make adjustments to the MA stars program so that an MA plan's star ratings for 2019 and later measurement periods are not adversely impacted due to the current healthcare emergency. This includes applying NCQA guidance for Medicaid and Commercial plans to MA plans, which would allow plans to use the higher of this year or last year's HEDIS measure results. • Provide flexibility in coverage determination/appeals timelines with respect to non-urgent health care issues and those unrelated to COVID-19, so plans can appropriately target their resources. • Offer flexibility in timelines for formulary submission and formulary updates to allow Part D plans to respond to emerging treatments. • Provide plans with flexibility and exercise enforcement discretion on enrollment/disenrollment and marketing procedural rules, including mandatory disenrollments, which are being affected by travel restrictions and other COVID-related circumstances. • Permit D-SNPs and MMPs to substitute face-to-face care coordination activities with telephonic or telehealth care management. • Issue bid guidance relating to COVID-19. • Consider extending deadlines for Innovation Center models, which interested plans may be unable to meet while focused on current challenges. Due to the disruption of normal business practices, the delay in available standards, and the shift of resources to address the COVID-19 outbreak, and to allow for time to adequately test the new technologies to ensure appropriate privacy and security standards are met CMS should: • Delay until January 1, 2022 the effective date of the Centers for Medicare & Medicaid Services (CMS) *Interoperability and Patient Access final rule* for Medicare Advantage Plans.

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MNsure Announces Special Enrollment Period for Uninsured Minnesotans in Response to Growing COVID-19 Concerns

March 20, 2020

FOR IMMEDIATE RELEASE

ST. PAUL, Minn.—Today MNsure announced a 30-day special enrollment period (SEP) (/new-customers/enrollment-deadlines/special-enrollment/covid19-sep.jsp) for qualified individuals who are currently without insurance in response to the potential growth of coronavirus (COVID-19) cases. This SEP, that begins Monday, March 23, and runs through April 21, will allow uninsured individuals 30 days to enroll in health insurance coverage through MNsure.org.

"As more cases of COVID-19 are diagnosed throughout the state, we want to make sure every Minnesotan has the security of health insurance to ensure they can get the care they need if they contract this serious illness," said MNsure CEO Nate Clark. "Uninsured Minnesotans can come to MNsure.org to sign up for coverage."

Governor Tim Walz recently declared a peacetime emergency (https://mn.gov/governor/news/?id=1055-423050) in response to the pandemic and stressed the importance of all Minnesotans to take care to avoid the spread of COVID-19.

Individuals seeking coverage can visit MNsure.org starting March 23 to complete an application and enroll in coverage. You must select a plan by April 21 for coverage beginning April 1.

Note: Individuals who enroll after April 1 but before 11:59 p.m. on April 21 will have a retroactive coverage start date of April 1.

Help is available:

- MNsure has a statewide network of expert assisters (/help/find-assister/index.jsp) who can help Minnesotans apply and enroll, free of charge.
- MNsure's online help tools (/help/contact-us/email-form.jsp) can be used to access frequently requested services.
- The MNsure Contact Center (/help/contact-us/index.jsp) is open between 8 a.m. to 4 p.m. Monday-Friday, at 651-539-2099 or 855-366-7873.

Have you lost or will you lose your employer-sponsored health insurance?

If you have lost or will lose health insurance through your employer, you may also be eligible for a special enrollment period through MNsure. Specific details, verifications and key dates (/new-customers/enrollment-deadlines/special-enrollment/sep-le/lost-coverage/index.jsp) are located on MNsure.org. Coverage would start the first day of the month following the date when you have selected a plan, but not before your other qualifying health coverage ends.

Other qualifying events

Minnesotans who experience another qualifying event (/new-customers/enrollment-deadlines/special-enrollment/sep-le/index.jsp) (such as marriage, birth of a child or a move) are also eligible to shop for coverage. Those who qualify for Medical Assistance or MinnesotaCare or are a member of a federally recognized American Indian tribe (/new-customers/who-can-enroll/american-indians/index.jsp) can sign up at any time year-round on MNsure.org.

Please note: Minnesotans with questions about COVID-19 should refer to the Minnesota Department of Health (https://www.health.state.mn.us/diseases/coronavirus/index.html) and the Centers for Disease Control (https://www.cdc.gov/coronavirus/2019-nCoV/index.html) for the most current information on the status of the virus in Minnesota and recommendations for preparedness planning.

Permalink: https://www.mnsure.org/news-room/news/index.jsp?id=34-423931 (https://www.mnsure.org/news-room/news/index.jsp?id=34-423931)

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3/20/2020 12:37:43 PM

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From:
Sent: Friday, March 20, 2020 10:09 PM
To:
Subject: RE: AHIP and NAIC call notes

From: Kraemer, Carolyn M. (CMS/CCIIO)
Sent: Friday, March 20, 2020 5:44 PM
To: O'Brien, Kelly P. (CMS/CCIIO) ; Bates, Alexander O. (CMS/CCIIO)
Subject: AHIP and NAIC call notes

Hi Kelly and Alex,

Below are a couple of notes from today's AHIP and NAIC calls. Blue is AHIP, and green is NAIC.

Let me know if you have questions,
Carolyn

Feedback from issuers on ongoing SBE SEPs:

- WA SEP started slowly, with only about 100 people, but is speeding up quickly; 11 or 12 days in, there are about 2300 enrollees (not clear if this is all QHP or some Medicaid/CHIP).
- One issuer in MD got 270 enrollees in the past 3 days.
- In MD, Carefirst has gotten 1500 new enrollees, about ½ commercial coverage and ½ Medicaid.

Feedback on possible CMS SEP (Randy noted CMS might offer one, asked attendees' thoughts):

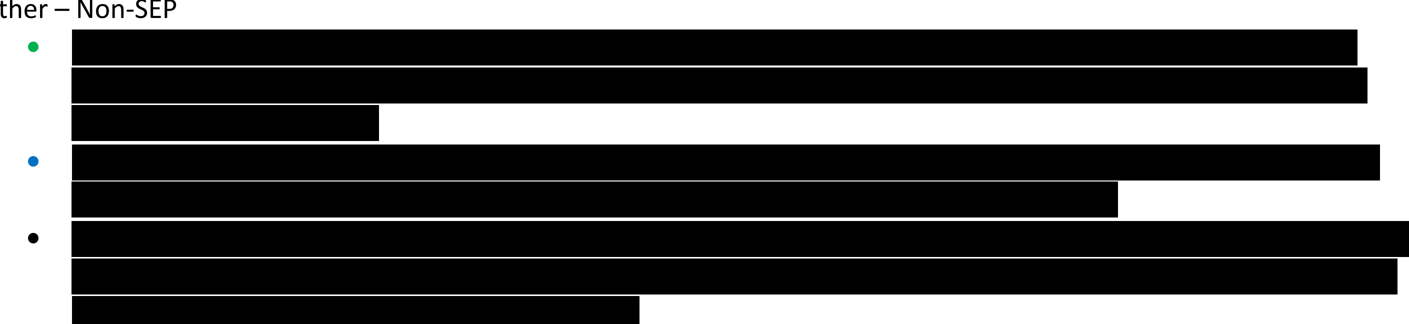
- Attendees thought that if CMS decides to offer a SEP, there should be funding to mitigate costs that weren't reflected in 2020 rates, but acknowledged that this would take Congressional action.
- One attendee noted that it's important that the SEP be available to anyone who is uninsured, not just people who are diagnosed.
- Issuers prefer a prospective coverage effective date.
- SC Commissioner asked if CMS could open up HC.gov platform for SBE-FPs to offer a SEP if they wanted to; Randy responded that that might not be necessary given upcoming events.

Other - SEP

- One attendee asked if there's a SEP for someone whose income decreases and they become newly APTC eligible; Randy explained that we hadn't yet implemented the new(ish) SEP at 155.420(d)(6)(v).

- PA Commissioner asked for data in anticipation of lots of individuals coming to the individual market (e.g. lost hours, or lost jobs) – interested in total enrollment, and anything specific to SEP type, like loss of coverage, is even better. Goal would be to match it up with employment data to understand whether people losing ESC were maintaining coverage by getting it from another source.

Other – Non-SEP



Carolyn Kraemer
Marketplace Eligibility & Enrollment Group (MEEG)
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services | U.S. Department of Health & Human Services
Phone:
Email:

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March 20, 2020

Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd, Baltimore, MD 21244

Mike Pence
Vice President
White House Special Task Force
1600 Pennsylvania Ave NW, Washington, DC 20500

Dear Secretary Azar, Administrator Verma, and Vice President Pence,

With the burgeoning nationwide spread of COVID-19, the Department of Health and Human Services must use all the tools at its disposal to combat the growing crisis. This letter focuses on one agenda item among many: **creating an Emergency, 60-Day Special Enrollment Period,** in both healthcare.gov and state-based exchanges.

Maximizing enrollment of the uninsured into coverage for which they qualify is a critically important strategy for addressing the current pandemic. Disease is typically detected when symptomatic consumers seek care. Consumers without insurance face cost barriers that delay their receipt of necessary care until illness worsens. During the current pandemic, this delays detection and treatment of COVID-19, accelerating the disease's spread.

It is thus no surprise that many states that operate their own exchanges, including Connecticut, the District of Columbia, Maryland, Massachusetts, New York, Rhode Island, and Washington, have already created emergency SEPs. We urge the Department to give Americans who live in the 38 states served by the HealthCare.Gov platform similar access to coverage and care.

The emergency SEP should be open to anyone who wishes to enroll. Limiting the SEP to defined groups who must verify eligibility would not only delay care receipt, it would deter enrollment by healthy consumers, endangering the individual-market risk pool. Additionally, the Department should waive any verification processes that would only delay critical access to coverage. The rapid commencement of treatment also requires an expedited effectuation date, coverage should begin as soon as possible, regardless of when plan selection occurs.

In order to get the word out to consumers the Department should invest significant resources in educating the public about this SEP through digital and television ads. Additionally, the Department should create materials in multiple languages, accessible formats for people with disabilities, and resources for hard-to-reach populations to give diverse populations access to this SEP. Engaging application assisters to help consumers sign up would make the SEP much more successful in reaching its goals. Finally, given the likelihood of rising unemployment and uncertainty among hourly workers, the Department should also focus significant outreach and advertising efforts to employers and employees most at-risk of losing employer-based coverage. These are all important first steps in enrolling the uninsured to limit the scope of the current public health crisis.

Sincerely,

1,000 Days

ABLE NH (Advocates Building Lasting Equality in NH)

ACA Consumer Advocacy

ACCESS (Michigan)

Access Living of Metropolitan Chicago

Advocates for Youth

African Services Committee

AIDS Foundation of Chicago

Alaska Children's Trust

Alliance for a Just Society

American Association on Health and Disability

American Cancer Society Cancer Action Network

American College of Obstetricians and Gynecologists

American Diabetes Association

American Federation of State, County & Municipal Employees

American Federation of Teachers

American Medical Student Association

American Muslim Health Professionals

American Psychological Association

Arcora Foundation

Arkansas Advocates for Children and Families

Asian & Pacific Islander American Health Forum

Association of State and Territorial Dental Directors

Bazelon Center for Mental Health Law

Bi-State Primary Care Association

Black Women's Health Imperative

California Pan-Ethnic Health Network

Catalyst Miami

Center for Health Progress

Center for Independence of the Disabled, NY

Center for Medicare Advocacy, Inc.

Center for Patient Partnerships

Center for Popular Democracy

Center for Public Policy Priorities (Texas)

Central Virginia Health Services

Champaign County Health Care Consumers

Chicago Coalition for the Homeless

Children's Action Alliance

Children's Defense Fund - Texas

Circle Up, United Methodist Women for Moms

Citizen Action of New York

Citizen Action of Wisconsin

Clare Housing

Clay-Battelle Health Services Association

Coalition for Asian American Children and Families

Coalition of Texans with Disabilities

Community Catalyst

Community Dental Health NPO

Consumers for Affordable Health Care

Covering Wisconsin

Detroit Community Solutions

Empire Justice Center

End Domestic Abuse Wisconsin

Epilepsy Florida

Equal Hope

EverThrive Illinois

Faith in Public Life

Families USA

Family and Child Treatment of Southern Nevada

Family Voices of Tennessee

FamilyCare

Farmworker Justice

First Focus on Children

Florida ADAPT

Foley Waite LLC, NJMSA

Foundation Communities Prosper Centers

Future Smiles

Gay Men's Health Crisis, Inc

Georgia Budget and Policy Institute

Georgia Watch

Georgians for a Healthy Future

Get America Covered

GO2 Foundation for Lung Cancer

Health & Medicine Policy Research Group

Health Care for All Massachusetts

Health Care for All New York

Health Care Voter

Hometown Action

Houston Health Department

HRCHC - Hope Rising

Human Rights Campaign

Illinois Academy of Family Physicians

Illinois Action for Children

Illinois Coalition for Immigrant and Refugee Rights
Illinois Primary Health Care Association
Illinois Public Health Institute
Indivisible
Iowa Citizens for Community Improvement
Jen Mishory, Senior Fellow, The Century Foundation
Justice in Aging
Kentucky Equal Justice Center
Kentucky Voices for Health
KidCare Coalition of Miami-Dade
Lakeshore Foundation
Latino Coalition for a Healthy California
Latino Outreach of New Jersey
Legacy Community Health Services
Leukemia & Lymphoma Society
Maine Equal Justice
Manatee Children's Services
Manatee County Habitat for Humanity
March for Moms
March of Dimes
MaryCatherine Jones Consulting, LLC
Maryland Citizens' Health Initiative
Medicaid-Medicare-CHIP Services Dental Association
Medicare Rights Center
Michigan Oral Health Coalition
Mississippi Center for Justice
Missouri Health Care For All
Missouri Rural Crisis Center
Monroe Health Center
Montana Women Vote
NAMI Texas

National Alliance on Mental Illness

National Association of Social Workers

National Association of Social Workers – Texas Chapter

National Council of Jewish Women

National Family Planning & Reproductive Health Association

National Health Council

National Health Law Program

National Institute for Reproductive Health (NIRH)

National Patient Advocate Foundation

National Women's Health Network

Nebraska Appleseed

New Futures

New Hampshire Nurses Association

New Jersey Citizen Action

New Voices for Reproductive Justice

New York Immigration Coalition

North Carolina AIDS Action Network

North Carolina Child

Northwest Health Law Advocates

Oklahoma Policy Institute

OneAmerica

Out2Enroll

Palmetto Project

Partnership for Children's Oral Health

PDI Surgery Center

Pennsylvania Health Access Network

People’s Action

Planned Parenthood Federation of America

PolicyRx

Power to Decide

Preston-Taylor Community Health Centers, Inc.

Prevention Access Campaign

Primary Care Access Network (PCAN)

ProHealth TES

Protect Our Care Illinois

Protect our Care New Hampshire

Public Citizen

Raising Women's Voices for the Health Care We Need

Senior Mobile Dental

Shea Writing and Training Solutions, Inc.

Shriver Center on Poverty Law

Sight & Sound Care LLC

South Carolina Appleseed Legal Justice Center

Southern Vermont Area Health Education Center

TakeAction Minnesota

TeethFirst

Tennessee Disability Coalition

Tennessee Health Care Campaign

Tennessee Justice Center

Texas Association of Community Health Centers, Inc.

Texas Nurses Association

The Actors Fund

The American Institute of Dental Public Health

The Bingham Program

The Commonwealth Institute for Fiscal Analysis

The Connecticut Oral Health Initiative, Inc.

The Kidz Club Prescribed Pediatric Extended Care Center

The Los Angeles Trust for Children's Health

The Praxis Project

The Rhode Island JASYCEE Alliance

Treatment Action Group

Triage Cancer

Trinity Health

Trust for America's Health

UHCAN Ohio

UnidosUS

Union for Reform Judaism

United Action for Idaho

United Vision for Idaho

United Way of Dane County

United Way of Williamson County

United Way Worldwide

United Ways of Texas

Utah Health Policy Project

Virginia Coalition of Latino Organizations

Virginia Health Catalyst

Virginia Organizing

Virginia Poverty Law Center

Voices for Vermont's Children

Washington CAN

Washtenaw Health Plan

West Central Initiative

West Virginia Center on Budget and Policy

West Virginia Citizen Action

West Virginia FREE

West Virginians for Affordable Health Care

Whole Child Manatee

Wisconsin Alliance for Women's Health

Wisconsin Faith Voices for Justice

Women's Health and Family Planning Association of Texas

Young Invincibles

From: Handelman, Justine [redacted]
Sent: Saturday, March 21, 2020 9:17 PM
To: Parker, Jim (HHS/IOS)
Subject: COVID-19 Leg Package: SEPs and Risk Mitigation
Attachments: Excess Loss global solution legislative language March 20 (002).docx

Jim - know things are moving fast and furious on many fronts and you have all our key recs but want to flag that given we are hearing CMS may soon issue guidance for SEP (which we support) it is critical Congress include risk mitigation protection given all uncertainties. Know this is part of discussions on Hill. If anything Administration can do to signal support we would greatly appreciate. Attached is language I shared earlier and we sent to Hill.

If anything else we can do to help, let me know. Heard productive calls with you on how to operationalize covering costs of tests for uninsured. We remain ready to help in any way and find right resources to help you and Administration through these challenging times. We appreciate all you are doing!

Justine

Sent with BlackBerry Work
(https://protect2.fireeye.com/url?k=861a9773-da4f9ea3-861aa64c-0cc47a6a52de-074e64a896cc71ba&u=http://www.blackberry.com/)

SEC. XX. Excess Loss Protection for Plans Covering COVID-19 testing and treatment.

(a) Administration-

(1) IN GENERAL-For calendar years 2020 and 2021, the Secretary of Health and Human Services shall establish and administer a program under which a qualifying plan shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums.

(2) DEFINITIONS- In this section:

(A) QUALIFYING PLAN- The term 'qualifying plan' means--

(i) a plan offered by a health insurance issuer in the individual market or small or large group market,

(ii) a Medicare Advantage (MA) plan, under part C of title XVIII of the Social Security Act,

(iii) a Medicaid Managed Care Organization (MCO) plan, under section 1932 of title XIX of the Social Security Act.

(B) OTHER DEFINED TERMS – The terms "health insurance issuer," "individual market," "large group market," or "small group market" have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(b) Participation-

(1) PLAN ELIGIBILITY- A participating qualified plan is a plan that--

(A) is a qualifying plan, as defined in subparagraph (a)(2);

(B) meets the requirements of paragraph (2) with respect to COVID-19 benefits provided under the plan; and

(C) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) COVID-19 BENEFITS- A plan meets the requirements of this paragraph if the plan provides coverage for the following items and services furnished during any portion of an emergency period emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) beginning on or after the date of the enactment of this Act --

(A) clinical diagnostic tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such tests; and

(B) health care provider office visits, urgent care center visits, and emergency room visits that result in an order for or administration of a test described in subparagraph (A) or other items and services intended for treatment of COVID-19.

(c) Allowable costs—

(1) For qualified plans described in subsections (a)(2)(A)(i) and (b)(1) allowable costs are

(A) In general- The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment - Allowable costs shall reduced by any risk adjustment payments received under Part E of Subchapter III

of Chapter 57 of the Public Health Service Act (42 U.S.C. section 18063).
(C) Reduction for state reinsurance payments – Allowable costs shall be reduced by any payments received from a state.
(2) For qualified plans described in subsections (a)(2)(A)(ii) and (b)(1) allowable costs are equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.
(3) For qualified plans described in subsections (a)(2)(A)(iii) and (b)(1), allowable costs are equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(d) Target amount—
(1) For qualified plans described in subsections (a)(2)(A)(i) and (b)(1) the target amount is is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.
(2) For qualified plans described in subsections (a)(2)(A)(ii) and (b)(1), the target amount is an amount equal to total premiums paid to the MA organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount, reduced by the administrative costs of the plan.
(3) For qualified plans described in subsections (a)(2)(A)(iii) and (b)(1), the target amount is an amount equal to total premiums including risk adjustment reduced by the administrative costs of the plan.

(e) Payments-
(1) APPLICATION FOR REIMBURSEMENT-
(A) IN GENERAL- A participating plan shall submit an application for reimbursement to the Secretary.
(B) BASIS FOR REIMBURSEMENT FOR 2020- Applications submitted under subparagraph (A) shall consist of 80 percent of a participating plan's allowable costs for any plan year that are more than 105 percent of the target amount.
(C) BASIS FOR REIMBURSEMENT FOR 2021-Applications submitted under subparagraph (A) shall consist of—
(i) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
(ii) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
(2) APPEALS- The Secretary shall establish--
(A) an appeals process to permit participating plans to appeal a determination of the Secretary with respect to applications for reimbursement submitted under this section; and
(B) procedures to protect against fraud, waste, and abuse under the program.

(f) Funding- There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, an amount equivalent to the amount of payments made by the Secretary under subsection (e). Such funds shall be available without fiscal year limitation.

(g) Rule of Construction- Nothing in this provision shall be construed as preventing a qualifying participating plan from modifying rates, or otherwise reduce, limit or restrict a state or federal program from making payments (including contractual payments) to such plan.

(h) Implementation- Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this section by program instruction or otherwise.

From: Meg Murray [redacted]
Sent: Monday, March 23, 2020 4:54 PM
To: Parker, Jim (HHS/IOS)
Subject: [MARKETING EMAIL]ACAP Sends Policy Recommendations to Congress, CMS

Strengthening the Safety Net Since 2000

The **Association for Community Affiliated Plans** (ACAP) is committed to partnership with all of our colleagues as we all work to confront the shared challenge of coronavirus and COVID-19.

After consultation with our member health plans, ACAP has identified a number of policy areas in Medicaid, Medicare, and the Marketplaces that we believe are critical to help SNHPs, our network providers and our plan enrollees when confronting COVID-19. We recently sent letters to Congress and CMS with our recommendations. Our comments fall under three primary themes:

1. **Extending and Sustaining Medicaid, Medicare, and Marketplace Enrollment, Coverage, and Benefits**
2. **Reducing Administrative Burden for Safety Net Health Plans and Other Health Care Stakeholders**
3. **Ensure Fair Payment to Plans, Providers, and States for Unprecedented and Unbudgeted Costs**

Medicaid

Access to Stable Medicaid Coverage for All Medicaid and CHIP Enrollees.

• ACAP asks CMS to immediately issue guidance to states related to implementation of continuous eligibility in Medicaid. Specifically, we urge CMS to require states to:

- Cease performing eligibility redeterminations.
- Cease use of periodic income checks.
- Cease other eligibility assessment activities that burden enrollees as well as eligibility personnel, which would counter the objective of section 6008(b).

Appropriate Resourcing for COVID-19 Prevention, Testing and Treatment.

- ACAP urges CMS to provide strong oversight of Medicaid managed care rate-setting to ensure that all plans receive rates from states that are actuarially sound, specifically with regard to services related COVID-19.

- ACAP urges CMS not to waive section 438.4(a) of Medicaid managed care rules and the underlying statute relating to actuarial soundness, including under 1115 Waivers, Healthy Adult Opportunity Waivers, or 1135 emergency waivers.
- ACAP urges CMS to provide guidance regarding mid-year Medicaid managed care rate adjustments to account for costs related to COVID-19.
- Institute a Moratorium on the Medicaid Fiscal Accountability Regulation (MFAR).
- ACAP urges CMS to withdraw the MFAR proposed rule (CMS-2393-P) and instead consult with the appropriate stakeholders on how to improve the financing and operation of state Medicaid programs and assess the effects of the proposed changes on Medicaid programs and beneficiaries.

Assure Mandatory Non-Emergency Medical Transportation (NEMT).

- ACAP asks CMS not to approve any Medicaid waiver of NEMT.
- ACAP also asks CMS not to promulgate any regulation reinterpreting the NEMT benefit as an optional, rather than required, benefit.

Medicare/Medicaid Dual Eligibiles

Cover the Increased, Unanticipated Medicare Advantage and Medicare-Medicaid Plan Costs Associated with COVID-19.

- ACAP urges CMS to adjust MA-PD base rates and/or risk-adjusted payments to MA plans, including D-SNPs, and MMPs to account for the increased and unanticipated costs associated with COVID-19.
- Include COVID-19 Under the “Extreme and Uncontrollable Circumstances Policy” for the CY 2021 Star Ratings.
- ACAP urges CMS to include the COVID-19 pandemic under the “Extreme and Uncontrollable Circumstances” policy for CY 2021 Star Ratings for affected plans.
- Suspension of Audits.
- ACAP urges CMS to suspend all MA-PD audits, including RADV audits during the COVID-19 pandemic.
- Permit D-SNPs and Medicare-Medicaid Plans (MMPs) to Substitute Face-to-Face Care Coordination Activities with Telephonic or Telehealth Care Management.
- ACAP urges CMS to permit D-SNPs and MMPs to substitute face-to-face care coordination activities with telephonic or telehealth care management.
- Regulatory Relief on Medicaid LTSS Requirements.
- ACAP urges CMS to work with states to quickly permit regulatory relief, particularly with respect to substituting telehealth for in-person assessments, timing of assessments, and eligibility requirements.

Individual Market Policy

Federal Special Enrollment Period (SEP).

- ACAP urges CMS to establish a federal, prospective SEP that is coupled with a federal backstop to ensure that issuers do not face overwhelming, unanticipated costs associated with new, mid-year enrollment.

Limit Short-Term, Limited-Duration Insurance.

- ACAP urges CMS to issue a temporary moratorium on STLDI plans altogether and enact a concurrent SEP to ensure that consumers are able to access comprehensive coverage and care. CMS should further act to restore such plans to their intended use of filling gaps in coverage.

Coverage Terminations.

- We urge CMS to allow issuers the ability to extend 90-day grace period for both subsidized and unsubsidized consumers, so that health plans are not forced to drop those in need from their health coverage. Likewise, we urge CMS to allow additional flexibility for consumers who are terminated from coverage due to non-payment of premiums to reinstate their coverage.

Risk Adjustment & Data Validation.

- ACAP urges CMS to delay risk adjustment and risk adjustment data validation submission deadlines given the operational delays necessitated by provider office closings and plans' real-time adjustment of operational activities in order to best respond to their enrollees and providers needs.

Overarching Policy

Delay Interoperability Rule, Plus Provide Funding to States and Health Plans for Interoperability Implementation.

- ACAP urges HHS to delay implementation of the interoperability rules.
- ACAP has urged Congress to provide funding to states and health plans to implement the rules, and asks HHS to work with Congress to ensure that it is used for appropriate technical support.

If you have any questions or you would like to discuss these issues in greater depth, please contact me, Jennifer McGuigan Babcock for Medicaid policy [redacted], Christine Lynch for Medicare policy [redacted], or Heather Foster for Marketplace policy [redacted].

In advance, thank you for your consideration of our recommendations.

Meg Murray
CEO
Association for Community Affiliated Plans
1155 15th Street NW, Suite 600
Washington, DC 20005
[redacted] | [redacted] mobile

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March 23, 2020

Vice President Mike Pence
The White House
Office of the Vice President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Re: COVID-19 Special Enrollment Period

Dear Vice President Pence:

The New Mexico Health Insurance Exchange (NMHIX) Board requests that the Center of Medicare & Medicaid Services open an Enrollment Period in response to the COVID-19 emergency. This request received a formal motion and unanimous support from our Board, which has representation from insurance carriers, advocates, government officials, brokers, care delivery professionals, and more.

As of the writing of this letter, there are already over 40,000 confirmed cases of COVID-19 infection in the United States. The uninsured and under-insured populations are especially at risk, as they may forgo testing and treatment due to a lack of coverage. Not only does this put their health at risk, it increases the likelihood of community spread.

First, the Board urges CMS to open a special enrollment period to all uninsured individuals. The importance of providing access to health care during this emergency cannot be overstated. Giving individuals a new opportunity to enroll in health coverage is another tool to help stem the tide of COVID-19. Seven states who operate their own completely independent state-based exchange have already begun enrollment periods. With thousands of more cases being announced every day, it is imperative that CMS follow their lead and authorize a new special open enrollment period now to expand access to coverage during this crisis. It is equally important that the enrollment process be accessible for individuals. The existing validation process would be overly burdensome, and must be updated to match the current needs.

Second, the Exchange also implores CMS to explore innovative strategies to help individuals maintain coverage. Given the sharp increase in unemployment benefits requests nationwide, we ask that, for a defined period of 2-3 months, CMS or any federal authority support enrollment with enhanced premium assistance. This could be offered to existing and newly enrolled eligible populations and aligned with recent, emergency federal funding, technological constraints, and legislative, and regulatory requirements. Our Contact Center has already heard from many New Mexicans, including Native American residents in the state, who are losing coverage because of the challenging economic conditions they face. This is worrying on an individual level and a substantial public health risk.

Should CMS not adopt a special enrollment period for all uninsured individuals, another innovative solution could be allowing a COVID-19 diagnosis to trigger a special enrollment period. While concern may exist for negatively impacting risk, as you are aware many states have already stated that testing and/or treatment must be provided without cost-sharing. Due to this, allowing an ongoing COVID-19 SEP would support insurance carriers by collecting premium and support individuals by knowing they are covered. CMS should communicate to Congress that a risk mitigation program is needed to avoid premium increases and instability in the market related to COVID-19. Finally, we request that CMS allow for some forgiveness in the reconciling of individual's income at the end of the year. Many New Mexicans may currently be eligible for coverage but uncertain what may happen with their income over the near future. People should not be adversely punished for the responsible decision of maintaining their coverage.

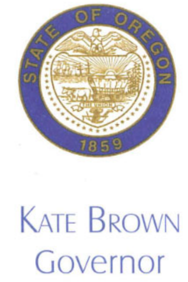
The Exchange Board realizes the challenges of not overburdening insurance carriers. With that said, best practices already exist to mitigate potential harm. Many of these best practices are already implemented in other states. The Exchange will readily share any information that may help accomplish both goals of connecting people to coverage and supporting insurance carriers.

Please do not hesitate to contact our Exchange if we may be of assistance. We look forward to your support of our request.

Sincerely,

David Shaw
Chairman of the Board
beWellnm, New Mexico Health Insurance Exchange

cc: Secretary Alex Azar
Administrator Seema Verma
Senator Tom Udall
Senator Martin Heinrich
Representative Debra Haaland
Representative Xochitl Torres Small
Representative Ben Ray Luján
Governor Michelle Lujan Grisham
Secretary David Scrase
Director Nicole Comeaux
Superintendent Russell Toal



KATE BROWN
Governor

March 23, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma,

As of today, Oregon is urgently experiencing the effects of the COVID-19 global pandemic with 191 confirmed cases, and tragically, five deaths.

On March 8, 2020, I declared a state of emergency and a public health emergency across Oregon. We have used state resources to help affected people and communities. We have also partnered with our insurance carriers to cover the cost of testing and waive cost-sharing requirements for treatment for those who are fully insured. However, more can be done to ensure that every person has meaningful access to testing and treatment during this crisis.

Many Oregonians are uninsured or underinsured and now find their families' budgets significantly tightened due to this national emergency. In order to remove any potential barriers that remain, it is critical for all Oregonians to have access to a special enrollment period (SEP) so uninsured and underinsured people can enroll in health coverage and access subsidies for which they may qualify. I urge you to open up an SEP of at least 30 days and for coverage to be effective as soon as possible.

In the face of the COVID-19 pandemic, access to health insurance helps all Oregonians. The Trump Administration has stressed the value of allowing Americans to make their own coverage choices. During open enrollment last fall, a moderate-income adult might have made a rational decision to skip coverage or buy one of the extremely limited, short-term plans now available under federal rules that currently are not required to cover testing for COVID-19 and waive cost-sharing for COVID-19 treatment. A national emergency has changed conditions vastly, and those Oregonians deserve a chance to get the coverage they need. When people have coverage, care is better coordinated, and that is critical for the stability of our health care system during this national emergency.

Thank you for your attention to this important and emergent issue as we partner together in keeping Oregonians healthy and safe.

Sincerely

Kate Brown

Governor Kate Brown

GKB:jyy/cb

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Congress of the United States
House of Representatives

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SUBCOMMITTEE ON HIGHER EDUCATION AND WORKFORCE INVESTMENT
SUBCOMMITTEE ON WORKFORCE PROTECTIONS

March 23, 2020

Ms. Maria Martino
Director of Congressional Affairs
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201-0004

Dear Ms. Martino:

My constituent, Mr. Neil Heller, on behalf of Piedmont Community Health Plan wrote to CMS regarding his support for a special enrollment period which he suggests be established in light of the COVID-19 epidemic. Mr. Heller is Director of Marketing for Piedmont Community Health Plan, a provider based in Lynchburg, Virginia that provides coverage to over 25,000 consumers. To date, a response from CMS to his correspondence has not been received by Mr. Heller.

I would appreciate your looking into the status of a CMS response to Mr. Heller's letter. He awaits your reply. You may also provide a copy to me via my Lynchburg office at 916 Main Street, Suite 300, Lynchburg, Virginia, 24504.

Thank you for your assistance.

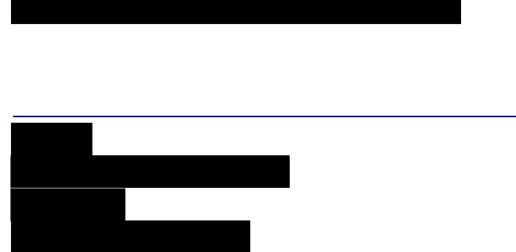
Sincerely,

Ben Cline
Member of Congress

BLC:ava

Enclosure

From:
Sent: Monday, March 23, 2020 3:00 PM
To:
Subject: FW: Covered California COVID-19 Cost Projection
Attachments: COVID-19-NationalCost-Impacts03-21-20.pdf; 03-23-20 - CoveredCA - COVID-19 Cost Projection - Final.pdf



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From: Green, Kelly (CoveredCA)
Sent: Monday, March 23, 2020 2:52 PM
To: Green, Kelly (CoveredCA)
Subject: Covered California COVID-19 Cost Projection

Good afternoon.

In light of the ongoing COVID-19, Covered California developed the first national projection of the pandemic's potential cost to 170 million Americans in the commercial market – which includes the individual, small-group and large-group markets. We have sent this brief to key congressional members and staff as it lays out the potential health care costs related to COVID-19 and the potential consequences absent any federal action.

The analysis, which was led by Covered California's chief actuary, John Bertko, found:

- The one-year projected costs in the commercial market range from $34 billion to $251 billion for the testing, treatment and care specifically related to COVID-19.
- Those potential COVID-19 costs for 2020 could range from 2 percent of premium to more than 21 percent of premium if they had been priced for.
- Premium increases in the individual and employer markets for 2021 – which are in the process of being set right now – could range up to 40 percent or more solely because of COVID-19 costs in the absence of federal action.

While there are many important issues to solve around COVID-19, these increased costs could force 170 million Americans - who are most likely all under the age of 65 - to drop their coverage and go without needed care as we battle a global health crisis. These are not "insurer" costs – these are costs directly borne by

individual Americans in the form of cost-sharing and premiums; these are costs to small and large businesses that are struggling; these are costs to individuals who may avoid needed care.

Attached is a copy of the analysis detailing the cost projections. Also attached is a press release, which includes the following suggestions for federal policymakers to consider to mitigate the impacts of COVID-19 costs: Specifically,

- Establish a temporary program to limit the costs of COVID-19 for health insurers, self-insured employers and those they cover, which would directly benefit individuals and small employers for 2020 and allow for more certainty in their pricing for 2021.

- Enhance the federal financial assistance provided in the individual market to increase the level of tax credits for those earning under 400 percent of the federal poverty level (FPL) and expand subsidies to those earning more than 400 percent FPL as California implemented on a three-year basis in 2020.

- Establish a national special-enrollment period for the individual market, such as has already been adopted by 12 marketplaces representing 30 percent of Americans.

Thank you very much, and please let us know if you have any questions.

Kelly

Kelly Green | Director | External Affairs
P [redacted] **E** [redacted]
Covered CaliforniaTM 1601 Exposition Boulevard, Sacramento, CA 95815 **CoveredCA.com**

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The Potential National Health Cost Impacts to Consumers, Employers and Insurers Due to the Coronavirus (COVID-19)

Introduction

This policy/actuarial brief provides projections and models the potential costs associated with coronavirus (COVID-19) testing and treatment on the national commercial health insurance markets (individual, small and large group employers — including both those employers that are insured and self-funded). There are additional cost and access implications for Medicare, Medicaid, other public programs, and the uninsured, but this brief focuses only on the impacts on Americans with commercial insurance coverage. Major findings include:

- **The one-year projected costs in the national commercial market range from $34 billion to $251 billion** for testing, treatment and care specifically related to COVID-19 — with the potential that costs could be higher than the high end of the range.
- **Potential COVID-19 costs for 2020 could range from about 2 percent of premium to over 21 percent of premium** if the full first-year costs of the epidemic had been priced into the premium.
- Health carriers are in the process of setting rates for 2021. If carriers must recoup 2020 costs, price for the same level of costs next year, and protect their solvency, **2021 premium increases to individuals and employers from COVID-19 alone could range from 4 percent to more than 40 percent**.

Background

The coronavirus (COVID-19) pandemic is causing large financial and personal impacts to virtually all Americans. In addition to the impacts on individuals and the major disruption of the national economy, this disruption is particularly acute in the health care sector. The impacts of the COVID-19 pandemic is huge in the United States with a possibility that 50%

Highlights

The potential impacts detailed in this report reflect what could happen absent decisive federal action. If these impacts are not mitigated, the public health and economic consequences to consumers, small and large employers and health insurers are potentially staggering, including:

- Consumers and employees not getting needed testing or treatments due to cost barriers, both for COVID-19 but also for other health conditions.
- Employers no longer being able to offer affordable coverage, or dramatically shifting costs to employees.
- Consumers and employers no longer being able to afford coverage, leading to employer groups dropping coverage or individuals deciding to go uninsured.
- Even more unsubsidized marketplace enrollees being priced out of individual markets.
- Small insurers risk insolvency, and if they close, put covered consumers at financial risk, damaging competition that benefits consumers and the employers that purchase on behalf of millions of Americans.
- Dramatic cost increases, many of which will be borne by the federal government in the form of higher Advanced Premium Tax Credits (APTC), or by both federal and state governments paying for increased Medicaid enrollment as individuals and employers drop coverage.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

of the total population may be infected with COVID-19. COVID-19 may have a devastating impact on America's seniors which will be reflected in illness, deaths and Medicare costs. It will have large impacts on Americans served by Medicaid programs and the state that operate these vital safety net programs; and it will affect the millions who remain uninsured. This policy/actuarial brief, however, focuses on the commercial market that includes up to 20 million high-risk people under age 60 who are at higher risk of having significant health needs due to the virus, and many in the commercial market who are not high-risk but will need testing and care when infected by COVID-19.

As roughly half of the US population receives its health care coverage through employers or through direct purchase in the individual market and exchanges, much of the COVID-19 testing and treatment will be paid through commercial health insurers. Claims for testing, hospitalization and other treatment will likely begin to emerge in a significant way in 2020, with those costs continuing into future years. Commercial-population insurance premium rates for 2020 were set six to nine months before January of this year and well before there was even any hint of the virus. The health care and insurance industries were unprepared for the onset of such an unexpected occurrence.

Projections of Potential National Commercial Market COVID-19 Costs

The summary of low, medium and high projections for the potential testing and treatment costs of COVID-19 on the Commercial Market is summarized in Table 1: Projected First Year Costs for National Commercial Market COVID-19 Testing and Table 2: Projected First Year COVID-19 National Commercial Market Treatment Costs.

As described in the discussion that follows these tables, while there is substantial uncertainty regarding many of the important variables for this analysis, all parameters were chosen based on best-available data and input from actuarial and clinical advisors.

The Medium Estimates in the tables are meant to reflect a "best estimate" given what we know today and the huge uncertainty in making projections. The Low Estimate may occur if mandatory "shelter in place" actions have a big effect. The High Estimate is not a "worst case" but represents a possible outcome with somewhat higher than expected positive test results and the percentage of patients requiring hospitalization is somewhat higher (i.e., 25%) than currently being observed in other countries.

Table 1: Projected First Year Costs for National Commercial Market COVID-19 Testing[1]

ESTIMATE RANGE	LOW	MEDIUM	HIGH
Commercially Insured Population	170 million		
Estimated Number at Higher Risk	20 million		
Assumed % of Higher Risk Tested	25%	50%	75%
Modeled Number Tested	5 million	10 million	15 million
Remaining Non-Higher Risk	150 million		
Assumed % of Non-Higher Risk Tested	10%	20%	30%
Modeled Number of Non-HR Tested	15 million	30 million	45 million
Estimated Number of All Tested	20 million	40 million	60 million
Lab-only Test Costs (includes what would have been consumer out of pocket portion)	$120		
% for Lab-only or Drive-Through	75%	25%	20%
Number of Lab-only or Drive-Thru	15 million	10 million	12 million
Lab AND PCP or Televisit Average Cost (includes what would have been consumer out of pocket portion)	$240		
% for Lab and PCP/Televisit	25%	75%	80%
Number for Lab and PCP/Televisit	5 million	30 million	48 million
Total Cost at Commercial rates (includes what would have been consumer out of pocket portion)	$3.0 billion	$8.4 billion	$13.0 billion

The Potential National Health Cost Impacts to Consumers, Employers and Insurers Due to the Coronavirus (COVID-19)

Table 2: Projected First Year COVID-19 National Commercial Market Treatment Costs[1]			
ESTIMATE RANGE	LOW	MEDIUM	HIGH
Projected number of positive cases (among those tested)	4.0 million	8.0 million	15 million
Assumed % requiring hospitalization (for those under 60)	10%	15%	20%
Projected number of cases requiring hospitalization	400,000	1,200,000	3,000,000
Assumed Length of Stay (severe cases)	12 days		
Assumed Insurance Reimbursement — Commercial (includes consumer out of pocket portion)[2]	$72,000		
Projected Hospital Costs for severe cases	$28.8 billion	$86.4 billion	$216.0 billion
Assumed % of cases that require outpatient services	90%	85%	80%
Projected number of cases that require outpatient services	3,600,000	6,800,000	12,000,000
Assumed physician reimbursement for cases that require outpatient services — Commercial (includes consumer out-of-pocket portion)	$600	$1,200	$1,800
Projected physician cost for cases that require outpatient services	$2.2 billion	$8.2 billion	$21.6 billion
Total projected costs for treatments at commercial insurance rates (includes consumer out of pocket portion)	$31.0 billion	$94.6 billion	$237.6 billion

Assumptions and Methodology

1. Likely People Affected Nationally by COVID-19 in the Commercial Market

- The total market for individuals covered by private health Insurance is about 170 million — which does not include those eligible for Medicare and Medicaid, or those who are uninsured.[3]
- Of those with private health insurance, there might be 29 million people *under* age 60 at risk due to health conditions.[4] (Many more people over 60 will also be at risk, but most will be covered by Medicare.) Of this number, there may be 4 million uninsured and, possibly 20% who are covered by Medicaid. Thus, we project that there are 20 million people under age 60 who are at higher risk of serious illness from COVID-19. This number may need to be revised to include people aged 61 to 64 with commercial coverage.

2. Estimates of Potential Testing Costs Nationally

- **Summary:** Assuming that there is a large outbreak of the disease, some estimates are that 120 million of the 170 million non-elderly Americans could show some symptoms (i.e., fever, etc.). If this happens, then consideration would likely be given to testing all of these individuals. But assuming that "only" 20 to 60 million get tested the costs could be around $3 billion to $13 billion for one year of testing.

- **Basis for this estimate:** The two variables that affect cost are the number of those in the commercially insured population who will get tested and the cost of providing those tests (see Table 1. Projected First Year Costs for National Commercial Market COVID-19 Testing, which shows the assumptions and calculations).

  - **Number of people getting tested:** For the purpose of developing these estimates, we modeled a Low Estimate of 25% of those at Higher Risk and 10% of non-Higher Risk individuals getting tested. For the High Estimate, we modeled 75% of those at Higher Risk and 30% of non-Higher Risk individuals getting tested. Some individuals might be triaged using online survey tools that could indicate they may not require testing.

  - **Costs of testing:** The costs of testing may vary dramatically. Generally, testing costs entail clinician/visit costs and the costs of the actual lab work. Based on expert review, the costs incurred for a primary care physician (PCP) visit or televisit could range from about $75 to $25, respectively, and lab work ranging from $36 to $51 at Medicare rates — for a total cost ranging from $61 to $126. For the purpose of estimating the cost of testing with a related clinician visit, we have used an average total cost of $100 (at Medicare rates), corresponding to $240 at estimated commercial rates. However, if the healthcare system widely offers "drive-through" visits as currently being done in South Korea and some U.S. cities, the physician component might be mostly eliminated, for such testing we have used a total cost figure of $50. The Low Estimate models the costs if testing is evenly split between "lab-only" testing and Lab and PCP/televisit testing, while the High Estimate models only 25% of the testing being lab-only. It is also possible that much of the cost taken be borne directly by the federal, state and local governments. To the extent direct public funding pays the testing costs, all of these estimates would need to be adjusted.

3. Estimates of Potential Treatment Costs Nationally

- **Summary:** Assuming that there is a large outbreak of the disease, which may result in half of the population getting infected, with from 4 to 15 million individuals in the national commercial market having confirmed cases after testing, the main cost drivers will be how many of those require hospitalization versus out-patient care and the costs of those services. Modeling from 10% to 20% of those getting infected needing hospitalization, and commercial rates, the costs could range from $31 billion to $238 billion for the first year.

- **Basis for this estimate:** The two variables that affect the treatment costs are the number of those in the commercially insured population who will get infected, the level of services needed for those infected and the costs of those services (see Table 2. Projected First Year COVID-19 National Commercial Market Treatment Costs, which shows the assumptions and calculations).

  - **Number of people getting infected and level of treatment:** For the 20 million high risk individuals in the commercial markets, there are not good estimates of the percent of people who would actually get infected and, of those, how many might need hospitalization and the length of their hospitalization.

We expect that relatively few COVID-19 cases for those under age 65 will end up in a hospitalization, but that the cases involving hospitalization will have lengths of stay around 10-14 days. While it is far more likely those that infected high-risk individuals will require hospitalization and other treatment, there will be lower risk infected individuals also requiring care, including hospitalization. These projections are based on best evidence that the majority of those infected with the virus will not need either outpatient services or hospitalization. For the purpose of developing these estimates, we modeled a low estimate of 20 million people being tested with an infection rate of 20%; and of those infected 10% requiring hospitalization. For the high estimate we modeled 60 million people being tested with an infection rate of 25%; and of those infected 20% requiring hospitalization. Those not hospitalized are modeled as cases receiving out-patient care. Under these models, assuming 50 percent of the individuals in the commercial market are infected, these projections assume between 5 percent at the Low Estimate and 17 percent at the High Estimate may need hospitalization or outpatient care. Also, while it is possible that as hospitals and doctors get more experience with COVID-19 patients, they may be able to divert lower-risk patients to alternative facilities, like Urgent Care and avoid high cost (and over-worked) hospitals, that is not modeled given the short-term nature of this potential program.

- **Costs of treatment:** The costs of treatment may vary dramatically. Costs could be roughly $30,000 per admission, based on Medicare rates and an average length of stay of 12 days (based on similar length of stay for flu or pneumonia patients), which translates to an average commercial cost of $72,000 (an estimate we validated with health plans and counsel from external actuaries. For cases requiring outpatient care, we have modeled the average cost at $600 per infected individual in the Low Estimate and $1,800 per infected individual in the High Estimate. The basis for these estimates is an assumption that each person with a case requiring outpatient care would have one primary care physician office visit and two televisits. The $600 is a best estimate based on estimated $250 that Medicare would pay for these three visits and applying the 2.4 multiplier.

Note that the cost estimates for 2020 are based only on the impacts due to testing and treatment for COVID-19 and do not include any estimates of cost impacts related to the potential impact to utilization for other conditions that may result from COVID-19's significant impact to the health care delivery system. These could include reductions in some services (e.g., elective surgeries), but also an unknown increase in adverse events due to delays in preventive care or disease management for chronic conditions.

Projected Costs for the Commercial Market Nationally for 2021

Given the significant uncertainty of projecting 2020 costs and the unknown incidence of the COVID-19 disease, projecting costs for 2021 is even more uncertain. In addition to the modeled testing, hospitalization and other treatment costs projected above for 2020 (which might be repeated in 2021), there could be additional treatment costs for:

- Anti-viral drug treatment at some unknown cost, perhaps in a wide range of $50 to $2,000 per dose. Some pharmaceutical companies are currently trying to determine if some of their current drugs might be effective in treating COVID-19; and

- There are multiple efforts underway to create and test a vaccine that would be effective on COVID-19 (much the same way the flu vaccine is effective in prevention of flu episodes). It is unknown when such a vaccine would be ready and whether it could be distributed for a 2021 COVID-19 season (if COVID-19 follows the "winter pattern" of the flu) and what its cost might be.

Another unknown factor for 2021 and later is that we do not know at this time whether COVID-19 will follow a seasonal pattern (i.e., higher in the winter and then very low in the summer months) like the flu or whether it would be a year-round affliction.

While projections of 2021 costs is difficult, we suggest that it is not prudent to plan today on lower costs related to COVID-19 in the 2021 calendar year than we project for 2020. Only when we know more about COVID-19 and whether drug treatments or a vaccine are effective should we consider modifying cost estimates for 2021.

Limitations of the Analysis of Potential National Commercial Market COVID-19 Costs

The analysis presented here is directional and needs fuller, more detailed review and modeling for a range of reasons. First, we note that there are currently many unknowns about the incidence of the COVID-19 virus in the American population. We also know very little at this point about the likely levels of severity and the length of hospital treatment needed. In all cases, we have tried to make reasonable estimates, based on treatment of similar conditions.

The analysis is further silent on the issues of facility capacity for treatment of individuals needing to be hospitalized for COVID-19 treatment. This analysis assumes that the United States will be at least somewhat successful in flattening the curve of the infection rate so that the healthcare system can manage the capacity needed. It is also silent on the supply of healthcare workers and does not address potential risks to healthcare workers and any potential staffing shortages.

This policy/actuarial brief was prepared by John Bertko, Covered California's Chief Actuary. Prior to joining Covered California, Mr. Bertko served as an actuarial consultant and director of special initiatives and pricing for CMS's Center for Consumer Information and Insurance Oversight, the federal office charged with implementing changes of the Patient Protection and Affordable Care Act impacting the individual and employer markets as well as working with states to establish new health insurance exchanges. In prior positions, Mr. Bertko was a senior fellow at the LMI Center for Health Reform, an organization that provides analysis and direction to government leaders on federal health reform. He's also been adjunct staff at RAND and a visiting scholar at both the Brookings Institution and the Center for Health Policy at Stanford University. Previously, Bertko was chief actuary at Humana Inc., a for-profit health plan in Louisville, KY. In that role, he directed work for Humana's major business units, including development of Part D, Medicare Advantage and consumer-driven health care products. He serves on the panel of health advisors for the Congressional Budget Office and completed a 6-year term on the Medicare Payment Advisory Commission (MedPAC).

The report reflects the engagement and counsel from experienced external actuaries with deep expertise in the commercial insurance markets, as well as expert clinical review and interviews with health insurance plans. It is informed by the best available data in a rapidly changing environment and has been prepared to inform the national response to the COVID-19 epidemic as policy makers prepare to cope with and mitigate its impacts. While informed by similar sources, this Covered California Policy/Actuarial Brief was prepared separately from work being done by the State of California to model the impacts of the COVID-19 pandemic on that state. Examples of data used to develop this report not referenced in the body of the report include those referenced in the Appendix.

Appendix – References

Kaiser Family Foundation. “How Many Adults Are at Risk of Serious Illness if Infected with Coronavirus?” https://www.kff.org/global-health-policy/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/ published March 2020

White, Chapin, Whaley, Christopher, “Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely,” 2019, https://www.rand.org/pubs/research_reports/RR3033.html.

CDC, Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) – United States, February 12-March 16, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm. March 18, 2020.

CMS posted a fact sheet providing a HCPCS code and fee schedule for COVID-19 testing performed by CDC laboratories and non-CDC laboratories: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf.

https://www.cnn.com/2020/03/02/asia/coronavirus-drive-through-south-korea-hnk-intl/index.html

Review of treatments and outcomes in Wuhan, China. One source is The Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

For estimate hospitalization length of stay, review of a consultant’s proprietary claims data sets with DRGs associated with pneumonia, the flu, and sepsis, which may be reasonable proxies for the treatment protocol for COVID-19

COVID-19 codes were recently assigned and were recently published and are available online at: https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding- Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

For Medicare beneficiary costs: https://www.urban.org/urban-wire/covid-19-treatment-costs-could-hit-some-medicare-beneficiaries-high-out-pocket-expenses

Endnotes

[1] All estimates for unit costs are derived from first calculating estimated costs at Medicare rates and then inflating those rates to estimated commercial rates based on published studies finding commercial payments to be on average 241 percent of Medicare across inpatient and outpatient settings – this Policy/Actuarial Brief uses a 2.4X multiplier for all costs originally derived from Medicare rates. See, White, Chapin, Whaley, Christopher, “Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely,” 2019, https://www.rand.org/pubs/research_reports/RR3033.html.

[2] Our research for hospital costs using a claims database from a large actuarial consulting firm suggests that the cost of hospitalization for related illnesses like the flu and pneumonia is approximately $72,000 for a 12-day average length of stay (ALOS), confirmed by interviews with commercial payers. We reviewed other publicly reported hospitalization costs based only on pneumonia from a different database, which estimated costs of approximately $20,000 and found those estimates to be far lower than actual costs. See https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/.

[3] Kaiser Family Foundation. State Health Facts. Health Insurance Coverage of the Total Population. https://www.kff.org/other/state-indicator/total-population/ (accessed March 17, 2020).

[4] Kaiser Family Foundation. “How Many Adults Are at Risk of Serious Illness if Infected with Coronavirus?” https://www.kff.org/global-health-policy/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/ published March 2020.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit CoveredCA.com.

News Release

Media line: (916) 206-7777 @CoveredCANews media@covered.ca.gov

FOR IMMEDIATE RELEASE
March 23, 2020

Covered California Releases the First National Projection of the Coronavirus (COVID-19) Pandemic's Cost to Millions of Americans With Employer or Individual Insurance Coverage

- *The one-year projected costs in the commercial market range from $34 billion to $251 billion for testing, treatment and care specifically related to COVID-19.*
- *The potential costs for 2020 could range from 2 percent to 21 percent of premium if the full first-year costs of the COVID-19 pandemic were priced into premiums.*
- *Premium increases in the individual and employer markets for 2021 — which are in the process of being set right now — could be 40 percent or more solely because of COVID-19 costs in the absence of federal action.*
- *This data comes as federal policy makers consider how to address COVID-19's impact on Americans, small and large employers and the public sector, which are all stepping up to meet urgent health and economic insecurity.*
- *Reinsurance policies under consideration — that provide mechanisms to provide federal funding for portions of unforeseen COVID-19 costs for the individual and employer markets, along with Medicaid managed care programs — could provide needed funds and certainty for consumers, employers and states.*

SACRAMENTO, Calif. — Covered California on Monday released the first national projection of health care costs due to the coronavirus (COVID-19) pandemic. The analysis estimates the projected costs for 170 million Americans in the commercial market — which includes the individual, small-group and large-group markets — for testing, treatment and care specifically related to COVID-19 ranges from a low of $34 billion to $251 billion or more in the first year of the pandemic.

(more)

"Covered California's analysis shows the impact of COVID-19 will be significant, and that absent federal action, consumers, employers and our entire health care system may be facing unforeseen costs that could exceed $251 billion," said Covered California Executive Director Peter V. Lee. "Consumers will feel these costs through higher out-of-pocket expenses and premiums, as well as the potential of employers dropping coverage or shifting more costs to employees."

Covered California's chief actuary, John Bertko, prepared the report after engaging with external actuaries with deep expertise in the commercial insurance markets and after analyzing expert clinical review and interviews with health insurance plan leaders.

The analysis found:

- The one-year projected costs in the commercial market range from $34 billion to $251 billion for testing, treatment and care specifically related to COVID-19.

- Those potential COVID-19 costs for 2020 could range from 2 percent of premium to more than 21 percent of premium if they had been priced for.

- Premiums in the individual and employer markets for 2021 — which are in the process of being set right now — could be 40 percent or more solely because of these unexpected COVID-19 costs in the absence of federal action, as insurers would seek to recoup unplanned for losses from 2020 and budget for pandemic-related costs in 2021.

"Given that insurers will be submitting 2021 rates in May and finalizing them around July 1, congressional action is needed very soon in order to affect 2021 premiums," Bertko said. "While there is a lot of uncertainty with anything related to COVID-19, one thing we can be certain of is that the impact will be significant, and now is the time to take action."

Covered California sent the policy/actuarial brief "The Potential National Health Cost Impacts to Consumers, Employers and Insurers in the Commercial Market Due to COVID-19" to members of Congress to help inform the ongoing discussions at the federal level about how to handle the COVID-19 response.

"These increased costs could mean that many of the 170 million Americans in the commercial market may lose their coverage and go without needed care as we battle a global health crisis," Lee said. "These are not 'insurer' costs — these are costs directly borne by individual Americans in the form of cost-sharing and premiums; these are costs to small and large businesses that are struggling; these are costs to individuals who may avoid needed care."

(more)

Covered California suggested several actions that Congress could take to mitigate the potential impact of these cost increases on consumers:

- Enhance the federal financial assistance provided in the individual market to increase the level of tax credits for those earning under 400 percent of the federal poverty level (FPL) and expand subsidies to those earning more than 400 percent FPL as California implemented on a three-year basis in 2020.
- Establish a temporary program to limit the costs of COVID-19 for health insurers, self-insured employers and those they cover, which would directly benefit individuals and small employers for 2020 and allow for more certainty in their pricing for 2021.
- Establish a national special-enrollment period for the individual market, such as has already been adopted by 12 marketplaces representing 30 percent of Americans.

"As we have seen throughout this crisis, there is no time to waste. We must take action now to prevent the pain of this epidemic from becoming worse for hundreds of millions of Americans next year," Lee said. "Reinsurance policies under consideration in Washington — that offer mechanisms to provide federal funding for portions of unforeseen COVID-19 costs for the individual and employer markets, along with Medicaid managed care programs — could provide needed funds and certainty for consumers, small and large employers and states across the nation."

Lee also noted that while Covered California's analysis deals with the commercial market, other populations — including those in Medicare, Medicaid, other public programs and the uninsured — will also need a comprehensive review and solutions to address the unplanned for costs.

COVID-19 Special-Enrollment Period

Covered California's analysis comes just days after it announced a special-enrollment period for uninsured individuals who need health care coverage amid the COVID-19 pandemic. From now until June 30, anyone who meets Covered California's eligibility requirements can enroll in health care coverage, similar to the rules in place during the annual open-enrollment period.

Staying Safe While Getting Help Enrolling

In an effort to support the state's social distancing recommendations, Covered California is working with the more than 10,000 Certified Insurance Agents who help Californians sign up and understand their coverage options through phone-based service models.

(more)

“We are in a different world right now, but social distancing does not mean you cannot get personal help,” Lee said. “Our agents and staff are stepping up to help people by phone and support them to enroll online.”

Consumers can easily find out if they are eligible Medi-Cal or other forms of financial help and see which plans are available in their area by using the CoveredCA.com Shop and Compare Tool and entering their ZIP code, household income and the ages of those who need coverage.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller.
- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

About Covered California
Covered California is the state’s health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California’s consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

###

Health Benefit Exchange Authority

coronavirus.dc.gov
Read Mayor Bowser's Presentation on DC's COVID-19 Situational Update: July 16.
Phase Two of Reopening Set to Begin on June 22

Health Benefit Exchange Authority

Office Hours
Monday to Friday, 8 am to 5:30 pm

Connect With Us
1225 Eye Street, NW, Suite 400, Washington, DC 20005
Phone: (202) 715-7576
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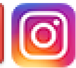
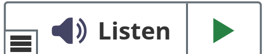




DC Residents Without Health Insurance Can Get Covered Now

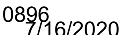
Tuesday, March 24, 2020

Responding to COVID-19 public health emergency, DC Health Link makes it even easier for DC residents to sign up for coverage now

(Washington, DC) – Uninsured District of Columbia residents can shop and enroll in private health insurance at DCHealthLink.com. A Special Enrollment Period (SEP) has been in place and is currently set to continue through June 15, 2020. Enrollment is just as easy as during open enrollment: visit DCHealthLink.com to shop, compare, and enroll in coverage. All plans cover diagnosis, testing, and treatment for COVID-19 without cost-sharing.

There are also new resources available on DCHealthLink.com for DC Health Link enrollees about how DC Health Link plans cover COVID-19. DC Health Link launched a Coronavirus page on March 13th where DC Health Link enrollees can find a simple summary chart highlighting how DC Health Link insurers cover COVID-19 related services.

For more information on new DC Health Link Coronavirus resources, visit https://www.dchealthlink.com/coronavirus.



Background
For District residents, there are 25 private health insurance options from CareFirst Blue Cross Blue Shield and Kaiser Permanente for individuals and families. Eligible District residents can enroll in a health insurance plan online through DCHealthLink.com. Small businesses—as well as individuals and families eligible for Medicaid—can enroll through DCHealthLink.com at any point.

The Affordable Care Act provides individuals, families, and small businesses in the District of Columbia with affordable options for quality health insurance. DC Health Link is the District's online health insurance marketplace which allows visitors to shop, compare, and enroll in coverage that fits their needs and budgets.

Resources

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How to Adapt ACA Marketplace to COVID-19

Jon Kingsdale and Jon Gruber, March 23, 2020

In theory, the ACA addresses even the large decrease in employment, income and group insurance that may well result from shutting down whole swaths of our economy. Those who lose group coverage qualify for a special enrollment period (SEP) and can access premium subsidies in the Marketplace based on estimated 2020 MAGI.

The problems arise from the sudden deluge of confused, temporarily uninsured people and the prospect of a sudden reduction in incomes for direct enrollees. Intake systems will be overloaded with applicants; applicants will be confused about whether their employers are continuing their group coverage, for how long and whether/when in 2020 they might be re-hired or find other employment; and few have any idea how much their MAGI this year will differ from their historical MAGI data available thru the federal data hub. (If an applicant attests to MAGI well below his/her historical income, they're required to provide substantiation of the change, such as a recent pay stub.)

This uncertainty and churn will, in turn, make health plans very nervous about taking on unpredictable risk. They may fear that only those who foresee the need for a lot of covered services will, when impoverished, pay for coverage; and/or that the carrier will have to pay 100% of total allowed amounts for an epidemic of Covid-19 ICU care; and/or that those who sign up in April will stop paying premiums with a drop in the rate of new cases in June (while the carrier retains liability for coverage).   But these are uncertain outcomes – in fact many of those losing ESI might be healthy and improve the risk pool, and the government may bail out a large share of ICU costs.

To deal with such large volume and uncertainty, states with their own SBMs might stage ESPs, suspend the normal rules for estimating MAGI, and offer to share underwriting risks with qualified health plans in the Marketplace.

1. For new applicants (whether previously eligible or newly qualifying for enrollment) allow a SEP, April through May, to determine eligibility for premium tax credits (and state supplementary premium subsidies, if any) and for cost-sharing reductions;
2. For those already enrolled through the Marketplace as of June 1st, allow re-determinations effective July 1st (or later); the changes would be prospective, but APTCs are reconciled at year-end for the full year, whereas CSRs would only take effect upon re-enrollment after re-determination;
3. Base determination of the applicant's 2020 MAGI on the applicant's best guess, informed by the latest information (supplied by the Marketplace) on federal stimulus payments to individuals and state unemployment compensation, but independent of the applicant's historical MAGI;

4. Set-up home-based telephone customer service lines, staffed by laid-off workers, and backed up by SBM-accredited brokers or web-based brokers, to handle the huge volume of calls;
5. Offer each sponsor of qualified health plans on the SBM a voluntary risk-sharing arrangement whereby the state will accept 50% of underwriting losses beyond 2%, 75% beyond 4%, and 90% beyond 6% in return for the same sharing rules for underwriting profits. This program only becomes active if carriers representing 90% of exchange enrollment agree to participate.

March 24, 2020

The President
The White House
1600 Pennsylvania Ave., NW
Washington, D.C. 20500

Dear Mr. President,

Thank you for the actions you have taken to respond to the COVID-19 pandemic, including the declaration of a national emergency, which has resulted in much needed flexibility for our health system. The ongoing spread of COVID-19 is a significant public health concern. As a national health system with facilities in 22 states and thousands of staff on the front lines, we are experiencing considerable resource and supply strains.

There remain important administrative actions the federal government can take to ensure our health system, and others across the country, can continue to respond to this pandemic crisis.

PAYMENTS TO HOSPITALS AND HEALTH CARE PROVIDERS TO CARE FOR PATIENTS AND COMBAT COVID-19
It is imperative the Administration supports legislation that places first the health of patients and the safety of health care providers. This includes funding to ensure all hospitals have reliable financial resources to maintain an adequate workforce, buy critical supplies, create additional infrastructure, and keep our doors open to care for patients and our communities. In addition, we ask the Administration to push for legislation to create a health system stabilization emergency fund to provide direct funding to hospitals during COVID-19 and times of emergencies.

IMMEDIATELY ADDRESS SUPPLY SHORTAGES
Across Trinity Health, our supply of masks, isolation gowns, face shields, eye protection and N95 respirators are already in short supply. We urge you to immediately use your Executive Authority to invoke the Defense Production Act to allow for increased production of critical supplies.

REMOVE REGULATORY BARRIERS THAT IMPEDE PANDEMIC RESPONSE
To allow community hospitals and health systems the ability to address the growing demand of services in response to COVID-19, we need more regulatory relief from the federal government. Among areas of greatest concern:

- Provide periodic interim payments to hospitals to address cash flow challenges.
- Require all payers to reimburse audio only consultations through telehealth.
- Allow for maximum telehealth flexibility – all payers should provide the same telehealth flexibilities the Centers for Medicare and Medicaid Services has provided for Medicare.
- Ensure all state licensure flexibilities also extend to telehealth. This includes cross state licensure and reimbursement for health professionals.
- Apply consistent prescribing rules to controlled substances via telehealth.
- Require health plans suspend administrative requirements in line with guidance issued by the state of New York.
- Allow a high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.
- Allow patients with HDHPs to use HSA funds to pay the monthly fee to a “direct primary care,” or concierge, physician practice that typically provides more remote care, including telehealth.
- Allow physician assistants, nurse practitioners and other professionals to order home health services for Medicare beneficiaries.
- Provide telehealth flexibilities for the delivery of home health.
- Allow home health agencies to bill separately for remote patient monitoring.

- Allow home health agencies and hospices to achieve face-to-face requirement via telehealth and bill for telehealth visits.
- Require payers suspend laboratory testing requirements that require tests be sent to specific labs.
- Require payers suspend prior authorization review requirements, document requests, and associated penalties.
- Require payers suspend the authorization process for skilled nursing facilities and other site-of-care transfers.
- Require payers to waive utilization review to allow hospitals to redeploy employees to care delivery areas.
- Require payers to refrain from using claim denials and suspend claim edits.
- Require payers suspend timely filing requirements for claims.
- Require payers extend current appeal and peer-to-peer request timeframes.
- Align 42 CFR Part 2 with existing patient protections under the Health Insurance Portability and Accountability Act to eliminate barriers to coordinated care for individuals with substance use disorder.
- Suspend all routine audits of facilities.
- Create a special enrollment period for health insurance marketplaces.
- Forego finalizing the Medicaid Fiscal Accountability Regulation to avoid disrupting state financing and the health care system.

PROTECT PARTICPANTS IN VALUE-BASED CARE ARRANGEMENTS
Federal policymakers should act quickly to ensure entities providing value-based care are not penalized when extreme costs are incurred in addressing the COVID-19 pandemic and can continue to focus exclusively on furnishing care, including:

- Harmonize requirements for ACO/BPCIA waivers with the 1135 disaster relief waivers to clinically and administratively simplify.
- Treat telehealth codes like other E&M codes for ACOs, for example include them in attribution logic.
- Provide relief from face-to-face components to complete annual wellness visits—a critical activity to address underlying conditions, create a patient-centered plan of care, and close clinical gaps for Medicare beneficiaries.
- Allow ACOs and BPCIA episode initiators to elect by June 30 2020 to continue in the program with no financial reconciliation for PY2020, similar to what was provided for the Pioneer ACO model in Y1. While it might be possible to adjust ACO benchmarks to fairly account for regional differences in disease prevalence, there are simply too many unknowns at this point.
- Do not include 2020 as a baseline year as models move forward.
- Provide a one-year extension of the Next Generation ACO Model – staff who are working to meet application deadlines to allow for continued participation in the Direct Contracting Model or the Medicare Shared Savings Program have been redeployed to support patients and front-line staff.
- Delay implementation of the Direct Contracting Model to 1/1/22.
- Pause monthly compliance monitoring audits for ACOs without any prior material findings or remediation plans.

Thank you for your leadership at this difficult time. Please do not hesitate to reach out to me should you want to further discuss our COVID-19 efforts.

Sincerely,

Michael A. Slubowski

Michael A. Slubowski, FACHE, FACMPE
President and Chief Executive Officer
Trinity Health

From: Handelman, Justine [redacted]
Sent: Wednesday, March 25, 2020 6:28 PM
To: Parker, Jim (HHS/IOS); Uehlecke, Nick (HHS/IOS)
Cc: Haltmeyer, Kris
Subject: BCBSA COVID-19 Regulatory Recommendations
Attachments: COVID19_Regulatory Adjustments_3.25.20.pdf

Jim, Nick –

First, let me thank you for everything you are doing in response to the COVID-19 national emergency. We especially appreciate the flexibility to expand telehealth access, the state guidance for rapid response, the IRS benefit flexibility, and valuable updates and communications from the Agency.

Attached are our latest regulatory recommendations related to Medicare Advantage, Part D, Medicaid and our commercial lines of business. We'd be happy to set time to walk you through. We are also close on the modeling, so can find time to go through that as well.

We're sending these to Administrator Verma, Demetrious, Calder Lynch, Kim Brandt and Randy Pate as well.

Also we are keeping our website up-to-date at BCBSProgressHealth.com and we've also compiled state by state information on how BCBS Plan actions across the country during this unprecedented time.

Hope you are both hanging in there!

Take care,
Justine

March 25, 2020

Regulatory Recommendations Related to COVID-2019

As health plans work to respond to the unprecedented demands on the healthcare system by the COVID-19 crisis, we wanted to bring to your attention areas where Plans will need flexibility due to technical and operational challenges that are surfacing from the emergency response and its related impacts to normal business operations. We appreciate your consideration of these recommendations and are available to answer any questions you may have.

All Markets

BCBSA recommends CMS take steps to educate the public on critical issues and to support efficient claims processing.

- Availability of medications. Educate the public on the status of available treatments based on the best scientific evidence and against unnecessary stockpiling of drugs in order to prevent drug shortages. It is important to prioritize access to drugs for patients in U.S. Food and Drug Administration (FDA) clinical trials, which assists in evidence generation for COVID-19 treatments and vaccines, for the entire population.

- Coding.

    - Effective date. Move up the effective date of COVID-19 diagnosis codes to help simplify and streamline coding for the disease. This will help ensure COVID-19 related services are appropriately covered and processed as quickly as possible.

    - Release additional codes. Make any additional codes that are developed for testing and treatment available as quickly as possible.

Medicare Advantage (MA) and Part D

We recommend CMS provide additional flexibility and clarification in response to the national emergency. Plans are seeking clarity on stars, risk adjustment and other key operational requirements and deadlines that are impacted by COVID-19. Chart retrievals are difficult now and patients and providers are canceling routine visits (including preventive care and wellness visits) in in light of the COVID-19 crisis. Even if the crisis passes this year, there may not be adequate capacity to reschedule these routine visits in 2020.

The following recommendations would provide clarity and flexibility for plans serving Medicare and dual-eligible Medicare/Medicaid beneficiaries during these unprecedented circumstances.

- Star Ratings

    - Adjustments for national emergency. Broaden the existing “Extreme and Uncontrollable Circumstances” policy to apply to this national emergency.

    - Part D measures. We recommend that CMS review and adjust star measures that may be impacted by unanticipated demands on refills and mail order.

- Health Outcomes Survey (HOS) measures. Allow plans to report the prior year's measures, disregard all HOS questions, or establish a floor on ratings from HOS questions asked during performance year 2019, (e.g., no plan can score below 3).

- Risk Adjustment
  - Submission deadlines. Delay current submission deadlines and other adjustments for Risk Adjustment data submissions on an interim basis as Plans retool their systems to account for COVID-19-related claims and encounters (e.g., Risk Adjustment Processing System [RAPS], encounter data, date of service risk adjustment data, RADV submissions).
  - Coding and encounter data. CMS should consider adjustments for COVID-19, including adding COVID-19 diagnosis into risk adjustment or other payment adjustments for plans with high volumes of members with the diagnosis of COVID-19. Additionally, risk adjustment data collected in telehealth visits should count for risk adjustment purposes. In addition, CMS should allow for risk adjustment data of certain chronic conditions without monitoring, evaluation, assessment and treatment (MEAT) criteria for 2020 dates of service.
  - Fee-for-service (FFS) normalization. CMS should consider maintaining the CY 2020 FFS normalization factor in CY 2021 to reduce reductions in payments.

- Part D
  - Cost of COVID-19 vaccine. Plans are thinking about 2021 bids and seeking information on potential costs for a vaccine for COVID-19. Additional communication with CMS on bid timing and other developments will be necessary. We also encourage CMS to encourage greater transparency on the cost of new vaccines as they become available.
  - Medication therapy management (MTM). Lower expectations as to MTM programs given lower face-to-face encounters with medical professional and pharmacists.
  - Telehealth prescribing. Allow medication prescribing by telehealth as appropriate for behavioral health and remove all state and federal barriers that would hinder expanded use of telehealth services in Part D.

- Other Flexibilities
  - Bids. Issue CY 2021 bid guidance as soon as possible and consider an extension to the bid filing date.
  - Balance billing. Amend CMS regulations to prohibit out-of-network providers from balance billing beneficiaries when a claim has been denied for not meeting medical necessity requirements. This should also apply to all durable medical equipment providers billing a Medicare beneficiary as a non-participating supplier or provider.
  - Marketing, enrollment and member communications. MA enrollment should allow for virtual and/or telephone enrollments (i.e., without paper applications). Flexibility should

be provided in MA marketing and communications needed to expedite information sharing. Also, plans should be allowed to suspend disenrollment for non-payment policies without a required member notice. Finally, CMS administrative regulations and rules around member service turnaround times, call handling time, appeals and grievances turnaround times should be suspended.

- Oversight and compliance. CMS should suspend and delay all audits and monitoring activities until the COVID-19 emergency has abated to allow plans to focus on operations and member care. Waivers or extensions should be provided for reporting requirements or required submissions that may be impacted by plan operations while plan workforces work remote. MA plans should be allowed to use existing "Designation of Authorization" that may expire during the national emergency to continue to be viable and not require new ones.
- Telemedicine. We thank CMS for the flexibilities it has recently granted related to telemedicine in Medicare. In addition to our request in regards to risk adjustment for telemedicine, we urge CMS to ensure that activities not already mentioned, such as D-SNPs face-to-face care coordination activities, can also be substituted with telephonic or telehealth care management during the emergency.
- Innovation Center. Allow more time for applications for models designed by the CMS Innovations Center for MA plans given the current Plan emphasis on operations related to COVID-19.

Medicaid and Dually Eligible Beneficiaries

During this time of disruption, it is critically important that we support continuity of care and access to services for Medicaid and dually eligible beneficiaries, especially those beneficiaries utilizing long-term care through home- and community-based services. In order for states and Medicaid managed care organizations (MCOs) to be able to meet the needs of beneficiaries, we believe the following regulatory actions will help to enhance Medicaid MCO engagement with beneficiaries and ensure stability as health plans respond to the COVID-19 crisis.

- General
  - MFAR and Public Charge. Suspend implementation of final Medicaid Fiscal Accountability Regulation (MFAR) and Inadmissibility on Public Charge Grounds rules for at least two years to ensure state Medicaid funding and access to treatment are not negatively impacted.
  - FCC Lifeline Program. Encourage the FCC to suspend the voice and broadband limits under the Lifeline program to help low-income consumers receive increased access to recently expanded telehealth benefits.
- Medicaid
  - Eligibility
    - Hospital Presumptive Eligibility. Broaden flexibility for hospital presumptive eligibility (HPE), allowing states to extend HPE determination periods to at least six months.

  - Face-to-Face requirements. Provide guidance that relaxes face-to-face interactions for the purpose of eligibility determinations and care coordination and encourage states to rely on telehealth and virtual platforms to reduce the physical movement of beneficiaries from their homes.
  - Promote continuous enrollment. In order to promote sustained enrollment during the pandemic, encourage states to utilize the state option for 12-month continuous eligibility and suspend disenrollment and periodic income checks during the period of the public health emergency.
  - Determinations for HCBS. Develop guidance to facilitate telephonic assessments that may be used for the purpose of determinations for home- and community-based services.
- Financial & Operational Considerations for Medicaid Managed Care
  - Special Rate Setting & Actuarial Soundness Guide. Develop guidance on rate setting methodology to ensure Medicaid managed care rates are actuarially sound, including:
    - Ensure 42 CFR 438.4 is not waived under any waiver authority (i.e., 1115, 1135, HAO)
    - Outline a process for performing mid-year rate adjustments and increased administrative activity stemming from outreach to beneficiaries receiving long-term care
    - Outline how actuaries may adjust rates to account for COVID-19-related diagnostic testing and treatment
    - Make accommodations for plans who have assumptions of reduced avoidable utilization and/or deinstitutionalization in their rates, but whose operations were disrupted by the pandemic
  - Service level requirements. Provide guidance to states to suspend certain service level requirements for Medicaid MCOs that do not directly impact beneficiary health. In particular, encourage states to allow plan staff to work remotely during the public health emergency to ensure they continue to serve as a critically important connection for beneficiaries.
  - Audits. Suspend financial and operational audits for the period of the public health emergency to account for disruption in staffing and administrative capacity.
  - HEDIS Collection and Care Survey. Develop guidance to extend the time period for collection of HEDIS measures and instructions for states to account for disruption of HEDIS measure collection in state value-based purchasing programs. Allow states to temporarily suspend experience of care surveys (i.e., Medicaid and HCBS CAHPS, NCI-AD, NCI-DD) during the public health emergency.

    - Long-term care. Develop guidance for providers and Medicaid MCOs on strategies to address loneliness and isolation among long-term care population.
    - NEMT. Disallow waivers of non-emergency medical transportation (NEMT) and postpone guidance that would consider NEMT as an optional benefit to ensure beneficiaries can access needed providers and services.

- Dually Eligible Beneficiaries
  - Personal care workforce. Designate personal care attendants (PCAs) and other homecare workers that assist individuals with activities of daily living (ADLs) as "health care providers" for the purposes of receiving emergency supports services and/or equipment.
  - Financial & Operational Considerations for MLTSS & MMPs
    - HEDIS collection. Develop guidance to extend the timing for collection of HEDIS measures and how states may navigate disruption with HEDIS measure collection.
    - Telehealth. Permit MMPs to substitute face-to-face care coordination activities with telephonic or telehealth care management and provide states with flexibility to enact regulatory relief for MLTSS plans, including greater use of telehealth and timing of reassessments.
    - Audits. Suspend financial and operational audits for the period of the public health emergency to account for disruption in staffing and administrative capacity.

Commercial Markets

We support improving access to coverage for individuals impacted by COVID-19 while mitigating potential negative down-stream impacts to the affordability of coverage for all enrollees. We ask CMS to consider delaying and/or providing flexibility on a subset of new requirements that are particularly resource intensive to implement. This will ensure the greatest amount of resources can be allocated to addressing the ongoing pandemic.

- Providing and Maintaining Access to Coverage
  - Special Enrollment Period (SEP). CMS should allow a one-time SEP for the individual market. This SEP should be limited to 30 days with prospective effective date(s) on the first of the month(s). The SEP should be available to all persons who are not eligible for Medicare or Medicaid. CMS should not allow for retroactive enrollment for individuals incur substantial medical costs. Given the uncertainty about the cost of treating those who would enroll through an SEP, this option should be coupled with risk mitigation funding.
  - Exchange premium payments. CMS should fund and conduct outreach to encourage exchange enrollees to update their current and anticipated annual income if they are struggling to make premium payments. CMS should also clarify operational expectations

for federally-facilitated marketplace issuers following state grace period guidance. Grace period policies should be reasonable and not cause revenue shortfalls for health plans.

  - Federal and state coordination. Coordinate with state entities, including the National Association of Insurance Commissioners (NAIC), State Departments of Insurance, and the National Governors Association (NGA), to align emergency coverage requirements where feasible.

  - Marketplace Quality Ratings. Adjust the Quality Ratings System (QRS) to address unintended consequences due to the current healthcare emergency. To prevent negative impacts to qualified health plans' (QHPs') ratings for 2019 and beyond, we encourage CMS to allow QHPs to use the higher of this year or last year's HEDIS measure results during the impacted period.

- Risk Adjustment

  - 2020 Risk Adjustment. CMS should ensure that diagnoses related to COVID-19 treatment are included in payment HCCs.

  - 2019 RADV. CMS should cancel the 2019 RADV. The COVID-19 epidemic has resulted in limited available office staff to perform medical record retrieval, and we anticipate that disruptions will persist through this year. If CMS desires to delay the 2019 RADV rather than cancel, we suggest that issuer timeframes should not be compressed or overlap with the following year's RADV activities.

- 2021 Submissions

  - Maximum out-of-pocket costs (MOOP). CMS should immediately announce that they are finalizing the 2021 MOOP as proposed. This would eliminate uncertainty as to whether they are potentially going to update the proposed MOOP when the NHEA updates their number allowing issuers scarce actuarial resources to focus on one assumption for benefit design. This allows more time for them to estimate the impact of COVID-19 on 2020 and 2021 premium and claims.

  - Rate filing timeline. CMS should compress the rate submission and approval deadlines to the maximum degree possible so issuers can have the latest available information.

- Plan Management

  - QHP certification timeline. CMS should review the 2021 QHP Certification timeline and, where possible, allow more time for issuers to complete the tasks. In particular, the proposed submission dates for Transparency in Coverage data submission and Machine Readable file posting should remain where they were for 2020 submissions and not be moved forward as proposed.

  - Summary of benefits and coverage notification. CMS should suspend the 60-day notification requirement for any mid-year benefit change so plans can rapidly respond to the need to cover items and services related to COVID-19.

- Health Information Technology

  - Provide flexibility and extend implementation of the CMS and ONC Interoperability and Information Blocking Final Rules. The CMS and ONC interoperability requirements must pace with the development and availability of usable and scalable standards, which are still in development. With the COVID-19 public health emergency, plans and providers are significantly challenged by the uncertainty of resources and bandwidth to develop, test and scale the necessary requirements in the rules.

  - Extend Office of Civil Rights enforcement discretion and HIPAA waivers to health plans. Similar to the waiver provided to providers, extend HIPAA waiver to plans that offer and manage widely used consumer communication applications via telehealth to support care coordination across state lines and out of marketplace service areas.

  - Delay finalization of the Transparency in Coverage rule. Delay finalization of the proposed Transparency in Coverage rule given the uncertainty of resources and provider and health plan bandwidth being focused on COVID-19.

Governor Ducey Requests Special Health Care Enrollment Period

News Release

March 25, 2020

PHOENIX — Governor Doug Ducey today made a request to Secretary of Health and Human Services (HHS) Alex Azar to open a special enrollment period on the Federal Insurance Marketplace. If granted, the action would allow individuals who have recently lost a job or had their income reduced due to COVID-19 to access health care on the federal marketplace.

"At this time when health insurance is of critical importance and so many people are experiencing a loss of employment, opening a special enrollment period will cut unnecessary red tape and lift a paperwork burden off individuals who are already facing challenges from a sudden and significant change in circumstances," Governor Ducey said in the letter. "Such a move would provide an important option to families in Arizona and across the country who are struggling right now."

Governor Ducey took additional action earlier today to expand health care access for Arizonans, including issuing an Executive Order requiring health care insurance companies to **expand telemedicine coverage (https://azgovernor.gov/governor/news/2020/03/governor-ducey-expands-telemedicine-coverage-arizonans)** for all services

that would normally be covered for an in-person visit. This morning, the Governor also made a request to the federal government to **expand nutritional assistance (https://azgovernor.gov/governor/news/2020/03/governor-ducey-requests-changes-food-assistance-program)** under the Supplemental Nutrition Assistance Program (SNAP).

View a PDF of the letter to HHS **HERE (https://azgovernor.gov/sites/default/files/20200325131134559.pdf)**.

Read the full letter below.

***

Secretary Azar,

I am writing to you today to strongly encourage you to open a special enrollment period on the Federal Insurance Marketplace which Arizona, like 31 other states, utilizes in place of running a state based exchange. As you are aware, at least 11 states that operate a state based marketplace have opened special enrollment periods, and we would ask that the Federal Insurance Marketplace do the same.

Opening a special enrollment period on the Federal Insurance Marketplace will allow individuals who have lost their employment or have seen their income dramatically reduced as the economic fallout of the Coronavirus outbreak unfolds to have the ability to purchase health insurance. Such a move would provide an important option to families in Arizona and across the country who are struggling right now.

While individuals who have lost their employment are permitted to

purchase a health insurance plan during a short time period after loss of employment, a substantial paperwork burden is placed on the individual to qualify. At this time when health insurance is of critical importance and so many people are experiencing a loss of employment, opening a special enrollment period will cut unnecessary red tape and lift a paperwork burden off individuals who are already facing challenges from a sudden and significant change in circumstances.

To ensure individuals have access to health insurance options at this critical time, we strongly encourage you to open a special enrollment period on the Federal Insurance Marketplace. Should you have any questions, please reach out to my office.

Sincerely,

Douglas A. Ducey
Governor of Arizona

###

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3 Ivy Foundation Makes Multi-million Dollar... (/governor/news/2020/04/ivy-foundation-makes-multi-million-dollar-contribution-az-coronavirus-relief)

4 Governor Ducey And State Child Care Leaders... (/governor/news/2020/04/governor-ducey-and-state-child-care-leaders-announce-launch-childcare-covid-19)

5 New Order Allows Certain Prescription... (/governor/news/2020/04/new-order-allows-certain-prescription-refills-without-having-see-doctor)

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APR 02 2020

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

March 25, 2020

Alex M. Azar II,
Secretary of Health and Human Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

I am writing to you today to strongly encourage you to open a special enrollment period on the Federal Insurance Marketplace which Arizona, like 31 other states, utilizes in place of running a state based exchange. As you are aware, at least 11 states that operate a state based marketplace have opened special enrollment periods, and we would ask that the Federal Insurance Marketplace do the same.

Opening a special enrollment period on the Federal Insurance Marketplace will allow individuals who have lost their employment or have seen their income dramatically reduced as the economic fallout of the Coronavirus outbreak unfolds to have the ability to purchase health insurance. Such a move would provide an important option to families in Arizona and across the country who are struggling right now.

While individuals who have lost their employment are permitted to purchase a health insurance plan during a short time period after loss of employment, a substantial paperwork burden is placed on the individual to qualify. At this time when health insurance is of critical importance and so many people are experiencing a loss of employment, opening a special enrollment period will cut unnecessary red tape and lift a paperwork burden off individuals who are already facing challenges from a sudden and significant change in circumstances.

To ensure individuals have access to health insurance options at this critical time, we strongly encourage you to open a special enrollment period on the Federal Insurance Marketplace. Should you have any questions, please reach out to my office.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

From: Noah Lang [redacted]
Sent: Monday, March 30, 2020 1:39 PM
To: Koltov, Michelle K. (CMS/CCIIO)
Cc: Pate, Randy (CMS/CCIIO); Jordan McIntosh
Subject: Re: Re: Stride's newest COVID-19 resources

Yes - will intro you to Kathrine Hempstead shortly.

Any relevant updates (aside from stay on our toes!) regarding a national SEP?

Noah

On Mon, Mar 30, 2020 at 10:07 AM Koltov, Michelle K. (CMS/CCIIO) [redacted] wrote:

> Hi Noah,
>
> Thanks so much for following up. I also wanted to follow up on the research you mentioned that RWJF was doing on SBEs. Could you share some more information or contacts?
>
> Hope you & your families are healthy and well!
>
> Michelle
>
> **From:** Noah Lang [redacted]
> **Sent:** Monday, March 30, 2020 12:40 PM
> **To:** Pate, Randy (CMS/CCIIO) [redacted]; Koltov, Michelle K. (CMS/CCIIO) [redacted]
> **Cc:** Jordan McIntosh [redacted]
> **Subject:** Stride's newest COVID-19 resources
>
> Randy & Michelle,
>
> Thank you for the conversation last week - I'm so glad to hear you are looking at every means possible to help more Americans stay well & access care during this crisis.

As promised, I wanted to share the COVID-19 Resource Guide for Independent Workers that we launched on Friday night - it has all the health coverage SEP extensions, care access & financial stimulus guidance contingent workers need right now.

You can expect it to be updated multiple times per week with the latest & greatest, and we hope to bring some interactive stimulus program-level eligibility guidance into the fold as well (a la the work we do together on health coverage).

We're standing at-the-ready should there be a national COVID-SEP (we're hopeful - we've engaged with many who would participate and need it dearly). Let us know how else we can help.

I hope you & your families are healthy and well,
Noah

--

Noah Lang

CEO & Cofounder

Stride Health

--
Noah Lang
CEO & Cofounder
Stride Health

From: Johnson, Veronica M. (CMS/CCIIO)
Sent: Monday, March 30, 2020 4:51 PM
To: HOGUE Cable E * DCBS; Gogna, Shilpa (CMS/CCIIO)
Cc: FLOWERS Chiqui L * DCBS
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Cable,
Here is an updated response to your inquiry:

CMS's top priority is protecting the health and safety of the Americans we serve. In light of the 2019 Novel Coronavirus (COVID-19), CMS is looking closely at all of its policies and across all of its programs to see where we can strengthen the nation's response to the Coronavirus outbreak. CMS is not currently offering a Special Enrollment Period specifically designated for COVID-19. However, consumers who are not currently enrolled in coverage can see if they qualify for other Special Enrollment Periods by visiting HealthCare.gov. We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time.

Please let us know if you have additional questions.
Thanks,

Veronica

From: Johnson, Veronica M. (CMS/CCIIO)
Sent: Monday, March 30, 2020 11:48 AM
To: HOGUE Cable E * DCBS [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Good morning Cable,
I don't have any new updates to share at this time, but we will be sure to keep you informed. We appreciate your circling back on this inquiry.
Thanks,

Veronica

From: HOGUE Cable E * DCBS [redacted]
Sent: Monday, March 30, 2020 11:43 AM
To: Johnson, Veronica M. (CMS/CCIIO) [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Ronnie,

This is my weekly check on the possibility of a SEP at the federal level as a result of COVID-19.

Thanks!

Cable

From: Johnson, Veronica M. (CMS/CCIIO) [redacted]
Sent: Tuesday, March 24, 2020 6:49 AM
To: HOGUE Cable E * DCBS [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Cable,
We appreciate you keeping us aware of your inquiry. There is still currently no SEP on the FFE. Our leadership is aware of your inquiry, and we will continue to keep you, and other SBE-FPs, posted on the FFE's status of considering such an SEP. Take care!
Thanks,

Veronica

From: HOGUE Cable E * DCBS [redacted]
Sent: Monday, March 23, 2020 1:00 PM
To: Johnson, Veronica M. (CMS/CCIIO) [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Ronnie,

Circling back for a weekly update on if there will be a SEP as a result of COVID-19.

Thank you!

Cable

From: HOGUE Cable E * DCBS
Sent: Monday, March 16, 2020 9:00 AM
To: 'Johnson, Veronica M. (CMS/CCIIO)' [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Thank you, Ronnie!

From: Johnson, Veronica M. (CMS/CCIIO) [redacted]
Sent: Monday, March 16, 2020 8:20 AM
To: HOGUE Cable E * DCBS [redacted]; Gogna, Shilpa (CMS/CCIIO) [redacted]
Cc: FLOWERS Chiqui L * DCBS [redacted]
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Cable,

I don't have an update on your question at this time, but will update you on any response that I receive and can share with you, as things are continually evolving. In the meantime, the upcoming Workgroup on Thursday may provide an opportunity to address your question.
Thanks,

Veronica

From: HOGUE Cable E * DCBS
Sent: Friday, March 13, 2020 7:25 PM
To: Johnson, Veronica M. (CMS/CCIIO) ; Gogna, Shilpa (CMS/CCIIO)
Cc: FLOWERS Chiqui L * DCBS
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hello Ronnie,

Reaching back out on this to see if you are able to provide any more details on the possibility of an SEP related to the COVID-19 pandemic, in light of the president's declaration of a National Emergency today?

Thank you for all your help,

Cable

From: Johnson, Veronica M. (CMS/CCIIO)
Sent: Thursday, March 5, 2020 1:21 PM
To: HOGUE Cable E * DCBS ; Gogna, Shilpa (CMS/CCIIO)
Cc: FLOWERS Chiqui L * DCBS
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Cable,
Thank you for your question. Please note that at this time, CMS does not have plans to implement a SEP for COVID-19. However, please note that CMS is actively monitoring the situation, and in the event that CMS does implement a SEP for COVID-19, we will let you and the other states know.
As always, please let us know if have any further questions.
Thank you,

Veronica

From: HOGUE Cable E * DCBS
Sent: Thursday, March 5, 2020 2:13 PM
To: Johnson, Veronica M. (CMS/CCIIO) ; Gogna, Shilpa (CMS/CCIIO)
Cc: FLOWERS Chiqui L * DCBS
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Thank you, Ronnie!

From: Johnson, Veronica M. (CMS/CCIIO)
Sent: Thursday, March 5, 2020 9:02 AM
To: HOGUE Cable E * DCBS ; Gogna, Shilpa (CMS/CCIIO)

Cc: FLOWERS Chiqui L * DCBS
Subject: RE: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hi Cable,
I'll see what I can find out in response to your request.
Thanks,

Veronica

From: HOGUE Cable E * DCBS
Sent: Thursday, March 5, 2020 11:54 AM
To: Gogna, Shilpa (CMS/CCIIO) ; Johnson, Veronica M. (CMS/CCIIO)
Cc: FLOWERS Chiqui L * DCBS
Subject: SEP for Oregonian's in case of emergency declaration related to COVID-19

Hello Ronnie and Shilpa,

I am hoping you can provide guidance to us on the possibility of using 45 CFR §155.420(d)(9) to allow for an SEP in the event that there is a state of emergency declared in Oregon as a result of COVID-19? I know this regulation has been cited and used in the event of weather related disasters in previous years, see: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf.

Let me know if you have questions.

Thank you,

Cable E. Hogue
Implementation Analyst and Federal Liaison
Oregon Health Insurance Marketplace
Department of Consumer and Business Services
| OregonHealthCare.gov |

From: Tai, Ernest (CMS/OPOLE)
Sent: Tuesday, March 31, 2020 7:29 PM
To: Erin Klug; 'Mary Boatright'; Catherine O'Neil; Kwok, Kalina (CMS/CCIIO); Akahane, Kaihe M. (CMS/OPOLE); Daskal, Jennifer A. (CMS/OPOLE); [redacted]; Norris, Anthony (CMS/CCIIO); Maria Ailor; King, Devon (CMS/CMHPO)
Subject: No FFE COVID-19 SEP

Good Afternoon,

At this time, we've decided not to offer a COVID-19 SEP –

> CMS's top priority is protecting the health and safety of the Americans we serve. In light of the 2019 Novel Coronavirus (COVID-19), CMS is looking closely at all of its policies and across all of its programs to see where we can strengthen the nation's response to the Coronavirus outbreak. CMS is not currently offering a Special Enrollment Period specifically designated for COVID-19. However, consumers who are not currently enrolled in coverage can see if they qualify for other Special Enrollment Periods by visiting HealthCare.gov. We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time.

Ernie

Ernest Tai, MHS, JD / Technical Advisor / Centers for Medicare & Medicaid Services / U.S. Department of Health & Human Services / 90 7th Street, 5-300 (5W) San Francisco, CA 94103-6708 / Tele: [redacted] / Fax: [redacted] / [redacted]

-----Original Appointment-----
From: Tai, Ernest (CMS/OPOLE)
Sent: Thursday, March 26, 2020 3:30 PM
To: Erin Klug; 'Mary Boatright'; Catherine O'Neil; Kwok, Kalina (CMS/CCIIO); Akahane, Kaihe M. (CMS/OPOLE); Daskal, Jennifer A. (CMS/OPOLE); [redacted]; Norris, Anthony (CMS/CCIIO); Maria Ailor; King, Devon (CMS/CMHPO) [redacted]
Subject: Agenda: ADOI - CMS State Engagement Coordinator (SEC) Check-In
When: Friday, March 27, 2020 8:30 AM-9:30 AM (UTC-08:00) Pacific Time (US & Canada).
Where: WebEx Online

Hi ADOI Colleagues,

Tony and I are proposing that, for tomorrow's call, we focus on our COVID-19 efforts (agenda, below). Please also raise any other issues.

Ernie

COVID-19

Governor's Executive Order 2020-16 "Increasing Hospital Capacity for COVID-19 Preparedness" (Mar. 26)
https://azgovernor.gov/governor/news/2020/03/governor-ducey-issues-executive-order-ensure-hospital-preparedness

Increase bed capacity by 50% by April 24

News Release: Governor Ducey Requests Special Health Care Enrollment Period (Mar. 25)

https://azgovernor.gov/governor/news/2020/03/governor-ducey-requests-special-health-care-enrollment-period

Request to HHS for SEP – for loss of job (even if no job based coverage?); decrease in income; paperwork and red tape.

Governor's Executive Order 2020-15 "Expansion of Telemedicine" (Mar. 25) https://insurance.az.gov/sites/default/files/documents/files/eo_2020-15_expansion_of_telemedicine.pdf
News Release: Governor Ducey Takes Step To Free Up More Physicians To Address COVID-19 (Mar. 24)

Request to CMS to exempt CRNAs from physician supervision

Governor's Executive Order 2020-13 "Enhanced Surveillance Advisory" (Mar. 23)
https://azgovernor.gov/governor/news/2020/03/governor-ducey-issues-executive-order-accelerate-tracking-covid-19

Governor's Executive Order 2020-10 "Delaying Elective Surgeries to Conserve Personal Protective Equipment Necessary to Test and Treat Patients with COVID-19" (Mar. 19) https://azgovernor.gov/file/34242/download?token=l3JvjX7I

Governor's Executive Order 2020-07 "Proactive Measures to Protect Against COVID-19" (Mar. 11) https://insurance.az.gov/governors-executive-order-2020-07-proactive-measures-protect-against-covid-19

All insurers to cover COVID-19 testing regardless of whether the lab is in-network; waive all cost sharing; cover telemedicine visits at lower cost sharing. (short term and other limited benefit plan? Self-insured?)

Governor's Declaration of Emergency (Mar. 11) https://azgovernor.gov/governor/news/2020/03/governor-ducey-statement-national-emergency-declaration

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Availability of testing kits; sites (Banner drive-thru?)

Push back from Issuers about waiving cost sharing?
Adoption of telehealth?
Relaxing grace period, not terminating for non-payment?
Relaxing prior authorization, utilization management?
Increasing hospital and physician capacity?
Procuring supplies

CMS / CCIIO Coronavirus Disease 2019 (COVID-19) Guidance https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#COVID-19

FAQs

- March 5, 2020
  Information Related to COVID–19 Individual and Small Group Market Insurance Coverage (PDF)
- March 12, 2020
  FAQs on Essential Health Benefits Coverage and the Coronavirus (COVID-19) (PDF)
- March 18, 2020
  FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19) (PDF)
- March 24, 2020
  FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19) (PDF)
- March 24, 2020
  Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency (PDF)
- March 24, 2020
  FAQs on Prescription Drugs and the Coronavirus Disease 2019 (COVID-19) for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets (PDF)

Other announcements:

Telehealth Toolkit for General Practitioners (Mar. 23) https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations (Mar. 19)

Earlier today at the White House Task Force Press Briefing, the Centers for Medicare & Medicaid Services (CMS) announced that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the 2019 Novel Coronavirus (COVID-19) outbreak.

You can find a copy of the guidance here: https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

Ernest Tai, MHS, JD / Technical Advisor / Centers for Medicare & Medicaid Services / U.S. Department of Health & Human Services /
90 7th Street, 5-300 (5W) San Francisco, CA 94103-6708 / Tele: [redacted] / Fax: [redacted] / [redacted]

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Ernest Tai has scheduled this WebEx meeting.

ADOI - CMS State Engagement Coordinator (SEC) Check-In

Host: Ernest Tai

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From: Tai, Ernest (CMS/OPOLE)
Sent: Tuesday, March 31, 2020 7:31 PM
To: Colin M. Hayashida; 'Gordon I. Ito'; 'Arlene R. Ige'; Kwok, Kalina (CMS/CCIIO); Estrada, Abraham B. (CMS/OPOLE); Daskal, Jennifer A. (CMS/OPOLE); Norris, Anthony (CMS/CCIIO); King, Devon (CMS/CMHPO)
Subject: No FFE COVID-19 SEP

Good Afternoon Commissioner and HI ID Colleagues,

At this time, we've decided not to offer a COVID-19 SEP –

> CMS's top priority is protecting the health and safety of the Americans we serve. In light of the 2019 Novel Coronavirus (COVID-19), CMS is looking closely at all of its policies and across all of its programs to see where we can strengthen the nation's response to the Coronavirus outbreak. CMS is not currently offering a Special Enrollment Period specifically designated for COVID-19. However, consumers who are not currently enrolled in coverage can see if they qualify for other Special Enrollment Periods by visiting HealthCare.gov. We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time.

Ernie

Ernest Tai, MHS, JD / Technical Advisor / Centers for Medicare & Medicaid Services / U.S. Department of Health & Human Services / 90 7th Street, 5-300 (5W) San Francisco, CA 94103-6708 / Tele: [redacted] / Fax: [redacted] / [redacted]

-----Original Appointment-----
From: Tai, Ernest (CMS/CMHPO)
Sent: Tuesday, January 7, 2020 4:54 PM
To: Tai, Ernest (CMS/OPOLE); Colin M. Hayashida; 'Gordon I. Ito'; 'Arlene R. Ige'; Kwok, Kalina (CMS/CCIIO); Estrada, Abraham B. (CMS/OPOLE); Daskal, Jennifer A. (CMS/OPOLE); Norris, Anthony (CMS/CCIIO); King, Devon (CMS/CMHPO) [redacted]
Subject: Agenda: HI Insurance Division - CMS State Engagement Coordinator (SEC) Check-In
When: Friday, March 20, 2020 12:00 PM-1:00 PM (UTC-08:00) Pacific Time (US & Canada).
Where: WebEx Online

Good Afternoon Commissioner and HI Insurance Division Colleagues, Tony and I are proposing the following agenda for our call tomorrow. Please let us know if you've additional topics to discuss / items you'd like us to research. Ernie

EHB / Mandated Benefits / Defrayal (Feb. 27, Mar. 16 calls)

COVID-19

> Emergency Proclamation for COVID-19 (Mar. 5) (through April 29). <https://governor.hawaii.gov/wp-content/uploads/2020/03/2003020-GOV-Emergency-Proclamation_COVID-19.pdf>
>
> Activate Major Disaster Fund. Emergency disaster emergency relief. Price gouging.

Supplementary Emergency Proclamation for COVID-19 (Mar. 16) (through May 15) <https://governor.hawaii.gov/wp-content/uploads/2020/03/2003109-ATG_COVID-19-Supplementary-Proclamation-signed.pdf>

Report incidence / suspected incidence of COVID-19 to DOH. Waive 1 week waiting period for unemployment insurance. Out of state physicians / nurses allowed to practice without a license.

Considering shelter-in-place / lockdown? Social distancing – ban large gatherings; close schools, restaurants and bars?
Mandating $0 cost sharing for COVID-19 testing (treatment)?

HI Dept. of Health < https://health.hawaii.gov/docd/advisories/novel-coronavirus-2019/>
22 presumptive and confirmed cases – HI, Honolulu, Kauai, Maui (as of Mar. 19)
HI DOH For healthcare providers < https://health.hawaii.gov/docd/for-healthcare-providers/news-updates/> "Patients Under Investigation" criteria.
Inform DOH; collect swab samples for State Laboratories Division.
Surveillance testing begun (Mar. 10) <https://health.hawaii.gov/news/newsroom/department-of-health-steps-up-testing-for-covid-19-about-200-tests-to-be-conducted-each-week/>

Availability of test kits? Test sites? Symptomatic patients being turned away?

Any Issuer issues / concerns?

Any updates on:

AHPs
HCSMs
O'NA Healthcare
ICHRAs
Texas Insurance Commissioner Issues Bulletin Clarifying Applicability of Texas Small and Large Employer Health Plan Requirements in Light of Recent Federal Rules Expanding Availability of HRAs (Feb. 26) <https://www.jdsupra.com/legalnews/texas-insurance-commissioner-issues-90369/>

Pending State Legislation:

First cross-over, March 5.
Hawaii lawmakers recess legislative session due to coronavirus concerns (Mar. 16) (for 8 weeks) <https://www.staradvertiser.com/2020/03/16/breaking-news/lawmakers-will-recess-legislative-session-tuesday-due-to-coronavirus-concerns/>

Individual Mandate
PBM Transparency
$100 Cap on Insulin
Other Benefit Mandates (reproductive health)

CMS Launches Groundbreaking Model to Lower Out of Pocket Expenses for Insulin
The Part D Senior Savings Model allows Medicare Part D prescription drug plans to offer beneficiaries

plan choices that provide a broad range of insulins at a $35 copay (Mar. 11)
<https://www.cms.gov/newsroom/fact-sheets/part-d-senior-savings-model>

CMS Announcements:

HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data

The U.S. Department of Health and Human Services (HHS) finalized two transformative rules that will give patients unprecedented safe, secure access to their health data. The two rules, issued by the HHS Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS), implement interoperability and patient access provisions of the bipartisan 21st Century Cures Act (Cures Act) and support President Trump's MyHealthEData initiative.

The CMS Interoperability and Patient Access final rule establishes policies that break down barriers in the nation's health system to enable better patient access to their health information, improve interoperability and unleash innovation, while reducing burden on payers and providers. Patients and their healthcare providers will have the opportunity to be more informed, which can lead to better care and improved patient outcomes, while at the same time reducing burden. In a future where data flows freely and securely between payers, providers, and patients,

To read the **full press release including ONC & CMS fact sheets** visit:
https://www.hhs.gov/about/news/2020/03/09/hhs-finalizes-historic-rules-to-provide-patients-more-control-of-their-health-data.html

Alert: CMS Publishes FAQs with Clear Information on Coverage Benefits for COVID-19
On March 13, 2020, the Centers for Medicare & Medicaid Services (CMS) released the Frequently Asked Questions (FAQs) on Essential Health Benefits (EHB) Coverage in response to the 2019 Novel Coronavirus (COVID-19) outbreak. This action is part of a broader and ongoing effort by the White House Coronavirus Task Force to ensure that all Americans – particularly the high-risk populations – have access the health benefits that can help keep them healthy while helping to contain the spread of this disease. Please access the press release here: https://www.cms.gov/newsroom/press-releases/cms-publishes-faqs-ensure-individuals-issuers-and-states-have-clear-information-coverage-benefits. The purpose of the FAQs is to provide guidance to Americans enrolled in individual or small group market health plans, including HealthCare.gov consumers. Also these FAQs include information detailing existing Federal rules governing health coverage that apply to both diagnosis and treatment of COVID-19.

- **CMS Released Draft PY2021 QHP Application Templates, Instructions, and Supporting Documents**
  CMS posted draft PY2021 QHP Application templates, instructions, and supporting documents to the QHP certification website. Issuers applying for or considering certification for QHPs, including stand-alone dental plans (SADPs), can review these materials prior to applying for PY2021 certification to participate in the Federally-facilitated Exchange (FFE).

  Draft PY2021 QHP Application templates are available on each review area's page here. Available draft templates include:
  - Essential Community Providers/Network Adequacy Template
  - Network ID Template
  - Plans and Benefits Template and Add-in file
  - Prescription Drugs Template

- Rates Table Template
- Business Rules Template
- Service Area Template
- Transparency in Coverage Template

The draft instructions provide step-by-step instructions for completing each component of the QHP Application. The full set of available instructions can be found here, while specific chapters and applicable supporting documents and justification forms can be found on each review area's page.

Please note that these draft materials are based on the Draft 2021 Letter to Issuers in the FFEs released on January 31, 2020, and are not considered final. CMS is not currently able to provide guidance on how closely these drafts may resemble the final materials. CMS will notify issuers and states once final application materials—including QHP Application templates, instructions, supporting documentation, and review tools—are available.

- **CMS Posted Updated Draft PY2021 Letter to Issuers**
  On February 14, 2020, CMS posted an updated version of the 2021 draft letter to issuers with two technical corrections. First, CMS updated the comment deadline to March 2, 2020, which is in line with the comment deadline for the notice of proposed rulemaking for the payment notice. Second, CMS noted a technical correction that, as proposed in the 2021 Payment Notice Proposed Rule, issuers offering QHPs through a State-based Exchange on the Federal Platform (SBE-FP) would be assessed a federal user fee rate of 2.5 percent of the monthly premium charged by the issuer for each policy under plans offered through an SBE-FP. CMS also noted on the CCIIO website that the document was updated for technical corrections.
- **CMS Released a Bulletin on Excepted Benefits HRAs**
  This bulletin provides guidance to applicable state authorities regarding the form and manner in which to submit a written recommendation to restrict excepted benefit health reimbursement arrangements (HRAs) from reimbursing short-term, limited-duration insurance (STLDI) premiums for certain employers in their state.
- **CMS Published the 2018 Plan Year FFE Issuer Compliance Summary Report**
  CMS conducts QHP issuer oversight and compliance monitoring activities in FFEs, including those in states performing plan management functions. This report summarizes the results from FFE compliance review activities related to plans certified for PY2018. By sharing this report, CMS can provide insights on identified areas of non-compliance in 2018 and help issuers ensure their processes, procedures, and activities comply with CMS regulations and guidance.

- **Alert: CMS Posts Guidance Extending Non-Enforcement of Affordable Care Act Compliance with Respect to Certain Policies**
  On January 31, 2020, CMS released a bulletin extending the limited non-enforcement policy through 2021. This bulletin extends the CMS policy under which CMS will not take enforcement action against certain non-grandfathered health insurance coverage in the individual and small group markets that is out of compliance with certain specified market reforms. The extended non-enforcement policy in this bulletin applies for policy years beginning on or before October 1, 2021, provided that all such coverage comes into compliance with the specified requirements by January 1, 2022.

- **Alert: CMS Publishes QHP Pharmacy Benefit Manager (PBM) Transparency Paperwork Reduction Act (PRA) Package**
  On January 28, 2020, CMS released the PBM Transparency PRA package. This PRA package would authorize CMS to collect certain prescription drug data from PBMs that manage prescription drug

coverage for Qualified Health Plans (QHPs). The PRA package is open for public comment until March 30, 2020, and is available for viewing at the Federal Register.

Ernest Tai, MHS, JD / Technical Advisor / Centers for Medicare & Medicaid Services / U.S. Department of Health & Human Services / 90 7th Street, 5-300 (5W) San Francisco, CA 94103-6708 / Tele: [redacted] / Fax: [redacted] / [redacted]

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Ernest Tai has scheduled this WebEx meeting.

Agenda: HI Insurance Division - CMS State Engagement Coordinator (SEC) Check-In
Host: Ernest Tai

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From: John Kaelin [redacted]
Sent: Tuesday, March 31, 2020 9:01 AM
To: CMS CCIIO Office of the Director; Pate, Randy (CMS/CCIIO); Anand Shukla; Daniel Martinez; Lindsey D. Peugh; Strauss, Emma (CMS/CCIIO); McLean, Rogelyn (CMS/CCIIO); Lynch, Matthew K. (CMS/CCIIO); Nelson, Peter (CMS/OA); Koltov, Michelle K. (CMS/CCIIO)
Cc: Antezana, Lourdes (CMS/CCIIO)
Subject: RE: Call with John Kaelin-Centene--materials for the call
Attachments: COVID SEPs for uninsured_03302020.docx; COVID-19 CMS and State Grace Period Guidance_CNC Markets_03252020.docx; COVID-19 Marketplace Key Issues.docx

Dear CCIIO colleagues

On behalf of our Marketplace team, we appreciate the opportunity to meet today.
Here are 3 documents, 2 of which provide our summary/understanding of what is happening “on the ground” and the third includes important policy ideas to help the market and most important the members keep coverage

John k.

-----Original Appointment-----
From: CMS CCIIO Office of the Director [redacted]
Sent: Friday, March 27, 2020 12:31 PM
To: CMS CCIIO Office of the Director; Pate, Randy (CMS/CCIIO); John Kaelin; Anand Shukla; Daniel Martinez; Lindsey D. Peugh; Strauss, Emma (CMS/OA); McLean, Rogelyn (CMS/CCIIO); Lynch, Matthew K. (CMS/CCIIO); Nelson, Peter (CMS/OA); Koltov, Michelle K. (CMS/CCIIO)
Subject: Call with John Kaelin-Centene
When: Tuesday, March 31, 2020 12:30 PM-1:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-in: 1-877-267-1577 ID: 991 009 450

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COVID-19 Special Enrollment Periods Across States
Last updated 3/30/2020

COVID SEPs Implemented in SBMs					
	Qualifying Event	Prior Coverage Required	Timing & Coverage Effective Dates	Plan Choice Limitations	Required Documentation & Other Ops/Notes
Washington (Press Release)	Uninsured	No – only uninsured individuals eligible	• SEP (3/10-4/30) • Coverage Start Date: 4/1/20	• Plan selection must be made by 4/8. • Individuals may enroll in any available QHP on-exchange	• Must contact HBE call center, and attest that they are uninsured • State has not yet announced SEP extension, but it is anticipated through end of April
Massachusetts (Press Release)	Uninsured	No – only uninsured individuals eligible	• 45-day SEP (3/11-4/25) • Coverage Start Date: 4/1/20	• Plan selection; and the first month's premium must be made by 3/23.	• No details published
Maryland (Press Release)	Uninsured	No – only uninsured individuals eligible	• SEP Enrollment: 3/16-4/15 • Coverage Start Date: 4/1/20	• No details published	• This SEP will run concurrent with the new Maryland Easy Enrollment Health Insurance Program that ends on 4/15
Nevada (Press Release)	Uninsured	No – only uninsured individuals eligible Consumers terminated due to failure to pay premiums are NOT eligible for this SEP, but could be eligible for other SEPs	• 31-day SEP (3/17-4/15) Coverage Start Dates: • 4/1/20: If enrollment completed between 3/17-4/1 • 5/1/20: If enrollment completed between 4/2-4/15	• Individuals may enroll in any available QHP on-exchange	• SEP will be processed through call center; and must attest that they are uninsured • Outreach - HIX will be conducting outreach via social media, website, and other means NV Exchange Analysis – Estimated cost to the agency for enforcement. See press release for more details. • Technology & Call-Center Changes - Estimates it will incur an estimated $30,000 in direct costs for necessary technological and call-center changes • Marketing & Advertising Costs – Estimates it will incur $357,698 in costs. • Testing & Verification of SEP – Exchange will incur $16,720 in costs related to the extension of 1 Quality Analyst through 4/30/20.
New York (Press Release)	Uninsured	No – only uninsured individuals eligible	• 30-Day: 3/16-4/15 • Coverage Start Date: 4/1/20	• Individuals may enroll in any available QHP on-exchange	• Can contact call center, apply online, or work with enrollment assistors
Rhode Island (Exchange Website; News Article)	Uninsured	No – only uninsured individuals eligible	• SEP open until 4/15 • Coverage State Date: The first of the month following the application	• No details published	• No details published
California (Press Release)	Uninsured	No – only uninsured	• 3 Month: 3/20-6/30	• Applies to on and off exchange	• Must contact call center, until online capabilities are available; and must attest that they are uninsured

		individuals eligible	• Coverage Start Date: The first of the month following plan selection		
Colorado (DOI Emergency Regulation)	Uninsured	No – only uninsured individuals eligible	• 15-day SEP (3/20-4/3) • Coverage Start Date: No later than 4/1/20, if plan selected by 4/3/20	• No details published	• Verbal attestation – individuals must attest that they are currently not enrolled in an ACA-compliant health plan
Connecticut (FAQs)	Uninsured	No – only uninsured individuals eligible	• SEP (3/19-4/2) • Coverage Start Date: 4/1/20	• No details published	• No required documentation, but consumer must attest that they are uninsured
Minnesota (Exchange Website)	Uninsured	No – only uninsured individuals eligible	• SEP (3/23-4/21) • Coverage Start Date: 4/1/20	• No details published	• No details published
Vermont (Exchange Website)	Uninsured	No – only uninsured individuals eligible	• SEP (3/27-4/17)	• No details published	• No details published

Updated 3/30/2020

Grace Period Activity across Centene Markets in Response to COVID-19 Emergency

CMS (link)	• CMS is providing Qualified Health Plans (QHPs) and Stand-alone Dental Plan issuers on the Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal Platform (SBE-FPs) the flexibility to protect the health and safety of new and existing enrollees during the COVID-19 national emergency. • CMS will exercise enforcement discretion for FFE and SBE-FP issuers that, in connection with the COVID-19 emergency, extend premium payment and binder payment deadlines, and delay cancellations or terminations of coverage for non-payment of premiums, with the permission of the applicable state regulatory authority. o This includes both individuals receiving APTC, and those not receiving APTC. o CMS encourages State-based Exchanges to take a similar approach. o The enforcement policy allows issuers to extend payment deadlines and delay the beginning of any applicable grace period. • However, once a grace period is triggered, the same basic requirements applicable to the grace period remain unchanged. This includes, in the case of individuals receiving APTC, the requirement for issuers to return APTC for the second and third months of an exhausted grace period if the grace period expires and there is a termination for non-payment.
Arizona	• No guidance issued at this time
Arkansas (link)	• DOI issued 60-day moratorium on cancellation of coverage for non-payment of premium • This only applies to individuals with a COVID-19 diagnosis and for individuals terminated, laid off, or who are self-employed or an independent contractor and have experienced a cessation of work (issuer may request evidence) • Extension must be requested by impacted consumer • Impacted consumers are still required to pay back premium
California (link)	• CDI requested issuers provide members with at least a 60-day premium payment grace period • On 3/25, Covered CA announced it will not be giving grace period guidance for now. Instead, they are going to survey the carriers on how we plan to handle grace periods • There is no guidance from DMHC at this time.
Florida (link)	• Insurers are encouraged to be flexible with premium payments in order to avoid lapses in coverage. Such flexibility includes relaxing due dates, extending grace or reinstatement periods, waiving late fees and penalties, and allowing payment plans • Insurers are encouraged to consider cancellation only if all possible efforts to work with consumers to continue coverage have been exhausted
Georgia (link)	• DOI Directive prohibits insurers from cancelling coverage due to nonpayment
Illinois	• No guidance issued at this time, but likely forthcoming
Indiana (link)	• Issuers are requested to institute a 60-day moratorium on policy cancellations for non-payment of premiums for any premium payment due from March 19 to May 18, 2020 • This does not suspend a policyholder's obligation to make payment
Kansas (link)	• The Commissioner of Insurance does not have the authority to mandate a moratorium on policy cancellations due to non-payment of premium • Consumers are encouraged to work directly with their insurer to explore options on payment plans, extended grace periods, etc.
Michigan	• No guidance issued at this time

Mississippi ([link])	• The DOI issued a 60 day moratorium on the cancellation/non-renewal of policies for the non-payment of premiums, effective March 24, 2020 • Insurers are directed to work with impacted policyholders in paying the premiums that become due during the moratorium period by either allowing a payment plan or a further extension of the due date for the amount in full
Missouri ([link])	• DOI strongly encourages insurers to extend a grace period of at least 60 days for coverage where premium charges are unpaid • Insurers are strongly encouraged to accept liability for valid claims incurred prior to the end of the grace period, if appropriate premiums are received by the insurer during the grace period • Insurers must notify the DOI how they will implement this change, including claims processing and provider communications
North Carolina ([link])	• Insurers are required to give members the option of a 30-day premium deferment period • DOI may extend the deferral period • After the deferral period has expired, all payments must be paid to issuer • The DOI is urging insurers to consider relaxing due dates for premium payments, extending grace periods, waiving late fees and penalties, and allowing payment plans for premium payments • Insurers should only consider cancellation or non-renewal of policies after exhausting other efforts to work with policyholders to continue coverage
New Hampshire	• No guidance issued at this time
Nevada	• No guidance issued at this time
New York ([link])	• All insurers are urged to offer payment accommodations (allowing consumers to defer payments, extending payment due dates, waiving late or reinstatement fees) and work to avoid cancellations/non-renewals
Ohio ([link])	• Issuers are to give members the option of deferring upcoming premium payments, interest free, for up to 60 calendar days from each original premium due date. The Superintendent will not take enforcement action with respect to filed forms and rates against insurers that adjust their policies and practices to provide the flexibility required by this bulletin
Oregon ([link])	• Insurers must take the following steps until the temporary emergency order, which will be in force through at least April 23, is no longer in effect: institute a grace period for premium payments on all insurance policies issued in the state; suspend all cancellations and non-renewals for active insurance policies; and extend all deadlines for consumers to report claims and communicate about claims
Pennsylvania ([link])	• The DOI suggests insurers consider relaxing due dates for premiums payments, extending grace periods, waiving late fees and penalties, and allowing payment plans for premium payments to otherwise avoid a lapse in coverage • Insurers should consider cancellation or non-renewal of policies only after exhausting other efforts to work with policyholders to continue coverage
South Carolina ([link])	• The DOI expects insurers to work with consumers to provide relief from certain insurance requirements. Relief may include, but is not limited to, extension of premium payment deadlines, additional time before non-renewals or cancellations become effective, and waiver of fees, penalties, or other charges related to an inability to submit premium payments as a result of the pandemic • Any extension or relief offered to consumers will not be considered unfairly discriminatory if it is focused on providing additional consumer protections and is consistently applied to all insureds that are similarly impacted
Tennessee ([link])	• The DOI requests that insurers provide individuals with as much flexibility as practicable during the period of the COVID 19 public health crisis, which includes explaining existing applicable

	grace periods and exploring ways to eliminate late fees, non-sufficient fund fees, and installment fees • Insurers are also encouraged to work with individuals to find the best ways to address concerns with the timing of premium payments in order to delay any cancellation of coverage for non-payment and collection activity
Texas (link)	• TDI expects all insurers to work with policyholders who may experience financial hardships due to the COVID-19 outbreak. TDI encourages insurers to use grace periods for payments, temporary suspension of premium payments, payment plans, and other actions to allow continuing insurance coverage as appropriate • TDI is extending claims-handling deadlines by 15 days to help insurers respond to the outbreak
Washington (link)	• Insurers must allow a premium grace period of no fewer than 60 days for all individual and group health plans, other than QHPs purchased by individuals receiving an APTC through the Health Benefit Exchange (the ACA-required 90-day grace period applies to these individuals) • If an insurer chooses to allow a grace period longer than 60 days, it must be applied uniformly to all health plans and to all enrollees within any given health plan • Any communication to enrollees during the grace period must clearly state the insurers' obligations during the grace period, and the enrollee's obligation to pay back premiums or potentially be subject to billing from health care providers for unpaid claims

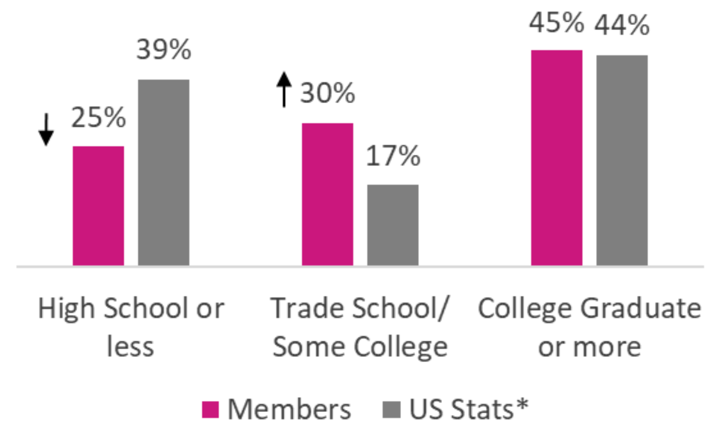
Marketplace

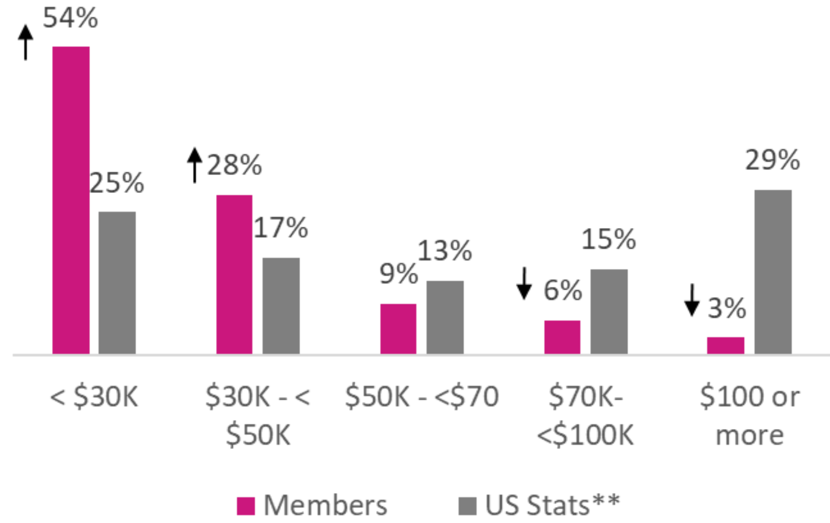
COVID-19: Cause, Effect & Intervention

Cause	Effect	Intervention
Prognosis of Recovery Faces High Degree of Uncertainty	1) Multi-year, high rate increases – resulting in higher APTC outlay – to reflect the wide-ranging uncertainties regarding nature and length of economic and health recovery, and risk of adverse selection 2) Issuer pullback / exits to avoid volatile environment 3) Significant destabilization of Marketplace and health care delivery system with long-lasting ramifications	a) Provide enhance protection of federal reinsurance program for 2020-21 (e.g. 2014 transitional reinsurance structure) b) Increase federal funding to provide higher APTC support to ensure coverage & prevent adverse selection c) Emphasize the need for health insurance and triage to Medicaid / Marketplace SEP enrollment during the unemployment filing process
Rapidly Increasing Un/Under Employment	4) Widespread economic hardship and uncertainty 5) High lapses caused by inability to pay monthly premiums 6) Significant rise in uninsured in midst of Pandemic, further exacerbating the precarious economic situation of millions of Americans 7) Adverse Selection by existing enrollees and SEP enrollees: sicker population prioritizing health insurance, while healthier people lapsing 8) Need for dependable, comprehensive health insurance coverage, more critical than ever	d) Stop administrative APTC reconciliation and termination activities during the national emergency (e.g., termination of APTC due to failure to submit DMI documentation) e) Allow issuers to provide payment flexibility to prevent members from entering a Grace Period – with guarantee to receive and retain APTC – to ensure members can maintain coverage and access to services f) For consumers in a grace period, ensure financial relief to prevent coverage lapses as consumers recover from economic impacts of COVID g) Issuers extending full coverage for COVID-19 screening and testing with no member cost sharing and removal of Prior authorization
Intense Focus on COVID-19 Operational Readiness	9) Hospitals and providers are overwhelmed with influx of patients 10) Administrative processes conducted by non-essential personnel on hold (e.g. RADV, chart reviews, etc.) 11) Patients asked to delay office visits, elective services and adhere to strict social distancing protocols 12) Issuers redirecting resources to focus on changing processes and operational workflows to prepare for COVID services	h) Work with industry to implement administrative changes to risk adjustment, RADV, and MLR to provide relief to providers and issuers during this unprecedented national healthcare emergency

Exhibit 1:

Socioeconomic Status





*US Census Bureau 2018
**US Census Bureau 2017

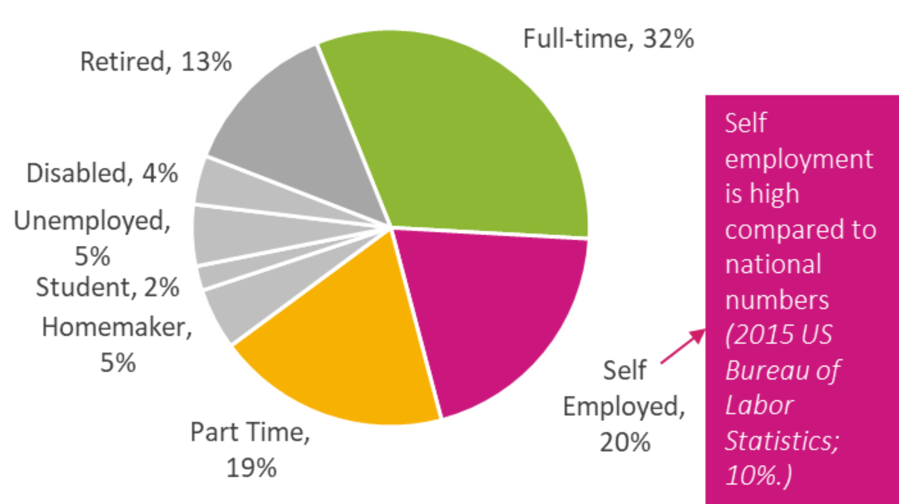


Exhibit 2:

Using 2019 PUF File, estimated incremental funding of **$8B is required to pay the remaining member share for all members, for the remainder of the year**.

- APTCs cover around 83% of premiums and cost around $5.1B per month
- Covering the remaining 17% of member portion of premium for the next 9 months will cost about $8B

Platform	Total Enrolled	Consumers with APTC	Average APTC	Average remaining Premium	Monthly Cost of APTC	Monthly Cost of Remaining Premium	% member share of premium	Pay through year end (9 months)
HC.gov	7,982,951	6,984,300	$544	$85	$3,797,807,103	$596,143,363	16%	$5,365,290,271
SBE-FPs	428,663	340,911	$441	$122	$150,420,593	$41,606,647	28%	$374,459,827
SBE	3,032,527	2,385,324	$492*	$104*	$1,174,765,776	$247,358,407	21%	$2,226,225,665
Total	**11,444,141**	**9,710,535**			**$5,122,993,472**	**$885,108,418**	**17%**	**$7,965,975,763**

**Estimated using average of HC.gov and SBE FPs*

HOUSE COMMITTEE ON
ENERGY AND COMMERCE

SUBCOMMITTEE ON ENERGY
SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON COMMUNICATIONS
AND TECHNOLOGY

KURT SCHRADER
FIFTH DISTRICT, OREGON

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202-225-5711
FAX: 202-225-5699

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621 HIGH STREET
OREGON CITY, OR 97045
503-557-1324
FAX: 503-557-1981

The 116th Congress
U.S. House of Representatives
Washington, DC 20515

March 31, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma,

We write in support of Oregon Governor Kate Brown's request for a special enrollment period (SEP) so that Oregonians may sign up for health insurance. Oregon now has more than 600 confirmed cases of COVID-19, a case number that has more than doubled since the Governor submitted her request last week. Nearly all states that run their own health insurance exchanges have opened a SEP; this should be an opportunity available to states who rely on the federal health exchange as well. In the face of such an unprecedented outbreak, Oregonians should be able to sign up for health insurance and access health care.

Oregonians are under orders to stay home and non-essential business has been directed to cease operations. Many Oregonians rely on their employers for health insurance and with small businesses being forced to close their doors, many folks are losing their health care coverage. In the first week of implementing social distancing measures, Oregon saw 76,000 unemployment insurance claims. Oregonians who lose their jobs meet the existing guidelines for a qualifying life event that would open an SEP. However, a broad SEP will ensure that all Oregonians facing far different circumstances than they could have predicted during the 2020 open enrollment period this past November, have an opportunity to adjust their health care coverage accordingly.

Oregonians who are uninsured and underinsured should be given the opportunity to obtain or improve coverage. For example, Congress has supported expanding access to no-cost testing for COVID-19, but short-term limited duration plans, which this Administration has expanded, are not subject to these rules. Testing and care for the uninsured remains a concern on overstrained health care systems.

The continued rapid spread of COVID-19 remains a serious threat to the health and economic livelihood of all Americans. Allowing a SEP so that Oregonians can access health care may be a question of life or death. A SEP would provide greater certainty in the health care marketplace by moving more people into health care coverage that will prevent graver long term financial consequences for everyone.

We appreciate your timely consideration and attention to Governor Brown's request to open an SEP as we work to ensure access to health care during this unprecedented outbreak. We look forward to working with you to ensure that we implement measures that will help address the COVID-19 pandemic.

Sincerely,

KURT SCHRADER
Member of Congress

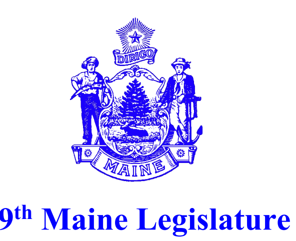
RON WYDEN
U.S. Senator

JEFFREY A. MERKLEY
U.S. Senator

PETER DeFAZIO
Member of Congress

EARL BLUMENAUER
Member of Congress

SUZANNE BONAMICI
Member of Congress



Troy D. Jackson
President of the Senate

129th Maine Legislature

Sara Gideon
Speaker of the House

April 1, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

As the novel coronavirus disease 2019 (COVID-19) spreads throughout Maine and the country, we write to you to express our concern regarding access to affordable health care. Maine, like 37 other states, offers Affordable Care Act-qualified health coverage to individuals only during enrollment periods available through the federal health care marketplace. As we encourage Mainers to stay healthy, seek preventative care, and respond quickly to any symptoms of COVID-19 to stop its spread, we ask that the Department of Health and Human Services and the Centers for Medicare and Medicaid Services work to establish a special enrollment period for qualified health plans offered through healthcare.gov so everyone can access quality health care without fear of the cost.

Despite recently expanding Maine's Medicaid program, approximately 105,000 Maine residents remain uninsured. This includes approximately 51,000 lower-income individuals who may qualify for subsidies to make health coverage affordable. The uninsured population likely also includes many younger, healthier individuals who may have chosen not to obtain coverage or who have insufficient coverage through a limited benefit short term health plan. Unfortunately, young and healthy individuals are contracting COVID-19 at alarming rates; we should be doing everything we can to encourage these individuals and all Mainers to seek care before symptoms of this disease or other health conditions become too severe for our scarce health care resources to accommodate.

The COVID-19 pandemic is wreaking havoc on the Maine economy while we close businesses, public spaces, and otherwise implement social distancing measures to keep people safe and healthy. Please help us minimize the impacts on our economy and our health by giving our residents the opportunity to access health care and contain the spread of COVID-19 without fear of incurring medical bills they can least afford at this difficult time.

Thank you for your consideration of this urgent matter. We strongly urge you to reconsider your recent decision not to reopen enrollment and look forward to your response.

Sincerely,

Sen. Troy Jackson
Senate President

Rep. Sara Gideon
Speaker of the House

Sen. Nate Libby
Senate Majority Leader

Rep. Matt Moonen
House Majority Leader

Sen. Eloise Vitelli
Senate Asst. Majority Leader

Rep. Ryan Fecteau
House Asst. Majority Leader

Sen. Shenna Bellows
Sen. Cathy Breen
Sen. Michael Carpenter
Sen. Brownie Carson
Sen. Justin Chenette
Sen. Ben Chipman
Sen. Ned Claxton
Sen. Bill Diamond
Sen. Susan Deschambault
Sen. Jim Dill
Sen. Geoffrey Gratiwck
Sen. Erin Herbig
Sen. Mark Lawrence
Sen. Louis Luchini
Sen. Rebecca Millett
Sen. David Miramant
Sen. Heather Sanborn
Sen. Linda Sanborn
Rep. Robert Alley
Rep. Betty Austin
Rep. Chris Babbidge
Rep. Shawn Babine
Rep. Donna Bailey
Rep. Pinny Beebe-Center
Rep. Seth Berry
Rep. Lydia Blume
Rep. Michael Brennan
Rep. Mark Bryant
Rep. Chris Caiazzo
Rep. Anne Carney
Rep. Kristen Cloutier
Rep. Ben Collings
Rep. Janice Cooper
Rep. Margaret Craven
Rep. Ed Crockett
Rep. Scott Cuddy
Rep. Mattie Daughtry
Rep. Diane Denk
Rep. Mick Devin
Rep. Jan Dodge
Rep. Donna Doore
Rep. Vicki Doudera
Rep. Dick Farnsworth
Rep. Jess Fay
Rep. Victoria Foley
Rep. Drew Gattine
Rep. Lori Gramlich
Rep. Nicole Grohoski
Rep. Jim Handy
Rep. Thom Harnett
Rep. Allison Hepler
Rep. Craig Hickman
Rep. Dan Hobbs
Rep. Brian Hubbell
Rep. Patty Hymanson
Rep. Henry Ingwersen
Rep. Chris Kessler
Rep. Tori Kornfield
Rep. Scott Landry
Rep. Colleen Madigan
Rep. John Martin
Rep. Danny Martin
Rep. Anne-Marie Mastraccio
Rep. Ann Matlack
Rep. Chloe Maxmin
Rep. Dave McCrea
Rep. Jay McCreight
Rep. Genevieve McDonald
Rep. Gina Melaragno
Rep. Victoria Morales
Rep. Steve Moriarty
Rep. Catherine Nadeau
Rep. Kevin O'Connell
Rep. Maggie O'Neil
Rep. Sean Paulhus
Rep. Sarah Pebworth
Rep. Anne Perry
Rep. Joe Perry
Rep. Lois Reckitt
Rep. Tina Riley
Rep. Tiffany Roberts
Rep. Deane Rykerson
Rep. John Schneck
Rep. Bettyann Sheats
Rep. Steve Stanley
Rep. Holly Stover
Rep. Rachel Talbot Ross
Rep. Denise Tepler
Rep. Ryan Tipping
Rep. Ralph Tucker
Rep. Charlotte Warren
Rep. Bruce White

From: Robin Walker
To: Robin Walker
Subject: FGA Praises Trump Administration Decision to Not Re-Open ACA Exchanges
Date: Wednesday, April 1, 2020 9:10:23 AM

FOR IMMEDIATE RELEASE
April 1, 2020

MEDIA CONTACT
James Scimecca

FGA Praises Trump Administration Decision to Not Re-Open ACA Exchanges

Naples, FL — Following a White House decision to reject a special Obamacare enrollment period, the Foundation for Government Accountability released the following statement.

"We applaud the Trump administration's decision not to open ObamaCare enrollment —despite tremendous pressure. That is why special enrollment periods, other public programs, and affordable options exist for anyone losing coverage due to layoffs during this difficult time," said Robin Walker, senior director of federal affairs at FGA. "Anyone who loses their job due to layoffs during this unprecedented moment in history will already be eligible for a special enrollment period, and may have access to more affordable options."

###

The Foundation for Government Accountability is a non-profit, multi-state think tank that specializes in health care, welfare, and work reform. To learn more, visit TheFGA.org

If you would rather not receive future communications from Foundation for Government Accountability, let us know by clickinghere.
Foundation for Government Accountability, 15275 Collier Boulevard Suite 201-279, Naples, FL 34119 United States

0944

ABBY FINKENAUER
1ST DISTRICT, IOWA

124 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2911

Congress of the United States
House of Representatives
Washington, DC 20515-4606

April 1, 2020

Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar:

I am writing to express my disappointment with the Trump Administration's decision on March 31st not to establish a special enrollment period for health insurance plans offered through exchanges created by the Affordable Care Act. I understand that the Administration considered offering a special enrollment period, and I strongly urge reconsideration of your final decision.

There are few times more urgent than a public health crisis to allow individuals to get covered and choose health insurance plans that best reflect their needs. As coronavirus continues to spread, insurance status should not stand in the way of people getting care and a special enrollment period is one way to extend coverage. Several states have already established special enrollment periods and taking this step will allow the 32 states with federally facilitated exchanges, including my home state of Iowa, to do the same.

Opening the exchanges could provide a lifeline to Iowans who cannot obtain insurance through their employer, have lost their jobs, or want the peace of mind that comes with comprehensive health insurance coverage. Swift action will provide certainty to these families and help protect public health in Iowa.

I look forward to hearing from you about this matter and ask that you reach out to Max Ernst (max.ernst@mail.house.gov) in my office with any questions.

Sincerely,

Abby Finkenauer
Member of Congress

From: Handelman, Justine
To: Parker, Jim (HHS/IOS)
Cc: Serota, Scott; Vachon, Jennifer; Cerisano, John
Subject: Follow-up from Scott"s Call with Secretary
Date: Thursday, April 2, 2020 1:27:21 PM
Attachments: image003.png
AHIP-BCBSA COVID Stability Package 031920.pdf

Hey Jim – Hope you continue to do well. Thanks for your help in arranging the call with the Secretary for Scott. We assume you were on the line and heard the Secretary asked if we had anything in writing on the need for the SEP to be tied to risk mitigation. Attached are the recommendations we and AHIP-BCBSA shared in mid-March. Key points are below. If you need anything else, let us know. Also, who should we share our release with when ready on an embargoed basis per the Secretary wanting to ensure he had in order to do his own statement? Thanks again for all your help! Justine

CMS should allow a one-time special enrollment period (SEP) for the individual market. This SEP should be time limited (30 days) with a prospective effective date(s) on the first of the month. The SEP should be available to all persons who are not eligible for Medicare or Medicaid. Given the uncertainty about the cost of treating those who would enroll through an SEP, this option should be coupled with risk mitigation funding as outlined above.

Justine Handelman
Senior Vice President
Office of Policy and Representation
Blue Cross Blue Shield Association
1310 G St, NW | Washington, DC 20005
O: [redacted] | **M:** [redacted]
Executive Assistant: Nikki Shedrick
E: [redacted] | **P:** [redacted]

From: Bash, Robyn [redacted]
Sent: Friday, April 3, 2020 8:47 PM
To: Parker, Jim (HHS/IOS)
Subject: AHA STATEMENT ON THE USE OF THE CARES ACT

Hi Jim,

Wanted to share our statement with you.

Best,
Robyn

Contact: Colin Milligan, [redacted], [redacted]
Marie Johnson, [redacted], [redacted]

AHA STATEMENT ON THE USE OF THE CARES ACT

Rick Pollack
President and CEO
American Hospital Association

April 3, 2020

Nobody has been a stronger advocate for covering the uninsured than America's hospitals and health systems, particularly during a public health emergency. That's why we have encouraged the Administration to look at various options to provide coverage for treatment of the uninsured for the Coronavirus other than utilizing the emergency fund from the CARES Act. This could include opening up a special enrollment period for the Affordable Care Act's marketplaces, expanding Medicaid and using the National Disaster Medical System or other federal emergency programs, among other ideas. Hospitals and health systems also support the proposals from members of Congress for a new, separate fund to specifically address the costs associated with treatment of the uninsured.

The emergency relief fund in the CARES Act was intended to provide hospitals with an infusion of emergency relief as providers incur substantial expenses in preparing and dealing with fighting this battle against COVID-19. At the same time, given that virtually all regular operations have come to a halt--such as elective or scheduled procedures--

there are limited revenues coming in, causing major cash flow concerns that threaten the viability of hospitals. This is also creating a historic financial crisis, threatening the ability to keep our doors open for both the insured and uninsured alike.

Because hospitals and health systems, and our dedicated caregivers, are on the front lines of this pandemic, we continue to urge the release of the CARES Act emergency relief funds as soon as possible. This critical funding will help ensure that our health care providers can continue to be there for everyone and have the support and resources that are needed to deliver care to their patients and communities.

###

Congress of the United States
Washington, DC 20515

April 3, 2020

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Verma,

Due to the widespread disruption in the lives and livelihoods of Americans during the COVID-19 outbreak, we request that the Centers for Medicare and Medicaid Services (CMS) allow Americans to enroll in Medicare coverage or coverage through HealthCare.gov during a special enrollment period (SEP).

Most people who are eligible for Medicare coverage are at high risk of serious illness and death from the virus because of their age or underlying health conditions, but the ability to enroll in Medicare has been severely impeded because of the outbreak. Additionally, a record number of Americans are currently seeking unemployment insurance after losing their jobs and their employer-sponsor health insurance. During this public health emergency, your agency must make enrolling in health coverage as fast and easy as possible so that all Americans can access COVID-19 testing and treatment.

For eligible Medicare enrollees, on March 17, 2020,[1] the Social Security Administration closed Social Security offices to the public, and Social Security staff are only processing "dire need" requests, which does not include Medicare applications, despite the General Enrollment Period (GEP) ending on March 31st. The public is instead being told to contact Social Security's 1-800 number for other issues, adding a barrier to enrollment by the deadline.

Eleven states and the District of Columbia have already announced special enrollment periods for their health insurance Marketplaces due to the COVID-19 outbreak.[2] Today, 38 states rely on the federal government and need CMS to declare a special enrollment period so individuals can enroll in coverage through HealthCare.gov. As more Americans lose their employer-sponsored health insurance and face serious economic insecurity, they would benefit immensely from enrolling in low-cost, high quality Marketplace coverage. While the Administration has indicated that it will not reopen the site for a special enrollment period,[3] that decision contradicts CMS's previous efforts to offer special enrollment periods during natural disasters. It is imperative that CMS allow

[1] https://www.ssa.gov/news/press/releases/2020/#3-2020-2
[2] California, Colorado, Connecticut, District of Columbia, Maryland, Massachusetts, Minnesota, Nevada, New York, Rhode Island, Vermont, and Washington have announced special enrollment periods for COVID-19.
[3] https://www.politico.com/news/2020/04/01/trump-obamacare-coronavirus-160732

American families the fast and easy opportunity to enroll in affordable coverage during a special enrollment period.

To ensure that all Americans have the time and opportunity to enroll in health insurance, I urge you to do the following:

1. **Extend the Medicare General Enrollment Period.** The Medicare GEP ended on March 31st. Because of the circumstances of the outbreak, many individuals who need to enroll in Medicare were not able to do so by the March 31st enrollment deadline. CMS should extend the GEP until after the end of a federal or state emergency declaration with respect to COVID-19.

2. **Offer a special enrollment period on HealthCare.gov.** Uninsured Americans need to have the streamlined option of a special enrollment period to access the plans offered on HealthCare.gov during this public health emergency. CMS should immediately offer a special enrollment period to allow Americans to enroll in high quality, low cost insurance coverage.

We urgently request that you do everything within your authority to extend enrollment periods for Medicare and HealthCare.gov so every American, regardless of age and employment status, can have access to health insurance during this public health emergency.

Most gratefully,

Anna G. Eshoo
Chairwoman
Subcommittee on Health

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce

Nanette Diaz Barragán
Member of Congress

Ben Ray Luján
Member of Congress

Ann McLane Kuster
Member of Congress

Darren Soto
Member of Congress

Paul D. Tonko
Member of Congress

G. K. Butterfield
Member of Congress

Yvette D. Clarke
Member of Congress

Jerry McNerney
Member of Congress

Dave Loebsack
Member of Congress

Jan Schakowsky
Member of Congress

Doris Matsui
Member of Congress

Bobby L. Rush
Member of Congress

Peter Welch
Member of Congress

Debbie Dingell
Member of Congress

Joseph P. Kennedy, III
Member of Congress

Lisa Blunt Rochester
Member of Congress

Robin Kelly
Member of Congress

Eliot L. Engel
Member of Congress

Kurt Schrader
Member of Congress

Diana DeGette
Member of Congress

Mike Doyle
Member of Congress

Kathy Castor
Member of Congress

A. Donald McEachin
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Scott H. Peters
Member of Congress

John P. Sarbanes
Member of Congress

Tom O'Halleran
Member of Congress

Tony Cárdenas
Member of Congress

Marc Veasey
Member of Congress

Congress of the United States
Washington, DC 20515

April 03, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

We write to you today with grave concerns regarding your administration's recent decision not to reopen the state-level health insurance exchanges run by the federal government. Yesterday, the Labor Department reported that unemployment claims soared to a record 6.6 million due to the COVID-19 public health crisis and ensuing economic fallout. With growing fears that people will be uninsured during the coronavirus outbreak, we urge you to allow individuals who are at-risk for COVID-19 to access affordable health care options through the health insurance marketplaces with a special enrollment period.

According to the U.S. Census Bureau, in 2017 the number of people without health insurance increased to 28.0 million, up from 27.3 million the year before. Of that number, about 1 in 3 uninsured workers were in service occupations. Despite individuals qualifying for a special enrollment period for losing job-based coverage, 1 in 3 Americans will remain uninsured.[1] Given the crisis at hand, CMS should authorize an emergency special enrollment period to ensure that all Americans have access to affordable health insurance that will cover needed health care services for testing and treatment, especially now.

The federal government has opened special enrollment periods in the past during previous declared major disasters or emergencies, claiming exceptional circumstances.[2] On January 31, 2020, Secretary Azar declared a nationwide public health emergency under Section 319 of the Public Health Service Act. As of Friday afternoon, more than 258,000 people in the United

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[1] United States Census Bureau. September 12, 2018. *Most Uninsured Were Working-Age Adults.* Retrieved from: https://www.census.gov/library/stories/2018/09/who-are-the-uninsured.html
[2] U.S. Centers for Medicare & Medicaid Service. April 2, 2020. *Special Enrollment Periods for complex issues.* Retrieved from: https://www.healthcare.gov/sep-list/

States have been infected, and at least 6,593 have died—the COVID-19 pandemic should be considered an exceptional circumstance.[3]

Medical costs are already a common concern in the U.S., particularly for people without insurance. The Kaiser foundation projects that the cost of inpatient admissions for COVID-19 treatment could top $20,000[4]. This is an unprecedent financial constraint that could prevent millions of people from seeing doctors to get tested or treated. We urge HHS and CMS to establish a special enrollment period for the coronavirus and rightfully extend the opportunity for millions of uninsured Americans to newly seek out coverage.

Thank you for your attention to this critical issue and we look forward to your response.

Nydia M. Velázquez
Member of Congress

Rosa L. DeLauro
Member of Congress

/s/ Jackie Speier
Member of Congress

/s/ Bobby L. Rush
Member of Congress

/s/ Tim Ryan
Member of Congress

/s/ Gwen Moore
Member of Congress

/s/ Juan Vargas
Member of Congress

/s/ John B. Larson
Member of Congress

/s/ Bonnie Watson Coleman
Member of Congress

/s/ Steve Cohen
Member of Congress

/s/ Jim Cooper
Member of Congress

/s/ Ayanna Pressley
Member of Congress

/s/ Terri A. Sewell
Member of Congress

/s/ Yvette D. Clarke
Member of Congress

/s/ Peter A. DeFazio
Member of Congress

/s/ Adriano Espaillat
Member of Congress

---

[3] Hernandez, Sergio; O'Key, Sean' Watts, Amanda; Manley, Byron; Pettersson, Henrik. April 2, 2020. *Tracking Covid-19 cases in the United States*. Retrieved from: https://www.cnn.com/interactive/2020/health/coronavirus-us-maps-and-cases/

[4] Rae, Matthew; Claxton, Gary; Kurani, Nisha; McDermott, Daniel; Cox, Cynthia. The Peterson Center on Healthcare and KFF (Kaiser Family Foundation). March 13, 2020. *Potential costs of coronavirus treatment for people with employer coverage.* Retrieved from: https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/

/s/ Jerrold Nadler
Member of Congress

/s/ Chris Pappas
Member of Congress

/s/ Eddie Bernice Johnson
Member of Congress

/s/ Donna E. Shalala
Member of Congress

/s/ Sheila Jackson Lee
Member of Congress

/s/ Debbie Wasserman Schultz
Member of Congress

/s/ Jim Himes
Member of Congress

/s/ Jared Huffman
Member of Congress

/s/ Cheri Bustos
Member of Congress

/s/ Frederica S. Wilson
Member of Congress

/s/ David Trone
Member of Congress

/s/ Suzanne Bonamici
Member of Congress

/s/ Harley Rouda
Member of Congress

/s/ Grace Meng
Member of Congress

/s/ Grace F. Napolitano
Member of Congress

/s/ Dina Titus
Member of Congress

/s/ Brenda L. Lawrence
Member of Congress

/s/ Marcia L. Fudge
Member of Congress

/s/ Joyce Beatty
Member of Congress

/s/ Bradley S. Schneider
Member of Congress

/s/ David N. Cicilline
Member of Congress

/s/ Judy Chu
Member of Congress

/s/ Jahana Hayes
Member of Congress

/s/ Linda T. Sánchez
Member of Congress

/s/ Darren Soto
Member of Congress

/s/ Abigail D. Spanberger
Member of Congress

/s/ Bennie G. Thompson
Member of Congress

/s/ Adam B. Schiff
Member of Congress

/s/ Daniel T. Kildee
Member of Congress

/s/ Alan Lowenthal
Member of Congress

/s/ Albio Sires
Member of Congress

/s/ James P. McGovern
Member of Congress

/s/ Chellie Pingree
Member of Congress

/s/ Donald M. Payne, Jr.
Member of Congress

/s/ Tony Cárdenas
Member of Congress

/s/ Ann Kirkpatrick
Member of Congress

/s/ Marcy Kaptur
Member of Congress

/s/ Jesús G. "Chuy" García
Member of Congress

/s/ José E. Serrano
Member of Congress

/s/ Joseph D. Morelle
Member of Congress

/s/ Mary Gay Scanlon
Member of Congress

/s/ Xochitl Torres Small
Member of Congress

/s/ John Yarmuth
Member of Congress

/s/ Dwight Evans
Member of Congress

/s/ David Scott
Member of Congress

/s/ Stephen F. Lynch
Member of Congress

/s/ Mark Pocan
Member of Congress

/s/ Carolyn B. Maloney
Member of Congress

/s/ Ted Deutch
Member of Congress

THE STATE OF CALIFORNIA
OFFICE OF THE ATTORNEY GENERAL

THE STATE OF NORTH CAROLINA
OFFICE OF THE ATTORNEY GENERAL

XAVIER BECERRA
ATTORNEY GENERAL

JOSH STEIN
ATTORNEY GENERAL

April 3, 2020

Secretary Alex M. Azar II
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Via Email and U.S. Mail

Administrator Seema Verma
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Via Email and U.S. Mail

RE: Opening Health Insurance Exchanges

Dear Secretary Azar and Administrator Verma:

The undersigned State Attorneys General of North Carolina, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaiʻi, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington urge the federal government to reconsider its shortsighted decision to deny a special enrollment period on HealthCare.Gov during the current international health crisis. The COVID-19 pandemic is killing people, causing economic upheaval, and stretching our nation's medical resources. Americans continue to experience the economic effects of the virus. Millions of individuals have lost their jobs—and with their jobs, their ability to pay for healthcare. We should not allow the virus to prevent sick people from obtaining treatment because they lack healthcare coverage or to face financial ruin if they seek care. People who lack health insurance are suffering the brunt of the pandemic. They work in grocery stores and food service, they drive trucks and sanitize buildings, and their jobs often do not provide sick leave.[1] Because they are uninsured, they are less likely to have a regular place to obtain healthcare and are more likely to delay obtaining care due to fears of the cost.[2] The administration has long touted choice and "informed healthcare decisions" to purportedly inform

[1] Jennifer Tolbert, "What Issues Will Uninsured People Face with Testing and Treatment for COVID-19?," Kaiser Family Foundation, Mar. 16, 2020, https://www.kff.org/uninsured/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/.

[2] *Id.*

its healthcare policies,[3] but is now denying many Americans the option of obtaining comprehensive healthcare coverage to combat this unprecedented healthcare care crisis.

While tests for the disease are free, treatment may not be.[4] And medical bills for uninsured individuals can be in the tens of thousands of dollars.[5] Therefore, the COVID-19 pandemic threatens to amplify our national problem of high medical bills, a problem the Affordable Care Act sought to address. But legal and policy solutions are easily at hand by extending the availability of healthcare coverage options through the federal exchange. Indeed, America's Health Insurance Plans (AHIP) has endorsed a special enrollment period as a measure to address the current healthcare crisis because it would give Americans the "opportunity to get the security and peace of mind that health care coverage provides."[6]

A national solution to the problem demands decisive and reasoned federal action. Some states run their own health insurance exchanges and may independently extend enrollment. For example, on March 20, 2020, Covered California announced that enrollment would be extended through the end of June to ensure that all Californians have an opportunity to obtain healthcare coverage.[7] But 38 states, including North Carolina, rely on HealthCare.Gov to run their exchanges.[8] The federal government should take similar action to make it possible for people in those states to obtain the healthcare they need during this critical time.

Under "exceptional circumstances"—a health crisis unlike any seen in the past hundred years and an economic downturn on pace to exceed the Great Recession—HealthCare.Gov is empowered to provide for a special enrollment period. 45 C.F.R. § 155.420(d)(9). We urge the

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[3] *See, e.g.,* Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," 82. Fed. Reg. 48,385 (Oct. 2, 2017).

[4] Megan Leonhardt, "Uninsured Americans could be facing nearly $75,000 in medical bills if hospitalized for coronavirus," *CNBC*, Apr. 1, 2020, https://www.cnbc.com/2020/04/01/covid-19-hospital-bills-could-cost-uninsured-americans-up-to-75000.html; Reed Abelson, "Now That Coronavirus Tests Are Free, Some Insurers Are Waiving Costs for Treatment," *New York Times*, updated Mar. 31, 2020, https://www.nytimes.com/2020/03/19/health/coronavirus-tests-bills.html.

[5] Abigail Abrams, "Total Cost of Her COVID-19 Treatment: $34,927.43," *Time*, Mar. 19, 2020, https://time.com/5806312/coronavirus-treatment-cost/.

[6] Bruce Japsen, "Calls Grow to Open Special Obamacare Sign-Up As Coronavirus Spreads," *Forbes*, Mar. 21, 2020, https://www.forbes.com/sites/brucejapsen/2020/03/21/calls-grow-to-open-special-obamacare-sign-up-as-coronavirus-spreads/#fedbb4842c8f.

[7] "California Responds to COVID-19 Emergency by Providing Path to Coverage for Millions of Californians," Covered California, Mar. 20, 2020, https://www.coveredca.com/newsroom/news-releases/2020/03/20/california-responds-to-covid-19-emergency-by-providing-path-to-coverage-for-millions-of-californians/.

[8] *See* Kaiser Family Foundation, "State Health Insurance Marketplace Types," 2020, https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

federal government to thoughtfully acknowledge the current dire circumstances by creating a special enrollment period. We must not allow a lack of insurance to prevent sick people from getting treatment or to bankrupt those who do receive care during these unprecedented times.

Sincerely,

Xavier Becerra
California Attorney General

Josh Stein
North Carolina Attorney General

Phil Weiser
Colorado Attorney General

William Tong
Connecticut Attorney General

Kathleen Jennings
Delaware Attorney General

Karl A. Racine
Attorney General for the District of Columbia

Claire E. Connors
Hawai'i Attorney General

Kwame Raoul
Illinois Attorney General

Brian E. Frosh
Maryland Attorney General

Maura T. Healey
Massachusetts Attorney General

Dana Nessel
Michigan Attorney General

Keith Ellison
Minnesota Attorney General

Aaron D. Ford
Nevada Attorney General

Hector Balderas
New Mexico Attorney General

Letitia James
New York Attorney General

Ellen F. Rosenblum
Oregon Attorney General

Josh Shapiro
Pennsylvania Attorney General

Peter F. Neronha
Rhode Island Attorney General

Thomas J. Donovan, Jr.
Vermont Attorney General

Mark R. Herring
Virginia Attorney General

Bob Ferguson
Washington Attorney General

Tom Miller
Iowa Attorney General

From: Nelson, Peter (CMS/OA)
Sent: Friday, April 3, 2020 11:15 AM
To: Strauss, Emma (CMS/CCIIO); Pate, Randy (CMS/CCIIO)
Cc: Koltov, Michelle K. (CMS/CCIIO); Wilson, Lisa J. (CMS/CCIIO)
Subject: RE: RE: Compilation of SEP Requests

Arizona Governor Ducey sent a letter to Sec Azar last week. See:
https://azgovernor.gov/sites/default/files/20200325131134559.pdf

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From: Strauss, Emma (CMS/CCIIO) [redacted]
Sent: Friday, April 3, 2020 10:48 AM
To: Pate, Randy (CMS/CCIIO) [redacted]; Nelson, Peter (CMS/OA) [redacted]
Cc: Koltov, Michelle K. (CMS/CCIIO) [redacted]; Wilson, Lisa J. (CMS/CCIIO) [redacted]
Subject: Compilation of SEP Requests

Attached and below – a compilation of a number of the SEP-related inquiries we've received to date.

SEP Request Letters (attached):

1. Tom Wolf, Governor of PA
2. Kate Brown, Governor of OR
3. Phil Murphy, Governor of NJ
4. Oregon Delegation
5. New Mexico Health Insurance Exchange Board
6. Maine Legislature
7. Representative Lloyd Doggett (D-TX) and House Democrats
8. Sen. Peters, Sen. Stabenow et al
9. Alliance of Community Health Plans
10. Erin Hemin of Young Invincibles and additional 200 patient advocacy organizations, labor unions and nonprofits
11. BCBSA Regulatory Recommendations Paper
12. AHIP/BCBSA Legislative Recommendations Letter

Stakeholder Questions/Requests:

1. Palmetto Project, South Carolina: Any word on a COVID19 Special Enrollment Period for FFM states like South Carolina?
2. DentaQuest: Mass Connector is going to reopen for applications due to the Covid situation. I wouldn't be surprised to see more States doing the same. Do you have any information about the FFM be reopening as well?
3. Community Health Options: Are you hearing any activity on a COVID-19 SEP? We're seeing it coming from a few of the state marketplaces and my team has asked me to see if it is in discussions at CMS.
4. Medical Mutual of Ohio: Issuer is wondering if we've heard anything regarding if CMS will offer special consideration re premium payment due to income loss that is COVID-19 related.

5. Paramount: Issuer is wondering if we've heard anything regarding if CMS will offer special consideration re premium payment due to income loss that is COVID-19 related.
6. Lakewood Resource and Referral Center: Is there any talk of activating a SEP on the FFE?
7. Virginia State Corporation Commission: FFM carrier reached out about the possibility of a SEP to mirror several state exchanges.
8. WPS Health Insurance: Should we direct our on-exchange members that are temporarily out of work to file a SEP due to "decrease in household income" since they could receive additional subsidy? Will the Marketplace open up enrollment for those that don't have insurance at this time?
9. Centene: Is the FFM considering a COVID-19 SEP for uninsured individuals to enroll in coverage?
10. Mara Youdelman, National Health Law Program: Is CCIIO working on any policies to create an SEP for healthcare.gov to cover people who didn't enroll but need coverage now because of the pandemic (not just for those who lose employment based insurance)?
11. Alaska/1332: In conversation, asked whether the FFM will consider a COVID SEP
12. Delaware/1332: In conversation, asked whether the FFM will consider a COVID SEP
13. National Association of Insurance Commissioners: Will the Federal Exchange add a Special Enrollment Period (SEP) for those without insurance or need to change insurance? While State-Based Exchanges can create an SEP – and some already have - can State-Based Exchanges using the Federal Platform create an SEP if the Federal Exchange does not?
14. We've also received a number of inquiries from agent and brokers as well as consumers.

Congress of the United States
Washington, DC 20515

April 3, 2020

The Honorable Michael R. Pence
Vice President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Vice President Pence and Secretary Azar:

We write regarding the Administration's deeply troubling decision to reject establishing a general Special Enrollment Period (SEP) amidst the coronavirus (COVID-19) pandemic.[1] We ask the Coronavirus Task Force and Department of Health and Human Services (HHS) to immediately reconsider this decision and allow uninsured and underinsured Americans to have access to comprehensive coverage through HealthCare.gov during this health crisis.

It is critical that the federal government use every tool at its disposal to avoid putting Americans' lives and financial security needlessly at risk from the COVID-19 pandemic. The Affordable Care Act's (ACA) Marketplaces and associated financial assistance can serve a critical role in protecting people who need health coverage — now is the time to set aside this Administration's longstanding attacks on the ACA and put American families' needs first. Unfortunately, this Administration's actions, including expanding access to short-term limited duration junk plans, have repeatedly undermined the health and financial security of families, exposing more Americans to high medical bills.

The decision not to establish an SEP creates the potential for additional financial stress on American families and jeopardizes the health of our communities. Initial reports suggest that uninsured Americans receiving treatment for COVID-19 could face medical costs upwards of $35,000.[2] Those who are uninsured and otherwise struggling to navigate these challenging times may avoid seeking medical treatment altogether as a result. Not allowing an SEP through

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[1] Politico, *Trump rejects Obamacare special enrollment period amid pandemic* (Mar. 31, 2020), https://www.politico.com/news/2020/03/31/trump-obamacare-coronavirus-157788.
[2] TIME, Total Cost of Her COVID-19 Treatment: $34,927.43 (Mar. 19, 2020), https://time.com/5806312/coronavirus-treatment-cost/.

HealthCare.gov is even more worrisome in states that have elected not to adopt the ACA's Medicaid expansion— as many lower-income Americans now at risk of losing their jobs as a result of COVID-19 will have no option to gain coverage.

Therefore, we strongly urge the Coronavirus Taskforce and HHS to reverse its decision regarding the SEP and allow Americans struggling during the coronavirus epidemic to have an opportunity to sign up for health coverage, which is key to protecting their health and the health of their communities.

Thank you for your urgent attention to this matter.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

Bobby Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives

Senator Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Senator Patty Murray
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
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Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

April 6, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks **the Secretary of Health and Human Services (HHS) to consider additional actions to temporarily suspend certain requirements in order for health care providers to better respond to the novel coronavirus (COVID-19) outbreak.**

Immediately following the President's national emergency declaration, HHS and its agencies took action to implement critical waivers consistent with section 1135 of the Social Security Act for hospitals and health systems across the country. Those initial steps, as well as additional waivers announced on March 30, are already playing a vital role in our response to the COVID-19 pandemic. In particular, we are grateful for your decisions to expand treatment location options to allow hospitals and their communities to better address the surge of patients; open up telehealth options for providers and their patients; and reinforce and support the health care workforce by adding flexibility to important licensing and privileging requirements.

While these actions are providing hospitals and health systems with more flexibility, additional steps are necessary to help providers quickly expand capacity to care for more patients in need of acute care. As you know, COVID-19 has placed unprecedented and rapidly evolving demands on hospitals and health systems, from needing to obtain the necessary certifications to re-open facilities for patient care to requesting the flexibility to transfer certain mechanically ventilated patients to free up capacity when possible. Each of these new challenges requires that providers have every tool at their disposal to combat this emergency and care for patients, which is why we are asking you to consider taking further action, including:

1. Take additional steps to fully implement waivers of the Emergency Medical Treatment and Labor Act, specifically for transfers of patients necessitated by COVID-19.
2. Delay audits related to the Medicare cost report, such as the Medicare disproportionate share hospital (DSH)/S-10 audit, and other federal reviews or audits until after the national emergency to reduce administrative burden and allow providers to focus on patient care.
3. Waive certain telehealth provisions to extend flexibility to hospital outpatient departments (HOPDs) and critical access hospitals (CAHs) by allowing HOPDs to provide care via telehealth and bill for outpatient therapy and psychiatry programs, and permitting CAHs to directly bill for telehealth services and be paid under the payment methodology they have already selected.
4. Ensure that teaching hospitals that increase their bed capacity to address the COVID-19 crisis are not penalized in their indirect medical education (IME) payments. Bed counts used to calculate the resident-to-bed ratio should not include those beds added to increase capacity for patient care during a public health emergency.
5. The Office of Civil Rights (OCR) should confirm that the Health Insurance Portability and Accountability Act (HIPAA) protection extends through the duration of the declared public health emergency. In the alternative, the agency should confirm and announce that it will exercise enforcement discretion and not take action against hospitals that fail to meet the requirements of HIPAA during the COVID-19 crisis.

A list of our specific suggested actions is attached.

In addition to actions already taken using the waiver authority in section 1135, we encourage the agency to continue to address actions private health plans, including those serving Medicare Advantage, Medicare managed care, and Health Insurance Marketplaces enrollees, must take to reduce access barriers and ensure the health care system has the resources to continuing functioning. Specifically, we ask that you work with health plans to ensure that they, like the fee-for-service Medicare program, are supporting network providers with stable cash flow by allowing for accelerated payments for the duration of the public health emergency. In addition, we urge more action by health plans to eliminate administrative processes that cause delays in both access to care and payment, as well as to ensure adequate coverage and reimbursement of services in alternative sites of care. Coordination and assistance from private health plans is necessary to address this pandemic effectively.

Communities rely on America’s hospitals and health systems to be there for them in the face of an emergency. Whether that emergency develops in the form of a natural disaster, like a hurricane or tornado, or as a virus, like COVID-19, hospitals and health systems are prepared to fulfill their commitment to patients. While our members continue to do everything they can to address COVID-19 cases, the additional actions

we are requesting will help them continue to put the health and safety of patients first by removing barriers that threaten to impede decisive and quick action by providers at a time when agility and flexibility are of utmost importance.

We appreciate your leadership and the ongoing work of the White House Coronavirus Task Force. As more information becomes available, we anticipate the need for additional assistance from HHS, and ask that the agency remain flexible as our hospitals and health systems continue to care for patients during this national emergency. We look forward to continuing to work with you during this critical time to protect the health of our nation.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Cc: Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Stephen M. Hahn, M.D., Commissioner, Food and Drug Administration
Robert R. Redfield, M.D., Director, Centers for Disease Control and Prevention

WAIVERS CURRENTLY IN PLACE REQUIRING ADDITIONAL ACTION

EMTALA. EMTALA sanctions are waived for the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan. In addition to the waiver concerning screening, waivers of sanctions for the following provisions are requested to assist hospitals in most effectively managing patient care and health care system capacity: - The transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency for the COVID-19 pandemic. - Permit the medical screening examination to be conducted by other qualified staff authorized by the hospital and acting within their state scope of practice and licensure, who are not formally designated to perform medical screening examinations in the hospital by-laws or in the rules and regulations. This waiver is not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.
Medical Review Audits. Pausing all audits during the emergency, including additional documentation requests and other audit work, would help free capacity in the health care system. While this list is not exhaustive, pauses on the following audit requirements are requested: - Medicare DSH/S-10 - Medicaid Payment Error Rate Measurement - Medicaid DSH - Quality Improvement Organization (QIO) reviews - Medicare Advantage plan audits - Occupational Mix Survey - Wage Index
Home Health (HH) Face-to-Face Requirement. We request an official statement from CMS confirming that the HH face-to-face encounter can be performed through telephonic or telehealth communications. Allowing this critical function to be accomplished through these means would materially advance both COVID-19 infection control and resource conservation efforts.
Increased VPN utilization for pathologists. Pathologists and other health care professionals can utilize review and sign out for pathology interpretation/diagnosis and other data reviews utilizing virtual private network (VPN) data access. This would allow laboratories to employ appropriate protocols to reduce the risk of infection among their own teams and to avoid hindering their ability to test and treat patients. If laboratory personnel were to be significantly impaired, it could become difficult for the country to continue to respond to this crisis. Providing this waiver will serve to minimize the disruption to the workforce that is occurring while maintaining the best possible patient care.
Prior Authorization for Post-acute Care (PAC). Requiring plans to accept presumptive authorization for PAC placement would enable hospitals to conduct timely patient transfers to free up inpatient bed capacity.

Emergency Use Authorizations (EUAs). Expediting the approval of EUAs for hospital laboratory developed tests (LDTs), including the approval of licensed automated testing systems and rapid response testing, would assist hospitals in expeditiously testing and confirming COVID-19 infection in patients and thus responding to the emergency.
Audio-only Communication. Allow providers to deliver Medicare telehealth services via audio-only communication.
Medicaid DSH Cuts. Delay Medicaid DSH cuts through FY 2021.
Make explicit that swing beds are included in 3-day SNF waiver. Ensure that the waiver of the 3-day inpatient stay for Skilled Nursing Facility services also is applied to swing bed services, and make this application explicit in documentation. The waiver should be applied to patients being discharged/transferred from both rural and non-rural hospitals to swing bed care, in order to support maintaining inpatient capacity during the COVID crisis.

ASSISTANCE MANAGING THE SURGE

Hospice and Home Health Services. Allow professionals that provide home health and hospice services (including nurses and therapists) to do so via telehealth and bill for them accordingly; also allow home health agencies and hospice organizations that bill under home health and hospice PPS to bill for telehealth services.
Medicare Outpatient Observation Notice (MOON). In addition to CMS' waiver of the SNF 3-day rule, waiving the MOON written and oral notification requirements is appropriate since undergoing observation care will have no implications for SNF eligibility.
Critical Access Hospital (CAH) 96-hour Condition of Payment. Waiving the requirement that a physician certify a patient can reasonably be expected to be discharged within 96 hours would provide critical flexibility for care in rural areas that may not have other options for inpatient care.
Transfer of Mechanically Ventilated Patients. Suspending the restrictions of Medicare Managed Care organizations surrounding transfer of mechanically ventilated patients to long-term care hospitals (LTCHs) would allow patients to be transferred as soon as they are physiologically stable enough. This would facilitate appropriate transfer of patients that benefit from the specialized care LTCHs provide and also add capacity to the health care system.
Waiving certain CMS certification requirements. If a nonprofit entity that holds multiple certificates to operate hospitals in that jurisdiction from the appropriate state licensing entity, a certificate of participation from CMS, a license from a state licensing authority to operate a new or refurnished hospital and has applied for accreditation to operate a new or refurbished hospital that facility may be deemed certified for billing by CMS and private insurance entities. The nonprofit entity would receive certification for no more than 90 days or until accreditation is received or the national emergency has ended. Entities may renew this temporary certification every 90 days for up to one year.

Medicare IME Payments. Hold harmless hospitals that increase their bed capacity during this crisis. As teaching hospitals increase their bed capacity to fight COVID-19, their resident-to-bed ratio, which determines their indirect medical education (IME) payments through Medicare, will be artificially depressed, and reimbursements will be cut.
Enable Better Use of E-visits. Clarify the meaning of "e-visit" and specifically whether patient-initiated screening questionnaires used to determine which patients need telehealth visits are considered e-visits.
Maintain sole community hospital (SCH) status. Hold SCHs harmless from the bed capacity changes among nearby providers. During the emergency, waive enforcement of the SCH classification criteria at 42 CFR 412.92 due to changes in the hospitals or bed counts in the service area.
Support increased bed capacity in rural areas. Hold hospitals harmless for increasing bed capacity during an emergency. Allow providers to maintain pre-emergency bed counts for applicable payment programs, designations, and other operational flexibilities including but not limited to: Medicare Dependent Hospital status, swing bed operation, and special reimbursement for certain provider-based rural health clinics.
LTCH ICU Requirement. Waiving the requirement that an LTCH patient have a prior hospital stay that includes three days or more in the intensive care unit (ICU) in order to qualify for the full payment rate would ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty.
IRF 3-hour Rule. Waiver of the 3-hour rule, which requires that inpatient rehabilitation facility (IRF) patients receive at least three hours of therapy a day, the "preponderance" of which must be one-on-one, would help ensure that IRFs are able to add capacity to the health care system, without penalty.
LTCH 50% Rule. Waiving both the numerator and denominator of the requirement that LTCHs have no more than 50% of Medicare cases paid at the site-neutral rate would help ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty

ENSURING STAFF CAN FOCUS ON CARE DELIVERY

Expanded Use of Telehealth. Insurers should support management of scarce resources, such as personal protective equipment, and efforts to reduce community transmission by expanding access to services delivered via telehealth.
Credentialing. Requiring expedited or presumptive credentialing, such as requiring health plans to establish a process to recognize and credential community physicians who offer to work at hospitals and health systems, would help to ease workforce shortages during this time.
Patient Assessments. Granting relief to all providers on the timeframes related to pre- and post-admission patient assessment and evaluation criteria would help ensure patients are treated in a timely manner.

Appropriate Use Criteria (AUC) – CMS should extend the Jan. 1, 2021 deadline for providers to use clinical decision support mechanisms to verify AUC before ordering and performing advanced imaging tests on Medicare patients. Compliance will require significant information technology (IT) systems changes, training and compliance resources at a time when IT budgets and staff are increasingly being re-directed to support expanded use of telehealth and other urgent technology needs for COVID-19 response.
CMS Interoperability Rule – CMS should delay compliance for the new condition of participation (CoP) established under this rule requiring hospitals to send admit, discharge, transfer notifications to community providers by at least an additional 12 months to a total of 18 months after publication of the final rule. Across the board, IT budgets and staff are being fully and urgently redirected to support COVID-19 response, including expansion of telehealth to operationalize the flexibilities provided by CMS' new waivers and policy changes. Given the severity of penalties for non-compliance with the CoPs, it is critical that hospitals have sufficient time to implement this requirement in order to focus all available resources on addressing patient care needs during the current pandemic.
Acute DRG patient exemption from certain IRF PPS requirements. Waiver to allow these Acute DRG patients to be exempt from the IRF PPS admission and coverage criteria, including, but not limited to the patient assessment instrument (IRF-PAI), "three hour rule," etc. as these items are designed to inform payment and quality measurement for patients undergoing rehab — not the general acute care patients we seek to temporarily house.

HELP US GET THE TOOLS WE NEED

340B Eligibility. Providing for a limited waiver of the 340B Hospital Medicare DSH eligibility threshold for current 340B hospitals responding to the COVID-19 national health emergency and experiencing a significant change in patient mix would help ensure that hospitals do not lose their 340B status in the future as a result of a time-limited change in patient mix.
340B GPO Prohibition for DSH hospitals: Waive the GPO prohibition for 340B DSH hospitals during COVID-19 emergency. Currently, 340B DSH hospitals cannot purchase covered outpatient drugs through group purchasing organizations. Waiving the GPO prohibition, would allow 340B DSH hospitals to more readily access drugs at a lower price than purchasing drugs at Wholesale Acquisition Costs (WAC).
Emergency Department Access to Oxygen. Allow emergency department providers to order home oxygen and provide increased flexibility and leniency of the requirement that 88% oxygen saturation must be met to qualify.

ENSURE COVERAGE SO ALL PATIENTS CAN SEEK HELP WHEN NECESSARY

Presumptive Authorization. Requiring plans to accept presumptive authorization in instances where health plans, due to business disruption such as reduced workforce capacity, cannot adjudicate requests within a timely manner, would help ensure patients are treated in a timely manner.
Presenting Symptoms as Basis for Coverage. Generally, insurers make coverage decisions in part by assessing whether care was medically necessary, and many insurers adjudicate medical necessity using information that becomes available during the course of treatment or testing. This approach could result in many coverage denials for individuals who were originally suspected to have COVID-19 but who ultimately are found to have the flu. The government should clarify that coverage decisions must be made on the presenting symptoms, not the final diagnosis.
Cost-sharing. Mandating that all forms of cost-sharing (co-pays, co-insurance, deductibles) be waived not only for testing, but also for treatment of COVID-19 would help eliminate cost as a barrier to care. CMS also should require plans to reimburse providers for the full contracted amount.
Out-of-network Care. We urge the government to direct health plans to hold the patient harmless for out-of-network care, such as laboratory services, and negotiate reimbursement with the provider.
Utilization Management Requirements. Requiring health plans to ease utilization management requirements during the emergency period to account for reduced workforce would help ensure there are not bottlenecks and unnecessary delays in care. Specifically, hospitals and health systems are expected to experience staff reductions and diversions and health plans should not be permitted to deny reimbursement for care for which providers were unable to complete prior authorization or other utilization management functions due solely to workforce constraints.
Ensuring Adequate Coverage and Resources. Refraining from implementing policies that would reduce Medicaid coverage and/or resources would help ensure patients get the care they need. Specifically, we ask that the Administration withdraw the proposed Medicaid Fiscal Accountability Rule, which could have a negative impact on coverage and health care system resources just as we seek to manage COVID-19 patients.
Automatic Medicaid Eligibility Renewal. Allowing states six month automatic eligibility renewal would help ensure continuity of coverage.
Increase Access to Hospital-based Presumptive Eligibility (HBPE). The Administration should require states to eliminate enrollment barriers for hospitals to expand participation in HBPE such as relaxing the enrollment process, performance metrics, and documentation during the COVID-19 period to increase access to coverage. CMS should encourage states to process HBPE applications for potential beneficiaries through on-line secured portals.
Children's Health Insurance Program (CHIP) Eligibility Limits. Federal law restricts states from increasing their CHIP eligibility limits. We urge flexibility to states seeking to expand CHIP eligibility within their current CHIP grants to enable access to testing and treatment for uninsured children.

Uncompensated Care Pools. Allow states to reestablish or create time-limited Medicaid-funded uncompensated care pools through Medicaid Section 1115 demonstration waivers to cover the costs of the uninsured.
Special Enrollment Period. Creating a special enrollment period for the federal Health Insurance Marketplaces would increase access to coverage and care.
Direct Provider Reimbursement. Establishing a federal program to directly reimburse providers for costs associated with caring for the uninsured would help ensure hospital have adequate resources for addressing the emergency. While federal law now provides a mechanism for reimbursement for testing and testing-related services, this must be expanded to treatment costs as well.

ENSURE PAYMENT FLOWS APPROPRIATELY

Medicaid DSH Allotment Increase. Establish a temporary Medicaid DSH allotment increase to help cover COVID-19 related testing and treatment, including equipment. The increase would apply to FY 2020 Medicaid DSH allotments by adding 2.5%, similar to ARRA. States, however, would be required to distribute payments funded by the allotment increase to directly to DSH hospitals to compensate for increased uncompensated care and Medicaid shortfall costs. The state would function as administrator of the payment, and could not redirect for other purposes (e.g., could not redirect to Section 1115 waiver programs).
Supplemental Payments. Allow states to create new time-limited supplemental hospital payment mechanisms (fee-for-service and managed care) to address COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents program.
Temporary Waiver of Certain Payment Caps. Allow states to suspend any Upper Payment Limit restrictions or Medicaid DSH hospital-specific caps to address hospital payments for COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents such payments.
Site-neutral Payment Cuts. Immediately cease paying claims for clinic visits provided at excepted off-campus provider-based departments at the reduced payment rate implemented with the 2020 Medicare final rule governing the hospital outpatient prospective payment system. Instead such clinic visit claims should be paid at the rate that would have been in effect absent the payment reduction. Refraining from reducing resources in this manner would help ensure patients get the care they need.
Waive IMD Exclusion for Acute DRG Patients. Allow Medicaid programs to reimburse for care provided in institutions for mental disease (IMDs) for patients transferred from general acute care facilities in order to make room in the latter facilities for COVID-19 patients.
Require Health Plans to Offer Periodic Interim Payments and/or Accelerated Payments. Hospitals are in dire need of continued cash flow to maintain staffing and general operations. While the fee-for-service program has several payment mechanisms that can help during the crisis (periodic interim payment option, as well as accelerated payments), private payers have not implemented similar provisions. This is particularly challenging for hospitals and health systems with high Medicare Advantage

penetration. Urge all private payers contracted with the government to provide these alternative payment options to providers, with an opportunity for reconciliation at the end of the public health emergency.
Medicaid UPL Prospective Payment. Allow hospitals receiving Medicaid UPL payments to receive a prospective payment similar to a loan. States (and hospitals) would then reconcile with CMS at a later date to see if their prospective UPL payment exceeded the UPL limit. If so, the state would enter into a payback arrangement with CMS at a point in the future after the COVID-19 emergency. States would coordinate reimbursement arrangements with UPL hospitals.
Managed Care COVID-19-related Directed Payment. Require hospital directed payments based on COVID-19 treatment through Medicaid managed care arrangements.
Medicaid Disaster Relief Fund. Provide hospitals disaster relief funds through the form of advanced payment programs for fee-for-service and managed care.
Maintain Access to Critical Therapy Services. Allow HOPDs to provide and bill for outpatient therapy services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, via telehealth using any currently approved platform.
Expand Eligibility to Deliver Telehealth Services to Additional Practitioners. Use authority under the CARES Act to waive the remaining statutory restrictions on practitioners eligible to provide services via telehealth, including licensed respiratory therapists, physical therapists, occupational therapists, and speech language pathologists, and allow these practitioners to provide telehealth services from their homes without updating their Medicare enrollment.
Allow CAHs to Provide Telehealth. Allow CAHs to directly bill for telehealth services and allow them to be paid according to the payment methodology they have already selected.
Improve Access to Prescription Drugs. Increase flexibility as providers are quarantined by allowing any other practitioner within the group of a provider who examined a patient within the past 24 months to prescribe via telehealth (rather than allowing only an individual provider covering for the original provider that examined the patient).
Alternative Approaches to Reliance on FY 2020 Medicare Cost Report. In light of the unprecedented challenges that providers currently face, CMS should consider alternative approaches (e.g., blended data, prior cost report years) to utilizing the FY 2020 Medicare Cost Report for programs that depend on cost report information.
Suspend CAH Final Settlement Payments until 12 months after COVID-19 Emergency has Ended. After each fiscal year, CAHs are required to reconcile the cost of providing Medicare services with the interim payments they receive throughout the year. To prevent additional cash flow concerns, any amounts owed by a CAH from this final settlement process should be delayed until after the public health emergency.
Increase Flexibility for Annual Wellness Visits (AWVs). Provide flexibility regarding collection and documentation of vital signs obtained as part of the "Measure" component of AWVs. CMS could achieve this flexibility in several ways, including by creating methods for providers to report AWVs without these components and/or by allowing patients to self-report vital signs when clinically acceptable. Further, waive the requirement of a face-to-face visit for recording hierarchical condition categories (HCCs),

such that providers can capture diagnoses impacting risk adjustment during telehealth visits, including AWVs, further increasing the number of patients who can stay at home and still receive needed care.

United States Senate
WASHINGTON, DC 20510

April 7, 2020

Vice President Mike Pence
The White House
Office of the Vice President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington D.C. 20201

Dear Vice President Pence and Secretary Azar:

We write to follow up on the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report (OEI-06-20-00300) detailing the significant challenges hospitals across the country are facing as the number of coronavirus cases continues to grow. We urge HHS to provide hospitals, nursing homes, and other essential community health providers with the financial support necessary to prevent, prepare for, and respond to the coronavirus pandemic immediately.

Front line health care workers across the country are facing widespread shortages of personal protective equipment (PPE) and other necessary supplies and equipment. According to the HHS OIG report, hospitals have also reported shortages of cleaning supplies, bed sheets, toilet paper, and other basic equipment. At the same time hospitals are reporting increased costs associated with preparing for an influx of COVID-19 patients, their cash flow is limited as a result of cancelling elective procedures and other routine services, and they are having difficulty maintaining and supporting adequate staff. We have also heard from other health care providers in our states – from skilled nursing facilities to community health centers to hospice providers – that they face similar challenges with supplies and staffing.

As you know, Congress included $100 billion as part of the Public Health and Social Services Emergency Fund (Emergency Fund) in the recently passed *Coronavirus Aid, Relief, and Economic Security* (CARES) *Act* to give hospitals and other front line providers resources for protective equipment, preparation, and surge capacity necessary to manage the spread of this disease. While we appreciate that HHS has expressed an intent "to distribute the funds in a way that is "fast, fair, simple and transparent," we are concerned by recent reports indicating the Trump Administration intends to delay the distribution of essential funds from the Emergency Fund and use them to retroactively reimburse hospitals for providing care to uninsured Americans. Holding Emergency Fund resources hostage with the intent to distribute them retroactively to certain hospitals for care provided to uninsured individuals would limit our capacity to manage this crisis, and result in an unequal distribution of resources that would come too little, too late.

The best way to provide much needed support to hospitals, skilled nursing facilities, community health centers, hospice providers, and other providers across the country is to immediately distribute an initial round of funding from the Emergency Fund and ensure the remainder of the Fund is distributed in a manner that is transparent and equitable.

We agree that HHS should take additional steps to help support hospitals and other providers who care for the uninsured and protect uninsured patients from high out-of-pocket costs. However, the best way to reduce the burden of uncompensated care on hospitals across the country is to ensure all Americans have access to comprehensive, affordable health insurance – not to withhold the resources hospitals and other front line providers desperately need today to prepare for the spread of the coronavirus. We urge you to reconsider reopening enrollment for the Affordable Care Act and work with the remaining states to expand their Medicaid programs. Doing so would allow all Americans to sign up for health coverage and reduce the potential burden of uncompensated care on hospitals across the country.

We look forward to working with you to ensure the Emergency Fund is operationalized immediately to provide equitable, up-front support to the hospitals, nursing homes, and other health care providers caring for our communities during this crisis.

Sincerely,

Sherrod Brown
United States Senator

Michael F. Bennet
United States Senator

Robert P. Casey, Jr.
United States Senator

Thomas R. Carper
United States Senator

Robert Menendez
United States Senator

Benjamin L. Cardin
United States Senator

Debbie Stabenow
United States Senator

April 7, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We write to urge you to reopen the Affordable Care Act's (ACA) online marketplace through a unique Special Enrollment Period (SEP) to allow any American to enroll in a comprehensive health insurance plan. Currently, millions of Americans are uninsured and anxious, not only about what the possibility of contracting COVID-19 could mean for their health and that of their family, but also for their financial stability. Opening up the ACA marketplace would provide an easy pathway to coverage for those who under previous circumstances may have decided to forego health insurance or purchase a substandard, junk insurance plan, but now in a global pandemic are in vital need of comprehensive coverage to protect themselves, their families, and our broader community.

The Trump Administration's reported decision not to open an SEP, despite earlier congressional requests, and leave millions of Americans uninsured and underinsured during this unprecedented public health crisis will inevitably mean fewer individuals seeking testing and treatment—prolonging the spread of the disease—and will put more families in dire financial straits. The COVID-19 pandemic is also causing millions of people to lose their jobs and their employer-provided health insurance. We should be promoting comprehensive health insurance plans to all those impacted, not looking to divert funds appropriated to support hospitals, or promoting junk insurance plans that don't have to provide coverage for needed services or offer consumer protections.

When the ACA was passed, Congress included the authority to establish SEPs because we understood that everyday Americans may face extenuating circumstances for which they should not be penalized. It is inexcusable for you not to exercise that authority during perhaps the largest extenuating circumstance of our lifetimes, and to choose to lock out millions of Americans from the ACA exchanges because they failed to predict a sweeping global pandemic. Furthermore, the Administration's continued promotion of junk plans which are not required to comply with consumer protections that limit out-of-pocket costs or coverage of essential health

benefits, including those that are needed to pay for the treatment and prevention of COVID-19 such as hospital care, emergency care, laboratory services, or preventive services, leave many Americans vulnerable. Families already struggling to make ends meet in light of the global economic downturn should not be exposed to potential financial ruin because of a lack of comprehensive insurance coverage.

An additional benefit of opening an SEP is that it would publicize to all Americans who have lost their jobs that the exchanges are open again and that they can enroll in high-quality health insurance, providing at least a modicum of reassurance during these deeply troubling times. Given the millions of job losses in recent weeks and the likelihood of millions more in the near future, now is the time to open up the health insurance marketplace to everyone so that people know that losing their job does not mean they must also lose access to health insurance coverage.

We believe opening an ACA SEP is the clearest way to cover the millions of uninsured and underinsured Americans in the 38 states that use the federal platform, and to provide comprehensive protections for COVID-19-related treatment and prevention. In a demonstration of the dramatic demand for such a move, all but one of the 13 state-based marketplaces have opened an SEP, with such high levels of interest that many are now extending the period by several weeks.

We urge you to put aside the partisan politics of the past, and to expand health coverage to millions of Americans by opening an SEP expeditiously.

Sincerely,

Senator Christopher S. Murphy
Senator Richard Blumenthal
Senator Robert P. Casey, Jr.
Senator Kirsten Gillibrand
Senator Martin Heinrich
Senator Tina Smith
Senator Chris Van Hollen
Senator Richard J. Durbin
Senator Angus S. King, Jr.
Senator Margaret Wood Hassan
Senator Amy Klobuchar
Senator Mazie K. Hirono
Senator Tim Kaine
Senator Doug Jones

Senator Tammy Baldwin
Senator Joe Manchin III
Senator Jon Tester
Senator Jeffrey A. Merkley
Senator Elizabeth Warren
Senator Dianne Feinstein
Senator Sherrod Brown
Senator Gary C. Peters
Senator Tammy Duckworth
Senator Jeanne Shaheen
Senator Kamala D. Harris
Senator Tom Udall
Senator Tom Carper
Senator Jack Reed

ATTN: Administrator Seema Verma
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

April 8, 2020

To Whom It May Concern:

On March 1, 2020, President Donald Trump declared the health crisis caused by the novel coronavirus (COVID-19) a national emergency with the World Health Organization (WHO) declaring COVID-19 a global pandemic ten days later. As of the date of this letter, there are more than 374,329 confirmed positive COVID-19 cases nationwide with over 13,549 cases here in the state of Illinois that has taken the lives of 380 Illinoisans. Unfortunately, federal health officials note that the number of infections and deaths associated with COVID-19 will grow exponentially in the coming days and weeks. The gravity of this global health emergency presents an array of significant challenges that is imperative we address.

As a coalition of organizations and individuals committed to health equity, Protect Our Care Illinois is very concerned about how individuals and communities across the state will access the medical care necessary to combat COVID-19. We are additionally alarmed by the millions of Americans that will lose their health insurance due to COVID-19 related employment layoffs, closures, and terminations. We strongly believe that, during these tumultuous times, we should be ensuring that all Americans are able to get the critical medical care that they need and deserve.

Considering these challenges, Protect Our Care Illinois believes that the following policy priorities should be adopted immediately:

- Officials at the Centers for Medicare and Medicaid Service (CMS) should alleviate existing barriers to individuals applying for Medicaid that may not have been addressed in the previous Section 1115/1135 waivers, including addressing lack of access to the online application for individuals without access to a computer during the federal emergency. Specifically, we ask that CMS allow Illinois to enable individuals to "sign" a Medicaid application via an assistor (e.g., an individual at a community-based organization that provides application assistance, whether or not they are a certified application counselor) without being physically present with that assistor during the federal emergency.
- Ensure all COVID-19 treatment is covered with no out of pocket costs to the consumer. Although testing is currently covered, additional costs remain, such as those related to copays, hospitalization, and physical therapy related to COVID-19 diagnosis and treatment;
- We strongly urge the Administration to reconsider their position and follow the example of nearly every state with a state-based marketplace, and enact a special enrollment period for 90 days with the possibility for an extension as the COVID-19 pandemic

continues. This must happen to allow uninsured and underinsured residents to enroll in health coverage through the federal health insurance exchange;
    - In addition, we request that any new coverage obtained on the federal Marketplace through a special enrollment period be in place as soon as possible.
- Adjust financial assistance for current Marketplace enrollees. Cost of coverage remains a barrier for many people, and even those who have coverage will be reluctant to seek testing and care, if they face a prohibitive cost-sharing burden. The federal government should temporarily boost advanced premium tax credits (APTC) for all eligible to no less than the lowest cost Bronze plan for the remainder of the calendar year.

Although not an exhaustive list, we believe that these policy recommendations will go a long way to guarantee that the most vulnerable in our communities do not fall through the cracks during this global pandemic. We look forward to working with the President's administration, CMS officials, and elected officials on Capitol Hill and in Springfield to address the challenges posed by COVID-19. As a coalition we remain steadfast in our commitment that all Illinoisans should have access to quality affordable health care.

Signed,

Protect Our Care Illinois
AIDS Foundation of Chicago
Legal Council for Health Justice
Heartland Alliance
Shriver Center on Poverty Law
Illinois Coalition for Immigrant and Refugee Rights
Illinois Alliance for Retired Americans
EverThrive Illinois
National Multiple Sclerosis Society
Citizen Action Illinois
Housing Action Illinois
AgeOptions
Smart Policy Works
Supportive Housing Providers Association
March of Dimes
NAMI Chicago
Access Living of Metropolitan Chicago
Respiratory Health Association
League of Women Voters of Illinois
Eerie Family Health Centers
Illinois Association for Behavioral Health
Healthcare Rights Coalition
ACA Consumer Advocacy
Indivisible Illinois
Trilogy, Inc.
Champaign County Health Care Consumers
Illinois 123GO
Coalition for A Better IL 6th

April 9, 2020

The Honorable Alex M. Azar II
Secretary of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Azar:

The undersigned organizations write to strongly urge that the Department of Health and Human Services take action to remove barriers and to streamline enrollment in health insurance coverage for low-income older adults and people with disabilities who are at highest risk of serious illness and death from COVID-19. Obtaining comprehensive health insurance coverage and access to treatment, whether related directly to COVID-19 or for underlying health conditions, is critical in maintaining their health and safety during this crisis. Yet, during this pandemic, administrative barriers to enrollment have become nearly insurmountable for many seeking Medicare and marketplace coverage.

The Social Security Administration closed offices to the public effective March 17, 2020, creating significant barriers for enrollment in Medicare. Even when applicants are successful in submitting an application, they are being informed that processing can take months. Closed enrollment periods also block many people eligible for Medicare from the opportunity to apply. Current rules requiring people who have been found disabled to wait two years before obtaining Medicare are another obstacle for hundreds of thousands who need Medicare coverage now.

In addition, many older adults age 50 to 64, who do not yet qualify for Medicare coverage, have lost their jobs and incomes as a result of this pandemic. Having access to health insurance coverage is critical to ensure they are able to obtain treatment now. While nearly all state-based marketplaces have created a special enrollment period to address COVID-19, the Department has to date refused to do the same for the 38 states with federally operated marketplaces, leaving millions without access to health coverage during a pandemic.

All of these elements have direct and immediate impact—individuals are attempting to seek immediate treatment and are turned down for being uninsured. Even if retroactive coverage is ultimately granted, applicants and providers need to know now that their treatment will be covered.

We ask the Department to act swiftly to expand and streamline access to coverage through the following actions:

Create a Medicare Special Enrollment Period and Effectuate Coverage Immediately. This would ensure that those individuals who have been unable to enroll in Medicare during the General Enrollment Period, their Initial Enrollment Period, or a Special Enrollment Period for

people losing employer coverage are able to do so without penalty. We ask CMS to provide this special enrollment period through October 15, 2020, or three months after the end of a federal or state emergency declaration with respect to COVID-19, whichever is later. We also ask that all new enrollments—including for individuals who have already enrolled during the normal GEP—become effective no later than the first day of the month after enrollment to provide more immediate access to coverage. People eligible for Medicare cannot wait months for coverage to begin.

Enact Medicare Presumptive Eligibility Guidance. With appointments being scheduled months out to process Medicare applications, individuals who have filed an application should be found presumptively eligible with coverage effective immediately. The Department, in partnership with the Social Security Administration, should issue guidance on what steps would be required to establish presumptive eligibility.

Provide a continuous special enrollment period for dual eligible and Low-Income Subsidy eligible beneficiaries in Medicare. Dually eligible beneficiaries and those receiving the Part D Low-Income Subsidy ("extra help") are currently only able to change their Medicare Advantage or Part D plan enrollment once per quarter. These individuals, who are already living in poverty, do not have the financial resources to weather any disruption or denial of care when in a plan that does not meet their needs. This is particularly problematic during this current crisis when their care and treatment needs may change quickly. Providing a continuous SEP would reduce administrative complexity and mitigate disruptions in access to care.

Suspend the two-year waiting period for Medicare. Close to two million individuals have been found disabled and eligible for Social Security Disability Insurance but remain ineligible for Medicare. We urge a suspension of the 24-month waiting period for Medicare for people with disabilities to provide them immediate access to Medicare coverage. We also urge the Secretary to support eliminating the 24-month waiting period in any COVID-19 relief legislation.

Implement a Federal Marketplace Special Enrollment Period. The Department should immediately create a federal marketplace special enrollment period to respond to COVID-19. Opening and widely publicizing a federal marketplace special enrollment period would streamline enrollment and minimize confusion and administrative burden, connect those who are not eligible for Medicare to coverage if they have lost coverage or are currently uninsured or underinsured, and ensure that individuals are not forced to spend down their resources during this economic crisis to obtain coverage through Medicaid.

Low-income older adults and people with disabilities are facing unprecedented barriers to meeting their basic needs on a daily basis while quarantined or sheltering in place and, in many cases, are experiencing significant economic insecurity. Your Department has the ability to mitigate impediments to health care, which is of greatest concern during a pandemic. We urge immediate action to address these pressing needs and welcome the opportunity to discuss these recommendations with you.

If you have any questions or would like to discuss, please contact Amber Christ, Directing Attorney at Justice in Aging, at achrist@justiceinaging.org.

Sincerely,

AFSCME
Aging Life Care Association
Alliance for Aging Research
Alliance for Retired Americans
Allies for Independence
American Association on Health & Disability
American Diabetes Association
American Federation of Teachers
American Kidney Fund
American Music Therapy Association
American Muslim Health Professionals
American Physical Therapy Association
American Society on Aging
Asian Counseling and Referral Service
Association of Asian Pacific Community Health Organizations
Autism Society of America
Autistic Self Advocacy Network
Brain Injury Association of America
Cancer Support Community
Center for Medicare Advocacy
Center for Public Representation
Christopher & Dana Reeve Foundation
Coalition on Human Needs
CommunicationFIRST
Community Catalyst
Disability Rights Education & Defense Fund
Easterseals
Epilepsy Foundation
Families USA
Hispanic Federation
HIV Medicine Association
Human Rights Campaign
Indivisible
Jewish Council for Public Affairs
Justice for Migrant Women
Justice in Aging
Legal Action Center

Legal Aid at Work
Medicare Rights Center
NAACP
NASTAD
National Action Network
National Adult Day Services Association (NADSA)
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance on Mental Illness
National Association for Home Care and Hospice
National Association of Councils on Developmental Disabilities
National Association of Social Workers (NASW)
National Association of State Long Term Care Ombudsman Programs (NASOP)
National Center for Transgender Equality
National Coalition for the Homeless
National Committee to Preserve Social Security & Medicare
National Community Action Partnership
National Council on Aging
National Disability Rights Network
National Education Association
National Health Law Program
National Immigration Law Center
National Multiple Sclerosis Society
National Partnership for Women & Families
National Women's Law Center
NETWORK Lobby for Catholic Social Justice
Network of Jewish Human Service Agencies
OCA-Asian Pacific American Advocates
PHI
Program to Improve Eldercare, Altarum
Public Advocacy for Kids
Service Employees International Union (SEIU)
Southern Poverty Law Center
The AIDS Institute
The Gerontological Society of America
The National Consumer Voice for Quality Long-Term Care
Union for Reform Judaism
United Spinal Association
Whitman-Walker Health

Cc:

Seema Verma, Administrator, Centers for Medicare and Medicaid Services

Andrew M. Saul, Commissioner, Social Security Administration

Majority Leader Mitch McConnell and Minority Leader Charles Schumer, U.S. Senate

Speaker Nancy Pelosi and Minority Leader Kevin McCarthy, U.S. House of Representatives

Chairman Charles Grassley and Ranking Member Ron Wyden, Senate Finance Committee

Chairman Lamar Alexander and Ranking Member Patty Murray, Senate Committee on Health, Education, Labor, and Pensions

Chairman Susan Collins and Ranking Member Bob Casey, Senate Special Committee on Aging

Chairman Richard Neal and Ranking Member Kevin Brady, House Committee on Ways and Means

Chairman Lloyd Doggett and Ranking Member Devin Nunes, Health Subcommittee, House Committee on Ways and Means

Chairman Frank Pallone and Ranking Member Greg Walden, House Committee on Energy and Commerce

Chairwoman Anna Eshoo and Ranking Member Michael Burgess, Subcommittee on Health, House Committee on Energy and Commerce

Poll Results: Furloughs, Lay-offs, and Health Benefit Decisions

Coronavirus (/our-thinking/listing.html?relatedTag=mercer%3Atopic%2Fcoronavirus)

Data and Technology (/our-thinking/listing.html?relatedTag=mercer%3Aus-health-news%2Fdata-and-technology)

09 April, 2020

Employers seeking to manage cost in the challenging business environment created by the COVID-19 pandemic have had to consider workforce alternatives that may influence the nature of work, the location of work, or the number of employees at an organization. A few have begun to explore novel solutions, like sharing workers with organizations that need extra hands, as described in this post (https://www.mercer.us/our-thinking/healthcare/company-needing-workers-seeking-company-with-workers-needing-hours.html)

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But when furloughs or layoffs seem inevitable, employers are striving to find ways to fuse economics and empathy in their choices about handling pay and benefits under various scenarios. As hard as these workforce actions can be, employers who get it right can maintain – or even improve – employee engagement and experience over the long term.

When an employer furloughs its employees, it requires them to work fewer hours or to take a certain amount of unpaid time off. An employer may require all employees to go on furlough, or it may exclude some employees who provide essential services. Generally, the theory is to have the majority of employees share some hardship as opposed to a few employees losing their jobs completely.

A layoff is a temporary separation from payroll. An employee is laid off because there is not enough workfor him or her to perform. The employer, however, believes that this condition will change and intends to recall the person when work again becomes available. Employees are typically able to collect unemployment benefits, and employers may allow employees to maintain benefit coverage for a defined period of time as an incentive to return to work. Or, if the employee loses coverage, employers may elect to subsidize their COBRA payments for a period of time.

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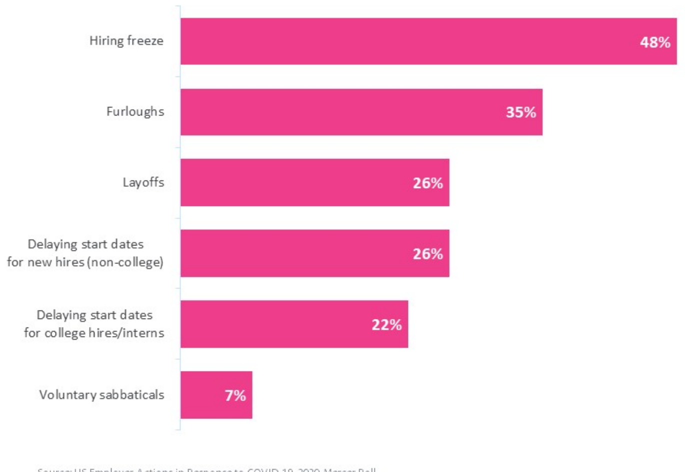

In a Mercer poll that opened on April 2, just over a third (35%) of the more than 400 employers that responded through April 9 said they are considering furloughs within the next 60 days, while just over a fourth are considering lay-offs. Under both scenarios, employers must decide whether to continue or terminate health and welfare benefits. While decisions must be validated by legal counsel, we can offer some important considerations:

If benefits will continue:

- Do plan eligibility/contract provisions allow or require continuation (do they need to be amended)? Note that this applies to all types of coverages, including voluntary benefits.
- Can the employee switch to a lower cost option, drop and enroll on a spouse's plan, public exchange coverage or Medicaid?
- Will the employer cover the full employee contribution? If so, for how long?
- If the employer will not pay the contributions, how will employee contributions be collected?

If benefits will be terminated:

- Is there a legal requirement to offer continuation of coverage (e.g. COBRA, conversion, portability)?
- Will the employer pay COBRA subsidies? If so, for how long?
- If benefits are terminated, how will they be reinstated upon return?

In the Mercer poll, 55% of the employers considering furloughs say they would continue health benefits while just 3% said they would not; the rest were still undecided. Those continuing coverage were fairly evenly split between waiving employee contributions (23%) and continuing them (29%), either by collecting contributions in installments (14%) or requiring "catch-up" contributions once employees return to work (15%); the rest were undecided.

The poll asked employers considering layoffs whether they would subsidize COBRA if health benefits were terminated. While half remain undecided, only 15% said they would be likely to partially or fully subsidize COBRA payments, while 33% said they would not.

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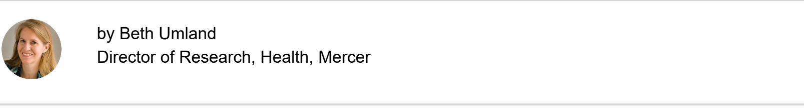
Seeking the best possible outcome for employees

While furloughs and lay-offs inherently have a negative impact on employee engagement in the short-term, employers have many choices to make that can mitigate the long-term impact. Because health benefits are very important to employees in the best of times, and even more so during a health crisis, as you work through the possibilities for handling benefits in a workforce action, test each one against the question, “is this the best possible outcome for our employees under the circumstances?” An integral part of this process will be the communication plan: determining how you will communicate with both workers who are furloughed and workers who continue to work, as well as with the marketplace and your customers.

Mercer’s poll, US Employer Actions in Response to COVID-19 (https://app.keysurvey.com/f/41484270/3033/)*, is still open. Please take the brief survey; you will be redirected to the live results as soon as you submit your responses. All individual responses are kept strictly confidential.*

More Mercer posts (https://www.mercer.us/our-thinking/healthcare.html)



by Beth Umland
Director of Research, Health, Mercer

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OK

From:
Sent: Friday, April 10, 2020 12:44 PM
To:
Subject: FW: ACHP Policy Requests to CMS in Addressing the COVID-19 Public Health Emergency

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From:
Sent: Friday, April 10, 2020 11:32 AM
To:
Subject: FW: ACHP Policy Requests to CMS in Addressing the COVID-19 Public Health Emergency

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From: Ceci Connolly
Sent: Friday, April 10, 2020 3:31:22 PM (UTC+00:00) Monrovia, Reykjavik
To: Verma, Seema (CMS/OA)
Cc: Kouzoukas, Demetrios (CMS/OA); Brandt, Kimberly (CMS/OA); Pate, Randy (CMS/CCIIO); Brooks, John (CMS/OA); Alexander, Alec (CMS/OA); Brookes, Brady (CMS/OA); Rice, Cheri M. (CMS/CM); Wu, Jeff (CMS/CCIIO); Richter, Elizabeth (CMS/CM); Mills, George G. (CMS/CPI); Greene, Mary G. (CMS/CPI); Good-Cohn, Meredith (CMS/OA); Czekai, Alina (CMS/CMMI); Shapiro, Jennifer R. (CMS/CM); Paul, Rebecca (CMS/CM); Coleman, Kathryn A. (CMS/CM); Parker, Jim (HHS/IOS); Uehlecke, Nick (HHS/IOS); Brady, Will (HHS/IOS); Michael Bagel; Virginia Whitman; Tricia Brooks
Subject: ACHP Policy Requests to CMS in Addressing the COVID-19 Public Health Emergency

April 10, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8016

RE: ACHP Policy Requests to CMS in Addressing the COVID-19 Public Health Emergency

Dear Administrator Verma:

The Alliance of Community Health Plans (ACHP) appreciates the ongoing collaboration with the Centers for Medicare & Medicaid Services (CMS) at this time of national emergency to ensure Americans have continuity and access to health coverage and care. Our non-profit, provider-aligned member organizations have deep roots in the

communities they serve, giving them insight into immediate needs and concerns. ACHP members embody the distinctive payer-provider aligned model that is an exemplar in delivery of high quality, coordinated care. The Administration has long been a proponent of a value-based system and that commitment is now more important than ever.

With this insight, ACHP identified key policy priorities we wish to discuss with CMS:

- **Immediately announce a Special Enrollment Period for the Federal Exchange throughout the COVID-19 Public Health Emergency.** In our March 19 letter to CMS, ACHP urged the opening of a Special Enrollment Period to provide access to urgently needed coverage to the more than 28 million uninsured Americans, specifically those who do not qualify under a "triggering event," such as loss of job-based coverage. The Exchange is an existing tool at the Administration's disposal that would help reduce spread of COVID-19, mitigate burden on hospitals and flatten the curve. Additionally, ACHP requests that CMS institute accommodations for Exchange risk-adjustment to account for substantial new entrants to the risk pool mid-year.

- **Create a full-year Special Enrollment Period for Medicare.** All Medicare fee-for-service enrollees should have the option to enroll in a Medicare Advantage plan this year and have access to additional benefits and services. In this time of crisis, health care spending is less predictable, and seniors may particularly benefit from the out-of-pocket cap available only to Medicare Advantage enrollees. In addition to this benefit, Medicare Advantage plans offer enrollees high-quality, coordinated care and supplemental benefits that enrollees may find especially useful during this time. For example, the majority of Medicare Advantage plans are waiving cost sharing for all telehealth services, not just those related to COVID-19, versus the 20% cost-sharing required for many of the non-COVID services in Medicare fee-for-service.

- **Delay Exchange and Medicare Advantage bid deadlines.** The costs and implications of the COVID-19 public health pandemic are just beginning. Without understanding the costs of this pandemic, health plans do not have the experience or data to appropriately formulate 2021 bids. Additional time is needed to develop realistic models and is essential given health plans' full attention is on responding to the crisis, often resulting in diverted staffing and resources from non-traditional activities. ACHP member plans are smaller than the national for-profits and maintain a smaller workforce, including actuaries. Additional time to meet deadlines would ease the burden on these teams, generate more accurate bids and allow plans to direct critical resources to where they are most needed.

- **Permit telehealth encounters to be used for risk-adjustment in Medicare Advantage plans.** We applaud CMS for its visionary thinking on the use of telehealth, even before the COVID-19 crisis. With the vast majority of provider

visits occurring via telehealth during this outbreak, it is essential that CMS allow telehealth encounters to be utilized for Medicare Advantage risk-adjustment. Not doing so would harm providers and health plans using telehealth to replace in-person visits during this public health emergency. The value of telehealth has been immeasurable during the crisis and it will continue to be a popular and possibly preferred method of care delivery post-pandemic. For accurate and complete documentation of Medicare Advantage enrollee acuities, it essential that CMS allow risk-adjustment in telehealth encounters in this new era of care delivery.

- **Institute a demonstration providing 3.5 star MA plans the Medicare Advantage Quality Bonus.** ACHP member plans invest significant resources to deliver high quality care and achieve high Medicare Advantage star ratings. Before the crisis, ACHP members were on track to improve their star ratings, including several plans moving from 3.5 to 4.0 stars. With the extensive financial implications of achieving 4.0 stars that benefit seniors in communities across the country, CMS should institute a demonstration that allows MA plans that have shown quality improvement to receive the quality bonus. This demonstration could be based on the premise and design of the Medicare Advantage Quality Bonus demonstration that CMS implemented from 2010 – 2012. Medicare Advantage plans, and the seniors to whom they provide supplemental benefits, should not be penalized in their star ratings because of this public health crisis and CMS effectively freezing star ratings for 2021.

- **Ensure Medicare Advantage payment protection for unforeseen COVID-19 treatment costs.** Medicare Advantage plan bids did not incorporate the possibility of a pandemic when they submitted bids in June 2019. CMS should implement a demonstration or other action to provide payment protection to MA plans – specifically non-profit community-based plans operating on historical margins of less than 3%– to protect from significant unforeseen costs from COVID-19 testing and treatment. Medicare Advantage enrollee out-of-pocket premiums and costs are at historic lows. Extending Medicare Advantage plans appropriate protections now for significant and unforeseen COVID-19 costs will allow these premium trends to continue.

- **Make accommodations for the End Stage Renal Disease (ESRD) benchmark and risk-adjustment methodology in light of the COVID-19 public health emergency.** As raised in our March 6 comments to the 2021 Advance Notice Parts 1 and 2, CMS should modify the 2021 Medicare Advantage policies to understand the short- and long-term impact to the program with the inclusion of the ESRD population. These policies need further consideration during a time when the Medicare Advantage benchmark and plans bids are more complicated and uncertain.

- **Delay audits during this public health emergency.** ACHP and our members are committed to robust and appropriate program integrity. As CMS has noted,

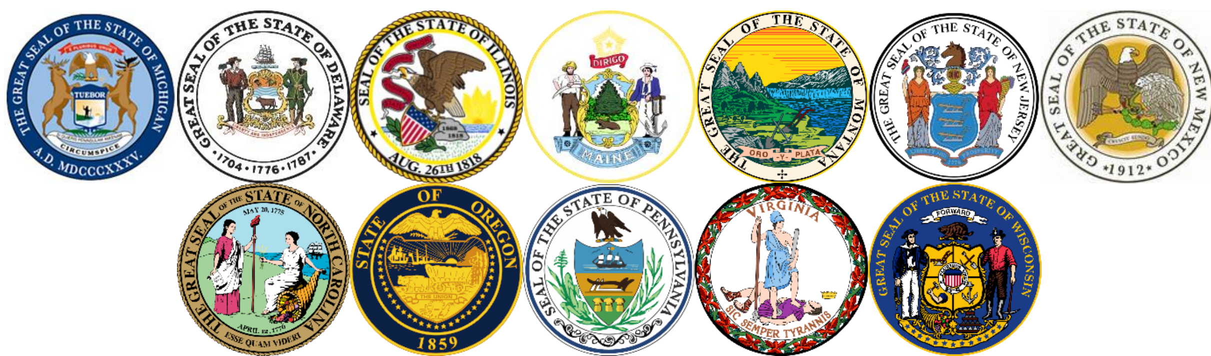
at the best of times, audits are time consuming and burdensome on health plans and providers. While ACHP appreciates CMS announcements to ease some of this burden, we encourage CMS delay audits to provide necessary and immediate relief. Confirming a delay in audits across programs would enable health plans and providers to redirect resources to other urgent concerns of the public health crisis.

ACHP looks forward to engaging with HHS and CMS to protect coverage and care during this crisis and to safeguard the stability of community-based health plans. We encourage the Administration to view ACHP and our member organizations as a resource to understand the needs of the individuals and communities our members serve. If you have questions or require additional information, please contact Michael Bagel, ACHP Director of Public Policy, at [redacted] or [redacted].

Sincerely,

Ceci Connolly

Ceci Connolly I President and CEO I Alliance of Community Health Plans
1825 Eye Street, NW, Suite 401, Washington, District of Columbia 20006
Email: [redacted] I Ph: [redacted] I **https://protect2.fireeye.com/url?k=8da74338-d1f36a13-8da77207-0cc47a6d17cc-690fd6b2e0f3243d&u=http://www.achp.org/**



April 13, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

In the face of the worst public health crisis in modern history, we as governors are taking unprecedented steps to protect the people of our states from the coronavirus pandemic and the economic devastation occurring in its wake. Many of our states have taken the step of waiving co-payments for coronavirus-related testing and treatment through our Medicaid programs and have encouraged our private insurers to do the same. We all know that more needs to be done to increase access to affordable health care during this crisis, however. To that end, we would ask that you reconsider your decision and immediately open a special enrollment period of at least 30 days on the federal health care exchange. A special enrollment period would ensure individuals in the 38 states on the federal exchange, in addition to those who already qualify, can purchase the coverage they need during this challenging time.

Too many of our constituents are uninsured or underinsured despite the steps we've taken at the state level. As a result, far too many of our residents are choosing to forgo coronavirus testing and treatment out of fear of the potential costs to themselves and their families at a time of increasing economic distress. Not only is this unacceptable, it's also dangerous as it undermines our ability as a nation to stop the spread of COVID-19. As you know, one of the most important tools we have as a country to get this virus under control is widespread testing. Testing allows us to identify where the virus is and where to allocate resources to prevent spread and ensure treatment for those who have been infected.

It is essential that we remove every barrier as quickly as possible to ensure those in our states and across the country are able to access the treatment they need. One of the most effective ways this can be done is by opening up a federal special enrollment period to give everyone the chance to enroll in a health plan that offers the coverage they need with access to any qualifying subsidies.

In a time of a fast-moving pandemic, taking every step possible to expand access to health insurance is not just a responsible choice for the health of the individual, but also for the health of our communities, our states, and the country. We as governors have done and will continue to do everything we can for our residents, and we hope that you will take all the necessary steps that only you can for them as well.

We thank you for your careful attention to this matter and hope that you will act swiftly to allow for a special enrollment period.

Sincerely,

Governor Gretchen Whitmer
State of Michigan

Governor John Carney
State of Delaware

Governor JB Pritzker
State of Illinois

Governor Janet Mills
State of Maine

Governor Steve Bullock
State of Montana

Governor Phil Murphy
State of New Jersey

Governor Michelle Lujan Grisham
State of New Mexico

Governor Roy Cooper
State of North Carolina

Governor Kate Brown
State of Oregon

Governor Tom Wolf
State of Pennsylvania

Governor Ralph Northam
State of Virginia

Governor Tony Evers
State of Wisconsin

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(http://www.youtube.com/user/waysandmeansdems)

DEMOCRATIC HEALTH LEADERS CALL ON TRUMP ADMINISTRATION TO HELP MILLIONS AFFECTED BY COVID-19 ACCESS HEALTH COVERAGE

Apr 13, 2020 | Press Release

WASHINGTON, DC – After another staggering and unprecedented spike in claims for unemployment benefits, House and Senate Democratic health leaders reiterated an urgent request for the Trump Administration to immediately establish a new Special Enrollment Period (SEP) for millions affected by the ongoing economic and health crisis. The Democratic health leaders also called on the Trump Administration to use all administrative tools available to assist the millions affected by the coronavirus pandemic in accessing health insurance coverage, including through expanded awareness of the existing SEP for those who lose their job-based health coverage.

House Ways and Means Chairman Richard E. Neal (D-MA), Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ), Education and Labor Chairman Robert C. “Bobby” Scott (D-VA), along with Senate Finance Committee Ranking Member Ron Wyden (D-OR) and Senate Health, Education, Labor, and Pensions (HELP) Committee Ranking Member Patty Murray (D-WA) sent a letter (/sites/democrats.waysandmeans.house.gov/files/documents/2020-04-13%20SEP%

20Ltr%20to%20HHS%20TREAS%20DOL%20.pdf) to Health and Human Services Secretary Alex Azar, Treasury Secretary Steven Mnuchin, and Labor Secretary Eugene Scalia asking them to make it as easy as possible for Americans to access comprehensive care through the Affordable Care Act's Marketplaces.

"As shown by the historic, unprecedented spike in new claims for unemployment benefits, millions of Americans have already lost their jobs because of COVID-19," **wrote the lawmakers**. "Tragically, almost 17 million Americans have filed for unemployment benefits in the past 3 weeks and many more claims are expected in the coming months. Since most Americans receive their health insurance through their employer, those losing their coverage along with their jobs need to know their options for obtaining insurance so they can keep themselves, their families, and their communities safe and healthy with access to health care."

The lawmakers continued, "We reiterate our urgent request that the Administration immediately establish a new [SEP] for millions affected by this ongoing economic and health crisis. It is imperative that uninsured and underinsured Americans have access to comprehensive coverage through Healthcare.gov during this crisis and that further steps be taken to assist Americans who could benefit today from existing SEPs."

The lawmakers concluded, "It is incumbent on this Administration — alongside local and state governments, as well as the private sector — to streamline the enrollment process and take other measures to increase the awareness of coverage options that can benefit lower- and middle-income Americans."

The lawmakers also requested answers to the following questions:

- What actions will the Administration take to increase awareness of an SEP to potentially eligible consumers? Please also provide a timeline of these actions.
- How will the Administration reduce the burden on applicants through HealthCare.gov who may need to provide supporting documentation to prove loss of coverage?
- How will the Administration reduce the burden on applicants through HealthCare.gov whose income data on file, such as a previous year's tax return, may trigger an income inconsistency?
- Will the Administration provide additional protections with respect to tax filing reconciliation for applicants through HealthCare.gov who may struggle to accurately project their annual household income as a result of COVID-19?

- What steps is the Administration taking to inform consumers about the lack of coverage non-ACA compliant plans may provide for COVID-19 and other serious medical conditions?

Full text of the letter is available **HERE** (/sites/democrats.waysandmeans.house.gov/files/documents/2020-04-13%20SEP%20Ltr%20to%20HHS%20TREAS%20DOL%20.pdf).

###

Congress of the United States
Washington, DC 20515

April 13, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Steven T. Mnuchin
Secretary of the Treasury
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Eugene Scalia
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Dear Secretary Azar, Secretary Mnuchin, and Secretary Scalia:

We write regarding the pressing need for the Administration to support uninsured and underinsured Americans and ensure that they have access to comprehensive coverage amidst the coronavirus (COVID-19) pandemic. We reiterate our urgent request that the Administration immediately establish a new Special Enrollment Period (SEP) for millions affected by this ongoing economic and health crisis. It is imperative that uninsured and underinsured Americans have access to comprehensive coverage through Healthcare.gov during this crisis and that further steps be taken to assist Americans who could benefit today from existing SEPs.

As shown by the historic, unprecedented spike in new claims for unemployment benefits, millions of Americans have already lost their jobs because of COVID-19. Tragically, almost 17 million Americans have filed for unemployment benefits in the past 3 weeks and many more claims are expected in the coming months.[1] Since most Americans receive their health insurance through their employer, those losing their coverage along with their jobs need to know their options for obtaining insurance so they can keep themselves, their families, and their communities safe and healthy with access to health care. The Affordable Care Act's (ACA) Marketplaces and associated financial assistance can play a vital role in providing help to these families as well as others who lack access to affordable and comprehensive health coverage.

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[1] Department of Labor, Unemployment Insurance Weekly Claims (Apr. 9, 2020), https://www.dol.gov/ui/data.pdf.

The federal Marketplace currently provides an SEP for people who lose their job-based health coverage. However, many remain unaware of how to sign up or the existence of financial assistance to lower their costs. Employers laying off or furloughing employees may also not know how to best communicate the availability of Marketplace coverage. Further, many people that lacked employer-sponsored insurance before the pandemic continue to struggle to enroll in comprehensive coverage. The Administration's promotion of non-ACA compliant junk plans, such as short-term limited duration plans and those offered by health care sharing ministries, causes further confusion and may expose consumers to substantial financial harm.

The COVID-19 pandemic also creates high levels of uncertainty that may make it difficult for consumers to complete the enrollment process on HealthCare.gov. Projecting annual household income may be especially daunting right now — potentially leading to inconsistencies with existing Marketplace data sources that may also require submission of certain documents or loss of financial assistance at a time when families are coping with job loss. It is incumbent on this Administration to streamline the enrollment process and take other measures to increase the awareness of coverage options that can benefit lower- and middle-income Americans.

With families facing crises on many fronts, the process for securing and maintaining comprehensive health coverage should be as straightforward as possible. Therefore, we request that answers be provided to the following questions by April 20, 2020:

1. What actions will the Administration take to increase awareness of an SEP to potentially eligible consumers? Please also provide a timeline of these actions.

2. How will the Administration reduce the burden on applicants through HealthCare.gov who may need to provide supporting documentation to prove loss of coverage?

3. How will the Administration reduce the burden on applicants through HealthCare.gov whose income data on file, such as a previous year's tax return, may trigger an income inconsistency?

4. Will the Administration provide additional protections with respect to tax filing reconciliation for applicants through HealthCare.gov who may struggle to accurately project their annual household income as a result of COVID-19?

5. What steps is the Administration taking to inform consumers about the lack of coverage non-ACA compliant plans may provide for COVID-19 and other serious medical conditions?

Thank you for your urgent attention to this matter.

The Honorable Alex M. Azar II
The Honorable Steven T. Mnuchin
The Honorable Eugene Scalia
April 13, 2020
Page 3

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives

Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

Bobby Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives

Senator Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Senator Patty Murray
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

United States Senate

WASHINGTON, DC 20510-3203

April 13, 2020

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We write to urge you to follow congressional intent as you prepare to distribute funds remaining from the $100 billion designated for health care providers in the Public Health and Social Services Emergency Fund (PHSSEF) enacted in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, prioritizing speed and efficiency, equity with regard to payer mix, and targeting those areas hardest hit by the coronavirus (COVID-19) outbreak. We understand that you have decided to allocate the first $30 billion of the fund to all providers enrolled in Medicare Parts A and B based purely on their claim volume. While we appreciate the need to get funds out quickly, it is our strong view that the administration must allocate the remainder of the fund in a more targeted manner.

Health care providers across the country are on the front lines of preparing for and responding to this crisis. The Department of Health and Human Services Office of the Inspector General report "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23-27, 2020" confirms what we have been hearing for weeks:[1] hospitals and other health care providers are bearing the brunt of this emergency. At the same time, in an effort to "flatten the curve" providers are seeing a significant decrease in revenue as they cancel elective procedures and routine office visits. This is creating an impossible task for health care organizations with few patients coming through their doors: fulfill their commitment as essential providers in their communities as dwindling resources make it more and more difficult to keep those doors open.

Those providers located in COVID-19 "hot spots" are overwhelmed, facing increased costs associated with training and protecting their staff and building surge capacity. Hospitals and other providers in areas hit hardest by the pandemic have invested millions of dollars. Retrofitting and constructing new facilities, purchasing essential medical supplies and equipment, and supporting an adequate workforce are just some of the costs providers are incurring. As cases of COVID-19 in the United States exceed 370,000, health care providers need immediate emergency relief as they work to save lives and stop the spread of this disease.[2]

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[1] https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf
[2] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

Congress allocated $100 billion for health care providers in the PHSSEF for exactly this purpose. There is currently significant geographic variation in the severity and duration of the COVID-19 outbreak. Providers in some states have been coping with increased costs and falling revenues for weeks and still haven't reached the peak of their outbreak. We urge you to consider this variation when distributing rounds of funds from the $100 billion allocation, ensuring that relief is targeted to areas that need it most. Any and all criteria used to allocate funds to providers should be relevant to the specific needs created by the COVID-19 emergency and should not discriminate against providers in need based on payer mix.

Finally, we are alarmed to learn of the Administration's plan to use these essential funds as a political tool. Yet again, this Administration is putting politics before patients by letting its opposition to the Affordable Care Act stand in the way of obvious solutions to expand coverage, such as opening a special enrollment period on the Federal marketplace and taking steps to facilitate Medicaid expansion in states that have not done so. Instead, the Administration wants to use limited dollars in the PHSSEF as a band-aid to offset providers' cost of uncompensated care while doing nothing to address the core issue – helping people get comprehensive coverage for all their health needs. This is at the expense of using those dollars as Congress intended – training and protecting health care workers, expanding surge capacity, and assisting those in the health care system who have been forced to ramp down services in an effort to prevent the spread of COVID-19. The Administration's decision to pay providers Medicare rates for treatment of uninsured adds further inequity to the fund distribution by disadvantaging providers in states that have worked to expand coverage. We urge you to use the $100 billion in funds for emergency relief purposes and to work with Congress on ways to cover the uninsured.

Congress intended the Administration to allocate the PHSSEF funding quickly in order to help those providers on the front lines of this outbreak. Any forthcoming package to continue the COVID-19 response must contain another $100 billion in the PHSSEF to ensure all providers have the resources they need. We request that these and future funds be allocated as quickly and simply as possible, while targeting resources for those providers struggling to meet the strain of increasing costs and falling revenue.

Sincerely,

Charles Schumer | Patty Murray | Ron Wyden

Charles E. Schumer
United States Senator

Patty Murray
United States Senator

Ron Wyden
United States Senator

[CORONAVIRUS] Attorney General Xavier Becerra +21: Job Loss Special Enrollment Period

---

From: Neli Palma <Neli.Palma@doj.ca.gov>

Sent: Tuesday, April 14, 2020 12:14 PM

To: Azar, Alex (OS/IOS) <Alex.Azar@HHS.GOV>; Verma, Seema (CMS/OA) <Seema.Verma@cms.hhs.gov>

Cc: Narasimhan, Sripriya <SNarasimhan@ncdoj.gov>; Restuccia, Eric (AG) <RestucciaE@michigan.gov>; Melanie Fontes Rainer <Melanie.Rainer@doj.ca.gov>; Neli Palma <Neli.Palma@doj.ca.gov>

Subject: Job Loss Special Enrollment Period Multi-State Letter

Dear Secretary Azar and Administrator Verma,

Please see the attached multi-state letter urging the administration to develop and implement an outreach plan to inform the millions of Americans who have already or will lose their employer-sponsored health insurance coverage due to the pandemic of the Special Enrollment Period that is available to them through Healthcare.gov and state-based marketplaces.

Thank you.

Neli

Neli N. Palma

Deputy Attorney General

California Department of Justice

Office of the Attorney General

1300 I Street, Sacramento, CA 95814

Office: (916) 210-7522

Cell: (415) 810-6354

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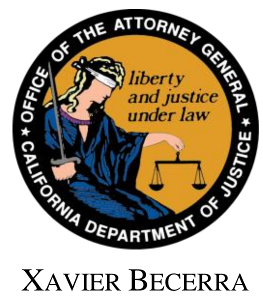

XAVIER BECERRA
ATTORNEY GENERAL

DANA NESSEL
ATTORNEY GENERAL

JOSH STEIN
ATTORNEY GENERAL

April 14, 2020

Secretary Alex M. Azar II
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Via Email and U.S. Mail

Administrator Seema Verma
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Via Email and U.S. Mail

Dear Secretary Azar and Administrator Verma:

The undersigned State Attorneys General of California, Michigan, North Carolina, Colorado, Connecticut, Delaware, the District of Columbia, Hawai‘i, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington urge the Centers for Medicare & Medicaid Services (CMS) to develop and implement immediately an outreach plan to inform the millions of Americans who have already or will lose their employer-sponsored health insurance coverage of the Special Enrollment Period that is available to them through Healthcare.gov and state-based marketplaces.[1] In the midst of this unprecedented international healthcare crisis, millions of Americans are suffering or will suffer the dual loss of their livelihood and their family's healthcare coverage. It is incumbent upon the U.S. Department of Health and Human Services (HHS) to provide those Americans the information and tools needed to navigate their healthcare options. The Affordable Care Act (ACA) specifically contemplates the need for adaptability to help people in these circumstances maintain coverage. 42 U.S.C. § 18031(c)(6)(B).

The ACA requires the HHS Secretary to provide for yearly open enrollment periods on the Exchanges. 42 U.S.C. § 18031(c)(6)(B). Outside of this period, individuals may enroll in coverage through the exchange only if they qualify for a special enrollment period due to certain

[1] This letter is a follow up to the multi-state letter sent on April 3, 2020, that urged HHS to open a special enrollment period to allow all uninsured individuals to obtain coverage due to the unprecedented circumstances of the COVID-19 pandemic. *See* https://www.oag.ca.gov/system/files/attachments/press-docs/CA%20NC%20COVID-19%20healthcare%20exchange%20letter%20plus%20IA.pdf.

life events such as loss of employment for individuals whose employers provided healthcare coverage. *See id*. § 18031(c)(6); 26 U.S. Code § 9801(f). Informing individuals of the potential for replacing the coverage they have lost through Healthcare.gov and state-based marketplaces is vital, as most Americans obtain their healthcare coverage through their employer. In 2018, for example, over half, or 55.1%, of individuals under age 65 had insurance through an employer.[2]

The importance of this outreach will only increase as the economic upheaval caused by this crisis continues to expand. A new study by the Health Management Associates estimates that the number of people receiving coverage from an employer could decline by up to 35 million, including both workers and covered family members, due to layoffs caused by the COVID-19 pandemic.[3] This same study estimates that the economic impact to the labor market could disproportionately impact the roughly 58 million non-elderly individuals who have employer-sponsored coverage and earn less than $50,000 per year.[4] This heavily hit population would greatly benefit from learning that they qualify for subsidies to help pay for healthcare coverage.

Recent polling indicates that awareness of coverage options even during the regular open enrollment period remains low among marketplace-insured and eligible uninsured. It is therefore likely that awareness about this Special Enrollment Period for the recent laid-off is even lower.[5] Concerns about a lack of awareness are heavily fueled by the administration's cuts to marketplace advertising and consumer assistance budgets.[6] But the evidence indicates that marketplace advertising and consumer assistance works in increasing enrollment numbers and stabilizing markets. It is for this reason that states that run their own Exchanges, like California, continue to invest heavily in such activities to support their state-based marketplaces. Indeed, one report indicates that if the federal government conducted marketing and outreach at a level

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[2] Edward R. Berchick, et al., "Health Insurance Coverage in the United States: 2018," U.S. Census Bureau, Nov. 2019, 2018, at 2, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[3] https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf.

[4] *Id.*

[5] Katie Keith, "CMS Could Do More In Light Of The Coronavirus Crisis," Health Affairs, March 25, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200325.501048/full/; *See also* Hart Research Associates, "New Polling among ACA Marketplace Insured and Eligible Uninsured, Oct. 23, 2019, https://drive.google.com/file/d/0BwWzJPQpHwx9VXdlX2hSUlR0VW1UZjBmMklqSlZtZ0Ffd2d3/view.

[6] Sabrina Corlette, et al., "States Lean in as the Federal Government Cuts Back on Navigator and Advertising Funding for the ACA's Sixth Open Enrollment," The Commonwealth Fund, Oct. 26, 2018, https://www.commonwealthfund.org/blog/2018/states-lean-federal-government-cuts-back-navigator-and-advertising-funding.

similar to Covered California, it could result in lower premiums and 2.1 million more enrollees.[7] HHS, as the operator of Healthcare.gov, must step in to get the word out to those impacted in 38 States that rely on the federal exchange and to fill in gaps for state-based exchanges that do not have budgeted funds for this unexpected campaign. *See*, *e.g*., 42 U.S.C. § 18031(b)(1)(a); *see also* 45 C.F.R. § 155.205(e) (directing that the exchange must conduct outreach and education activities to educate consumers about the exchange and insurance affordability programs to encourage participation). HHS should also ensure that outreach materials are translated into the same range of languages as other HHS vital documents, in order to ensure meaningful access to information about the Special Enrollment Period.

We must empower individuals and working families across the country to pursue the best coverage option for them, whether it is Exchange coverage, COBRA, Medicare, Medicaid, or the Children's Health Insurance Program. The federal government's promise to reimburse for testing and treatment of COVID-19 for the uninsured[8] is a step forward but it will not help provide recently unemployed Americans the comprehensive healthcare they may so desperately need to avoid large hospital and insurance bills in the long-run.

It is imperative that HHS actively and immediately implement outreach and education for consumers as directed under the Affordable Care Act. This will ensure that people across the country are informed and empowered to make the best decision about their healthcare options.

Sincerely,

Xavier Becerra
California Attorney General

Dana Nessel
Michigan Attorney General

Josh Stein
North Carolina Attorney General

Phil Weiser
Colorado Attorney General

[7] Peter V. Lee, et al., "Marketing Matters: Lessons from California to Promote Stability and Lower Costs in the National and State Individual Insurance Markets," Covered California, Sept. 2017, https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

[8] *See* https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-18/.

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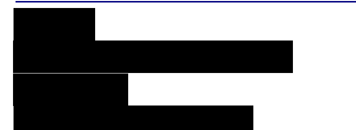
Virginia Attorney General

Bob Ferguson
Washington Attorney General

From:
Sent: Tuesday, April 14, 2020 1:28 PM
To:
Subject: FW: Covered CA - SEP Enrollment Update
Attachments: 041420 - CoveredCA - COVID-19 Enrollment - Final.pdf; External Affairs Social Media Toolkit April 2020[26473].pdf



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From: Green, Kelly (CoveredCA)
Sent: Tuesday, April 14, 2020 1:22 PM
To: Green, Kelly (CoveredCA)
Subject: Covered CA - SEP Enrollment Update

Good morning!

Covered California announced today that more than 58,000 consumers have enrolled in health insurance coverage through the exchange since it announced a "Special Enrollment Period" in response to the COVID-19 pandemic. The pace of sign-ups has been nearly three times the level that Covered California saw during the same period in 2019.

The enrollment data released today covers a three-week period from March 20th, the date the Special Enrollment Period was launched, through April 7th. Additionally, Covered California has seen significant interest online with more than 885,000 new users visiting CoveredCA.com (twice as many as the number of visits seen during the same time period last year) and more than 129,000 unique views of the Medi-Cal page.

The attached press release details more information about today's announcement, including highlights of a partnership with the California Employment Development Department (EDD) to reach the unemployed and alert those who are uninsured that they can get health insurance coverage through Covered California or Medi-Cal. The press release also includes important reminders related to telehealth options, free medically necessary COVID-19 screening and testing, and the availability of financial assistance to help consumers with their health insurance costs.

As a reminder, Covered California launched a Special Enrollment Period in response to the COVID-19 pandemic which allows any eligible uninsured individual who needs health insurance coverage to sign up by June 30, 2020. Depending on their eligibility, consumers who sign-up through Covered California could enroll in a Covered California health insurance plan **or** in Medi-Cal, which provides free or low-cost coverage to eligible individuals and families. In addition to enrolling online at CoveredCA.com, consumers who need health care coverage can visit Covered California's "Find

Help" page to get assistance over the phone from one of Covered California's thousands of Certified Insurance Agents. The Help on Demand feature allows consumers to get a call back from a certified enroller.

Additionally, current Covered California enrollees may qualify for more financial help to lower the cost of their coverage if they have experienced a loss of income due the COVID-19 pandemic. Consumers can report an income change by logging in to their account at CoveredCA.com.

We encourage you to continue raising awareness of the Special Enrollment Period to your respective constituencies. We are resending our social media toolkit that your office can use to help promote enrollment at this very important time.

Please don't hesitate to reach out if you have any questions about the information provided in today's announcement. We will continue to provide updates as we can, and in the meantime hope you are taking care and staying safe.

Thank you!

Kelly

Kelly Green | Director | External Affairs
P [redacted] **E** [redacted]
Covered California™ 1601 Exposition Boulevard, Sacramento, CA 95815 **CoveredCA.com**

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News Release

Media line: (916) 206-7777 @CoveredCANews media@covered.ca.gov

FOR IMMEDIATE RELEASE
April 14, 2020

Covered California Enrolls Tens of Thousands as Impacts of COVID-19 Pandemic Hits California Households

- *More than 58,000 people have signed up for coverage through Covered California since March 20, when a special-enrollment period was announced in response to the COVID-19 pandemic.*
- *Covered California has seen a tremendous surge in consumers visiting CoveredCA.com and the website's Medi-Cal page.*
- *The special-enrollment period allows anyone uninsured and eligible to enroll in health care coverage through Covered California to sign up through June 30.*
- *Consumers can enroll in as little as 30 minutes, either through CoveredCA.com or over the phone with the help of one of Covered California's thousands of Certified Insurance Agents or enrollers.*
- *In addition, Medi-Cal enrollment is open year-round for consumers who qualify.*

SACRAMENTO, Calif. — Covered California announced on Tuesday that 58,400 people had enrolled in health care coverage since the exchange announced a special-enrollment period in response to the COVID-19 pandemic. The pace of sign-ups has been nearly three times the level that Covered California saw during the same period in 2019.

"We want to remind consumers that they can get access to the care they need during this crisis, either through Covered California or Medi-Cal," said Peter V. Lee, executive director of Covered California. "We know there are hundreds of thousands of people out

(more)

there who have either lost their health insurance or were uninsured when this crisis began, and we want them to know there is a path to coverage ready for them."

The enrollment data covers the three-week period from March 20, when Covered California opened the health insurance exchange to any eligible uninsured individuals who need health care coverage amid the COVID-19 emergency, through April 10. Anyone who meets Covered California's eligibility requirements, which are similar to those in place during the annual open-enrollment period, can sign up for coverage through June 30.

In addition, Covered California has seen tremendous consumer interest online, with more than 885,000 new users visiting CoveredCA.com, which is twice the number of visits seen during the same time period last year. During the same period, of those coming to CoveredCA.com, there were also more than 129,000 unique page views to the Medi-Cal page.

"While Covered California is enrolling tens of thousands of people, we know that is only a small part of California's response and that many, many more people will get the health care they need through Medi-Cal," Lee said.

Signing Up for Health Care Coverage

Consumers can easily enroll through CoveredCA.com and find out whether they are eligible for financial help through Covered California or if they are eligible for no-cost or low-cost coverage through Medi-Cal. People who sign up through Covered California will have their coverage begin on the first day of the following month. Those eligible for Medi-Cal can have coverage that is effective retroactively to the first day of the month from when they submitted their application.

"We are living in unprecedented times, and California is doing everything it can to make sure people have access to care during this public health emergency," Lee said. "Having more people insured and protected is the right thing for California's families and helps keep everyone better off as those with insurance don't delay getting needed care."

In addition to enrolling online, consumers who need health care coverage can visit Covered California's "Find Help" page to get assistance over the phone from one of Covered California's thousands of Certified Insurance Agents. The "Help on Demand" feature allows consumers to get a call back from a certified enroller.

"Right now, when social distancing is the new normal and an essential response to the coronavirus pandemic, health insurance is only a phone call away," Lee said. "Being restricted to your home does not mean you cannot get personal and confidential help that is free."

(more)

Consumers can easily find out if they are eligible for Covered California or Medi-Cal, and see which plans are available in their area, by using the Shop and Compare Tool and entering their ZIP code, household income and the ages of those who need coverage.

Reaching the Unemployed

Covered California is also working with California's Employment Development Department (EDD) to alert the uninsured that they can get health care coverage through the exchange or Medi-Cal. Covered California produced the following insert, which is being included in unemployment benefits that are being sent to consumers. During each of the next three months, Covered California plans to deliver 3.5 million inserts to EDD for distribution.

Lost Your Job and Need Health Insurance

If, when you lost your job, you lost your health insurance, Covered California can help. We can guide you on how to get low or no-cost health insurance that you need to protect you and your loved ones. We all know, now more than ever, how important it is to have coverage. If you or someone you know is without coverage, financial help to pay for health insurance may be available through Covered California.

Visit us online or call our knowledgeable experts. **CoveredCA.com | 855.312.3234**

Health Plans Available Through Covered California

Insurance companies vary by region.

Lowering the Cost of Coverage for Those With Insurance

Existing Covered California consumers may be able to lower the cost of their coverage if they have experienced a loss of income due to the economic impacts of the COVID-19 pandemic. The price of consumers' monthly premiums is based in part on their income, and if that income goes down, they may be eligible for additional financial help from the federal government, state, or both.

Consumers can report an income change by logging in to their account at CoveredCA.com. Consumers who are having trouble accessing their account can reset their password online.

(more)

Coverage You Can Count On

During this public health emergency, it is important to note that all health plans offered through Covered California and by Medi-Cal provide telehealth options for enrollees, giving individuals the ability to connect with a health care professional by phone or video without having to personally visit a doctor's office or hospital.

All medically necessary screening and testing for COVID-19 are free of charge. This includes telehealth or doctor's office visits as well as network emergency room or urgent care visits when necessary for the purpose of screening and testing for COVID-19. In addition, Medi-Cal covers costs associated with COVID-19 testing, evaluation and treatment services in both its managed care plans and with fee for service providers. Covered California health plans will help cover costs that arise from any required treatment or hospitalization.

In addition, most Covered California plans offer "first-dollar" coverage, meaning outpatient services are not subject to a deductible.

"A core part of our mission is improving access to high-quality health care, and that has never been more important than it is right now in California," Lee said.

New State Subsidies Help Californians Lower Their Health Care Costs

Californians who sign up for coverage may be able to benefit from a new state subsidy program that expanded the amount of financial help available to many people. The subsidies are already benefiting about 625,000 Covered California consumers. Roughly 576,000 lower-income consumers, who earn between 200 and 400 percent of the federal poverty level (FPL), are receiving an average of $608 per month, per household in federal tax credits and new state subsidies (which averages $23 per household). The financial assistance lowers the average household monthly premium from $881 per month to $272, a decrease of 70 percent.

In addition, nearly 32,000 middle-income consumers have already qualified for new state subsidies, with average state subsidy to eligible households at $504 per month, lowering their monthly premium by nearly half.

Many of those eligible for the new middle-income state subsidies are an estimated 280,000 Californians who are likely eligible for new state or existing federal subsidies but kept their "off-exchange" coverage. They are also eligible to switch to Covered California and benefit from the financial help. During this special-enrollment period, Covered California, its health insurance companies and Certified Insurance Agents will be reaching out to these Californians to let them know how they can save money on their premiums – which will help them keep their coverage in challenging financial times.

Covered California had established a special-enrollment period for those who were newly becoming aware of state subsidies or the new California mandate penalty, and

(more)

sign-ups during the special enrollment period prior to March 20 were up 80 percent over the same period in 2019.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- Get free and confidential assistance over the phone, in a variety of languages, from a certified enroller.
- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

About Covered California

Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

About the California Department of Health Care Services (DHCS)

DHCS is the backbone of California's health care safety net. It provides access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. DHCS funds health care services for about 13 million Medi-Cal beneficiaries and is the largest health care purchaser in California. It collaborates with the federal government and other state agencies, counties, and partners to invest more than $100 billion for the care of low-income families, children, pregnant women, seniors and persons with disabilities. For more information about DHCS, please visit www.dhcs.ca.gov.

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Special Enrollment 2020
Social Media Toolkit
External Affairs

April 2020

‘How to’ Instructions

All copy and images can be used on Facebook, Instagram, Twitter or LinkedIn.

1. Copy and paste the caption on the post you’d like to share. You may make any necessary edits as you see fit, or to personalize with your contact information.

2. Be sure to tag Covered California so people can click to learn more. For Facebook or LinkedIn, type “@Covered California” and select the page from the drop-down when it appear. For Instagram or Twitter, type “@CoveredCA” to tag the page.

3. Don’t forget to include the #CoveredCA hashtag!

[IMAGE HERE]

Save the matching image from the shared folder and
upload it to Facebook or Twitter.

COVID-19 as Qualifying Life Event

Suggested Copy:

Do you need health coverage due to the #coronavirus? You can enroll now in a health plan through Covered California due to the #COVID19 crisis and may be eligible to receive financial help to reduce what you pay for coverage. Get started here: https://covrdca.com/3ac3J6E

¿Necesitas seguro médico debido al #coronavirus? Ahora puedes inscribirte en un plan de salud a través de Covered California debido a la crisis del virus #COVID19 y podrías calificar para recibir ayuda económica para ayudarte a pagar por tu cobertura. Empieza aquí: https://covrdca.com/33EGaAV

Note: This is a video file, but it can be uploaded the same way as a JPG (photo file).

COVID-19 as Qualifying Life Event - 2

Suggested Copy:

We know it's a stressful time. That's why Covered California is here to help you get health coverage if you've recently lost yours. Learn more about enrolling here: https://covrdca.com/2Uhy6CU #COVID19 #Coronavirus

Sabemos que estos son momento estresante. Y por eso Covered California está aquí para ayudarte a obtener cobertura médica si recientemente perdiste la tuya. Obtén más información sobre cómo inscribirse aquí: https://covrdca.com/2UEIZ1E #COVID19 #Coronavirus

Report a Change

Suggested Copy:

Have you had a loss in income due to #coronavirus? If you're a Covered California member, be sure to report a change in your income, as it could mean you may receive additional financial help to pay for health coverage. #COVID19 https://covrdca.com/2R8H2tk

¿Has tenido una pérdida en tus ingresos debido al #coronavirus? Si eres miembro de Covered California, asegúrate de reportar un cambio en tus ingresos, ya que podrías recibir ayuda económica adicional para pagar por tu cobertura médica. #COVID19 https://covrdca.com/2JuZhUO

Local Help

Suggested Copy:

Need help getting covered? Call one of Covered California's certified enrollers in our area! They'll guide you through the enrollment process at no cost. https://covrdca.com/2wVsXHF

¿Necesitas ayuda para obtener cobertura? ¡Llama a uno de los agentes certificados de Covered California en nuestra área! Ellos te guiarán de forma gratuita por el proceso de inscripción. https://covrdca.com/2I2JJqI

“Enroll Now” TV Spot – Video

Suggested Copy:

You can enroll now! Covered California is here to help you find health insurance you can afford. It’s also the only place you can get financial help to pay for coverage. #COVID19 #Coronavirus

https://youtu.be/_X_avBOBvXU

¡Puedes inscribirte ahora! Covered California está aquí para ayudarte a encontrar un seguro médico que se ajuste a tu bolsillo. También es el único lugar donde puedes obtener ayuda económica para pagar por tu cobertura. #COVID19 #Coronavirus

https://youtu.be/4SFJg6c9g2k

Follow & Tag "@CoveredCA" on these channels:

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Twitter - www.twitter.com/CoveredCA

Instagram - www.instagram.com/coveredca

LinkedIn - www.linkedin.com/company/coveredca

*Don't forget to include the **#CoveredCA** hashtag!*

THANK YOU!

RON WYDEN
OREGON

RANKING MEMBER OF COMMITTEE ON
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SELECT COMMITTEE ON INTELLIGENCE
JOINT COMMITTEE ON TAXATION

April 15, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington D.C. 20201

Dear Secretary Azar:

As the Department of Health and Human Services (HHS) prepares to distribute the $70 billion in remaining funds allocated for health care providers to prevent, prepare for, and respond to the COVID-19 crisis, we urge you to prioritize transparency, equity, and urgency in issuing additional rounds of funding.

As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), Congress provided $100 billion in funding for the Public Health and Social Services Emergency Fund (PHSSEF) to help support hospitals and other health care providers across the country during this time of need. While we appreciate your efforts to distribute the first $30 billion of these funds based on fiscal year (FY) 2019 Medicare fee-for-service claims data, the Administration failed to deliver much needed relief to many essential providers across the country due to this approach. We continue to hear from providers in each of our states, including children's hospitals, hospice organizations, hospitals in rural and underserved urban areas, physicians, nursing homes, residential care and senior living communities, behavioral health care providers, community health centers, home health agencies and direct service providers, and other front line providers that need additional financial support immediately to ensure they make it through this crisis.

Congress intended the PHSSEF to provide necessary financial support to providers for health care expenses related to COVID-19 that would be otherwise ineligible for reimbursement. On behalf of our constituents – from those in the intensive care unit managing acutely sick patients to those who have done their part to stop the spread by closing their doors to elective and routine procedures – we urge you to act swiftly and distribute the remaining funds in a manner consistent with Congressional intent. In particular, we urge HHS to:

Provide Complete, Appropriate, and Immediate Transparency

1. HHS should provide a detailed and publicly available account of all distributed funds, including the $30 billion that has already been released. For this initial tranche, HHS should release this information broken out by state, congressional district, and provider. The methodology used to determine the distribution of these funds should also be described. This information and all information on future allocations should be easily accessible such that providers and the taxpayer can locate this critical information in a timely fashion.

2. HHS should be transparent about what criteria is used to determine the providers receiving funds, including how it defines "hot spot" areas or other characteristics used to identify providers with the greatest needs, as well as the level of funding those providers receive as a result of that criteria.

Ensure Equitable Distribution of Funds

1. Any methodology used for future distribution should, at a minimum, take the following factors into account: 1) providers left out by the methodology applied in the first distribution of funds, such as Medicaid-dependent safety net providers, and those with variable payer mix, including Medicare Advantage; 2) the impact of lost revenue as a result of a moratorium on elective care; 3) the burden on community-based organizations providing routine care essential to keeping patients at home; and 4) the severity of the outbreak in a geographic area.
2. HHS should refrain from using funds from the PHSSEF to make up for gaps in coverage as a result of a state's decision not to expand Medicaid, or the Administration's decision to reject opening a nationwide Special Enrollment Period. HHS should ensure that all states, and therefore all providers, receive the resources they need and are not penalized for their efforts to expand qualified, comprehensive health coverage.

We are committed to supporting our nation's health care providers with the resources they need to manage this crisis and continue providing care to their communities after the COVID-19 emergency. We stand ready to work with you at this critical juncture, and will support any additional funding necessary to protect and support our health care providers and the individuals and families they care for.

Thank you in advance for your efforts to distribute the remaining $70 billion in PHSSEF resources rapidly to provide equitable, transparent support to the health care providers caring for our communities during this crisis.

Sincerely,

Senator Ron Wyden

Senator Debbie Stabenow

Senator Sherrod Brown

Senator Thomas R. Carper

Senator Michael F. Bennet

Senator Sheldon Whitehouse

/s/

Senator Robert P. Casey, Jr.

Senator Robert Menendez

Senator Benjamin L. Cardin

Senator Margaret Wood Hassan

/s/

Senator Mark Warner

Senator Catherine Cortez Masto

Association for Community Affiliated Plans
1155 15th Street, N.W., Suite 600 • Washington, DC 20005
202.204.7508 • www.communityplans.net
Christopher D. Palmieri, Chair • Margaret A. Murray, Chief Executive Officer

April 16, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Randy Pate
Deputy Administrator & Director
Center for Consumer Information and
Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Sent via Email

Dear Administrator Verma & Deputy Administrator Pate:

The growing spread of COVID-19 poses an unprecedented challenge to the nation's health care system and will place a significant and unpredictable strain on the resources of all stakeholders in the United States health care system. The Association for Community Affiliated Plans (ACAP) stands in committed partnership with the U.S. Department of Health and Human Services as we all work to address this crisis.

ACAP is a national trade association representing 75 not-for-profit Safety Net Health Plans (SNHP). Collectively, ACAP plans serve more than 20 million people through Medicaid, Medicare, the individual Marketplaces, and other publicly-supported coverage programs, including one-third of all individuals covered in Medicaid managed care. Our mission is to support our member plans' efforts to improve the health and well-being of people with low incomes and with significant health care needs.

As part of that mission, 54 of ACAP's community-based Safety Net Health Plans signed a pledge to their Medicaid and Medicare members on April 2. These 54 plans from around the country committed to waive all deductibles, co-insurance, and co-payment for diagnosis and medically-necessary acute treatment of COVID-19; to waive prior authorization requirements for those same tests and treatment; to waive early medication refill limits on prescriptions; and to support efforts to move provider visits to a telehealth setting to the maximum extent possible. A number of ACAP's plans have committed to the same policies for their Exchange enrollees. These efforts are already underway, along with plans' efforts to support their providers, members, and staff over the coming months.

ACAP has received input from its members in the individual market, and now writes to urge further necessary policy changes that will equip Safety Net Health Plans in the Marketplace to fight COVID-19 as effectively as possible. ACAP urges CMS to:

1. Implement a **federal Special Enrollment Period**
2. Issue a temporary moratorium on **Short-Term, Limited Duration Insurance**
3. Allow issuers to **reinstate coverage for consumers** that have been terminated due to non-payment of premiums
4. Delay the recently-released **rate filing** submission deadlines

5. Extend the comment period for the **QRS and QHP Enrollee Survey**
6. Delay implementation of rule on **Interoperability**
7. Delay **Transparency in Coverage** rule

ACAP also thanks CMS for implementing several delays and providing requested guidance that ACAP previously asked for on behalf of our plans in the individual market. In particular, we want to thank you for the recent guidance on telehealth and ways to prevent member disenrollment following the 90-day nonpayment grace period. Likewise, we thank you for the delays to the 2019 Risk Adjustment EDGE filings and 2019 RADV program, which will allow plans' operational and financial teams to devote their full energy to addressing the impact of COVID-19.

ACAP asks CMS to address the following issues:

Federal Special Enrollment Period (SEP). While we recognize the funds set aside for the uninsured in the CARES Act, we are also aware that such funds will not be sufficient for addressing the full medical needs of consumers presenting with COVID or COVID-like symptoms. Media accounts are starting to document consumer fears of presenting for COVID testing and treatment by those who are uninsured or underinsured. We believe that a federal SEP, similar to that instituted by many states so far, would be a valuable tool in lessening the impact of COVID-19 on consumers, providers, and our nation's health care infrastructure. Scholars at the American Enterprise Institute have urged the creation of a federal SEP to mitigate the spread of COVID across our nation and ensure adequate hospital capacity for those who need it most.

Likewise, as suggested in the same article, we also believe that a risk mitigation program, such as reinsurance or a risk corridor program or even direct payments to plans that exceed a specified MLR, should be paired with any new SEP in order to ensure that premiums do not skyrocket in 2021 due to adverse selection and unanticipated, mid-year changes to the risk pool. A federal SEP paired with a risk mitigation program will be a more efficient use of federal dollars than direct payments for the uninsured, who are expected to wait until they are sicker to seek treatment.

- ACAP urges CMS to establish a federal, prospective SEP open to all, coupled with a federal, risk mitigation backstop.

Limit Short-Term, Limited-Duration Insurance. As with the federal SEP discussed above, ACAP believes that comprehensive health care coverage is of vital importance – especially during recessions and times of economic need. For example, it is one reason that the counter-cyclical nature of the Medicaid program has played such a vital role during times of emergency. While ACAP's objection to short-term, limited-duration insurance is well-documented, we believe that its shortcomings will only serve to exacerbate the public health crisis we are facing. Specifically, consumers with such plans have expressed concern about getting COVID-19 testing or treatment, and those who do present for testing and treatment can expect to receive significant surprise medical bills given that STLDI plans often do not have true provider networks. Given the limited benefits and coverage generally offered by STLDI plans, consumers with such plans will quickly discover that they are left essentially without

coverage. Accordingly, we urge the Administration to limit STLDI to both align with its true intent—as short-term insurance to fill gaps in coverage rather than as an alternative form of primary coverage, and to issue a moratorium on such plans during this time of emergency. We urge a return to the 2016 CMS regulatory definition in an expeditious manner while at the same time establishing, at minimum, a temporary moratorium on such plans altogether or requiring that such plans provide benefits and coverage for COVID testing and treatment equivalent to that provided by QHPs. In order to minimize impact on consumers whose short-term plans would be terminated, we urge CMS to consider a concurrent special enrollment period (such as above) to permit consumers to purchase comprehensive coverage.

- ACAP urges CMS to issue a temporary moratorium on STLDI plans altogether and enact a concurrent SEP to ensure that consumers are able to access comprehensive coverage and care. CMS should further act to restore such plans to their intended use of filling gaps in coverage.

Coverage Terminations. The economic impact of this pandemic is well-documented, from deceased revenues for individuals working in the "gig economy" to staggering unemployment numbers. We appreciate CMS' guidance on how to delay the grace period and associated coverage terminations during this emergency for consumers that cannot afford their premiums. However, we urge CMS to also permit issuers to reinstate coverage for consumers who lose their coverage due to nonpayment of premiums. We do not believe that consumers impacted by job-losses during this trying time should further punished by the loss of their health coverage if they are able to start paying premiums again later in the year.

- Likewise, we urge CMS to allow additional flexibility for consumers who are terminated from coverage due to non-payment of premiums to reinstate their coverage.

Rate Filing Submission Deadlines. The recently-finalized timeline for QHP certification in the Federally-Facilitated Exchanges set the initial rate filing submission deadline on July 22. The most recent estimates predict the virus's peak will come in May, tapering off by mid-June. This would give health plans barely one month to estimate and fully account for the virus's impact on their finances and next year's rates. Even without accounting for possible revised estimates that may push the peak to summer, this is unrealistic and places undue burden on health plans that will still be dealing with large numbers of COVID-19 cases. Furthermore, there is no way to tell which areas of the country will see their peaks come sooner and which will come later, which would lead to disparities between those plans able to accurately set rates for next year and those not able to do so. Therefore, ACAP urges CMS to delay the rate filing deadlines by at least 30 days, to give health plans a better picture of their finances and actuarial projections for 2021 premiums. Likewise, delaying this deadline will limit the work—for both CMS staff and issuers—associated with forthcoming applications to change rate filings later in early fall.

- ACAP urges CMS to delay the recently-finalized rate filing deadlines by at least 30 days in order to allow health plans dealing with the worst of the pandemic sufficient time to revise their rates accordingly. Health plans will not know the full impact of the pandemic on their finances for many months at least, and will need time to factor this new reality into next year's rates.

QRS and QHP Enrollee Survey Comment Period. The proposed changes to the QHP Enrollee Survey are incredibly important to health plans in the Marketplace as they impact member decision-making. Given this importance, it is equally important that health plans are able to offer full and complete feedback before CMS finalizes the changes. Quite simply, heath plans and other stakeholders dealing with the pandemic do not have the bandwidth to provide complete feedback to CMS by the current due date of April 20—especially as so many of these changes affect CMOs and quality directors who are currently working around the clock to fight the coronavirus. For this reason, ACAP urges CMS to extend the comment period for an additional 60 days, to allow health plans to provide the most useful feedback possible.

- ACAP urges CMS to extend the QRS and QHP Enrollee Survey Comment Period for an additional 60 days. These proposed changes are very important and necessitate a full response from health plans and industry stakeholders. A 60-day delay gives plans currently focused on the pandemic sufficient time to provide complete feedback to CMS.

Delay Interoperability Rule Implementation. CMS and the Office of the National Coordinator for Health Information Technology (ONC) within the Department of Health and Human Services (HHS) recently finalized "interoperability" rules, imposing an implementation date of January 1, 2021. ACAP registered our grave concerns with HHS's aggressive timeframes in our response to the proposed rules prior to the onset of COVID-19, stating that unless the deadlines were substantially delayed, successful adoption of the rule will be impeded, and plans and members would face significant risks.

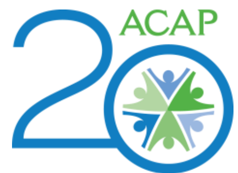
Even prior to the advent of the COVID-19 pandemic, ACAP did not believe the standards finalized in the rule were ready for adoption. Furthermore, we harbor worries that states and plans are not sufficiently prepared to fund the substantial and complex changes required by the rule. Given the magnitude of the resources required to combat the COVID-19 crisis, we strongly urge HHS to delay implementation of the interoperability rules until all required stakeholders are better able and better resourced to make the complex changes in the rules.

- ACAP urges HHS to delay implementation of the interoperability rules.

Delay Transparency in Coverage Rule Implementation. Similarly, the proposed Transparency in Coverage rules represent a drastic departure in the way health plans do business. While we have significant policy concerns about adverse impact of the proposed rule, we also note that plans will need adequate time to make such significant systems changes and prepare for implementation of any new transparency requirements in all corners of their business. As plans are currently devoting their full energy to the COVID-19 response, it would be prudent to delay the changes proposed in the forthcoming Transparency in Coverage final rule.

- ACAP urges HHS to delay implementation of the proposed transparency in coverage rule.

Please contact Heather Foster, Vice President for Marketplace Policy, at hfoster@communityplans.net if you would like to discuss any of these issues in greater depth.



Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer
ACAP

From: [redacted]
To: [redacted]; [redacted]
Subject: FW: AHA Statement
Date: Wednesday, April 22, 2020 6:48:20 PM

From: Weger, Kristina [redacted]
Sent: Wednesday, April 22, 2020 6:29 PM
To: Beck, Gary (OS/IEA) [redacted]; Trueman, Laura (HHS/IEA) [redacted]
Subject: AHA Statement

Gary and Laura,

Including AHA's statement that will go to media this evening – appreciate all your work on this, along with today's call for the hospitals!

AHA STATEMENT ON HHS ANNOUNCEMENT ON DISTRIBUTION OF ADDITIONAL FUNDS FROM CARES ACT

Rick Pollack
President and CEO

American Hospital Association

April 22, 2020

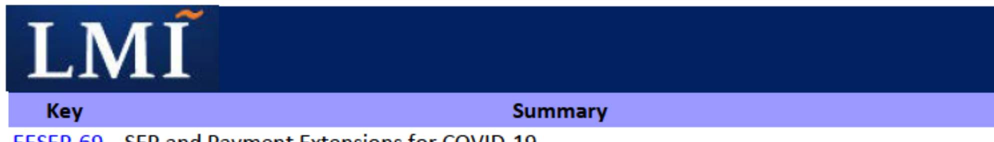
America's hospitals and health systems appreciate the announcement from HHS regarding the distribution of additional funds from the CARES Act emergency relief fund. As urged by the AHA, this will help hospitals with a high percentage of payments under Medicare Advantage and hospitals caring for high numbers of Medicaid patients. We also are pleased that HHS has allocated additional targeted relief for hospitals in hot spots and rural hospitals.

Nobody has been a stronger advocate for covering the uninsured than America's hospitals and health systems, particularly during a public health emergency. That's why we continue to encourage Congress and the Administration to look at other options to provide coverage for treatment of the uninsured for the Coronavirus other than utilizing the emergency fund from the CARES Act. This could include opening up a special enrollment period for the Affordable Care Act's marketplaces, using the National Disaster Medical System or other federal emergency programs, and creating a new, separate fund to specifically address the costs associated with treatment of the uninsured. The emergency relief fund in the CARES Act was intended to provide hospitals with an infusion of emergency relief as providers incur substantial expenses and lost revenue in preparing and fighting this battle against COVID-19.

The AHA continues to urge remaining emergency funds to be sent as soon as

possible to all providers on the front lines. This funding is a life-line to hospitals and health systems and will help ensure that we can continue to deliver the care that our patients and communities are depending on.

Kristina Weger
American Hospital Association
Desk: [redacted]
Cell: [redacted]



Key	Summary
EESEP-69	SEP and Payment Extensions for COVID-19

Question
Will there be a SEP due to COVID-19? Will there be an extension for payment or relaxed reinstatement rules due to COVID-19? We anticipate terminations due to non-payment/hardships and members asking for exceptions to reinstate, waive premiums or re-enroll. Issuer ID: 91661

Response

Thank you for contacting the CMS Help Desk. This is in response to your Help Desk Ticket #CS0557991.

CMS's top priority is protecting the health and safety of the Americans we serve. In light of the 2019 Novel Coronavirus (COVID-19), CMS is looking closely at all of its policies and across all of its programs to see where we can strengthen the nation's response to the Coronavirus outbreak. CMS is not currently offering a Special Enrollment Period specifically designated for COVID-19. However, consumers who are not currently enrolled in coverage can see if they qualify for other Special Enrollment Periods by visiting <a href="http://healthcare.gov/">HealthCare.gov. We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time.

Additionally, on March 24, CMS published guidanceoutliningPayment and Grace Period Flexibilities Associated with the COVID-19 National Emergency at <a href="https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf">https://www.cms.gov/files/document/faqs-payment-and-grace-period-covid-19.pdf.

For more information on CMS' Coronavirus guidance, please check:<a href="https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page" title="Follow link">https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

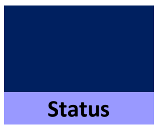
Information for consumers and their families is also available here, on HealthCare.gov:<a href="https://www.healthcare.gov/coronavirus/">https://www.healthcare.gov/coronavirus/

If you have any additional questions, please contact the Marketplace Service Desk (MSD) at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

Respectfully,
CMS Help Desk team

Issuer/State/Other	First & Last Name
Horizon Healthcare Services, Inc.	Lesley Warren

Email Address	Phone Number	Created	Resolved
		3/19/2020	4/23/2020



Status
Closed

EESEP-67 Special Enrollment Period for COVID-19

We expect the COVID-19 pandemic to cause an increase in the number of people seeking health insurance.

Can you please advise whether HHS will be establishing an SEP in response to COVID-19 based on the "exceptional circumstance" language in 155.420(d)(9)? If so, how will an issuer know that an individual qualifies for the exceptional circumstance? Or will there be a full open enrollment period without qualifications?

Similarly, can you please advise as to the status of an SEP under 155.420(d)(6)(v)? Page 250 of the NBPP for PY 2020 states: "We are finalizing all policies under 155.420 as proposed. We note that the proposed new special enrollment period under 155.420(d)(6)(v) is available at the option of the Exchange. HHS is determining the date on which this special enrollment period will be implemented for Federally-facilitated Exchanges and State Exchanges using the federal eligibility and enrollment platform, and anticipates it will not be available until after January 1, 2020." We expect people will be facing financial hardship as a result of the economic downturn and will become eligible for APTC. Has the date this SEP will be implemented been decided?

Thank you for contacting the CMS Help Desk. This is in response to your Help Desk Ticket #CS0562989.

Question 1:Can you please advise whether HHS will be establishing an SEP in response to COVID-19 based on the "exceptional circumstance" language in 155.420(d)(9)? If so, how will an issuer know that an individual qualifies for the exceptional circumstance? Or will there be a full open enrollment period without qualifications?

Response 1:

CMS's top priority is protecting the health and safety of the Americans we serve. In light of the 2019 Novel Coronavirus (COVID-19), CMS is looking closely at all of its policies and across all of its programs to see where we can strengthen the nation's response to the Coronavirus outbreak. CMS is not currently offering a Special Enrollment Period specifically designated for COVID-19. However, consumers who are not currently enrolled in coverage can see if they qualify for other Special Enrollment Periods by visiting <a href="http://healthcare.gov/">HealthCare.gov, including information provided here: <a href="https://www.healthcare.gov/coronavirus/">https://www.healthcare.gov/coronavirus/. We will continue to work closely with states and health plans around the country to assess what additional actions are necessary to ensure the American people have coverage for and access to the services they need during this time.

Additional information on Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities for members affected by an emergency or major disaster that is recognized with a formal declaration from the Federal emergency Management Agency (FEMA) may be found in the "Evergreen" disaster guidance, located here:<a href="https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf" title="Follow link">https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf

As CMS evaluates the situation, additional guidance will be provided.CMS has released FAQs as it relates to benefit coverage which can be found here:<a href="https://www.cms.gov/newsroom/press-releases/cms-publishes-faqs-ensure-individuals-issuers-and-states-have-clear-information-coverage-benefits" title="Follow link">https://www.cms.gov/newsroom/press-releases/cms-publishes-faqs-ensure-individuals-issuers-and-states-have-clear-information-coverage-benefits

Lastly, for more information on CMS' Coronavirus guidance, please check:<a href="https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page" title="Follow link">https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

Horizon Healthcare Services, Inc.	Meghan Dougherty

		3/25/2020	4/23/2020

Closed

THE STATE OF CALIFORNIA
OFFICE OF THE ATTORNEY GENERAL

THE STATE OF NORTH CAROLINA
OFFICE OF THE ATTORNEY GENERAL

XAVIER BECERRA
ATTORNEY GENERAL

JOSH STEIN
ATTORNEY GENERAL

April 28, 2020

Secretary Alex M. Azar II
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Via Email and U.S. Mail

Administrator Seema Verma
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Via Email and U.S. Mail

Jerome M. Adams, M.D.
United States Surgeon General
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Via Email and U.S. Mail

Dear Secretary Azar, Administrator Verma, and Doctor Adams:

Recently the Administration stated its intent to promote access to mental health services during the COVID-19 pandemic.[1] These efforts, including guidance on telehealth and supplemental grant funding from the Substance Abuse and Mental Health Services Administration, could help some Americans obtain the mental and behavioral health resources they need at a time of widespread crisis and disruption. While this stated intent is important, it falls short of the additional steps necessary to ensure Americans have access to mental health services through health insurance coverage. For this reason, we write to reiterate our urgent request that the Administration create a special enrollment period on HealthCare.Gov so that the 22 million individuals and families who have already suffered recent job loss—and the millions more who are also likely to lose their jobs—can access coverage,[2] including the mental health and substance abuse care the Administration says it is prioritizing during these unprecedented times.

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[1] *See* https://www.justice.gov/usao-sdca/sdca-covid-19-resources (Apr. 16, 2020).

[2] *Unemployment Insurance Weekly Claims*, U.S. Dep't of Labor (Apr. 16, 2020), https://www.dol.gov/ui/data.pdf.

Broader availability of mental health services is imperative. Many Americans are suffering as millions of workers have lost their jobs, including many who have lost their healthcare coverage. Others are underinsured, and some low-wage workers lack employer-provided health insurance. Many Americans, including workers whose jobs are essential during the emergency—truckers, grocery store workers, delivery carriers, cleaners—do not receive healthcare coverage through their employment. As a result, healthcare may be out of reach for Americans who need it the most. HealthCare.gov could be a lifeline for these people. The federal exchange can connect them with resources to preserve their physical and mental health and help them avoid both the financial costs of care and the negative consequences of untreated mental or behavioral health issues. The Administration's stated commitment to choice and "informed healthcare decisions"[3] would also be advanced by giving Americans the option to obtain comprehensive healthcare coverage to combat this unprecedented healthcare care crisis.

The Affordable Care Act's inclusion of mental health and substance use disorder treatments as an essential health benefit will play an important role in assisting federal efforts during the pandemic by ensuring that prevention, treatment, recovery support services, and safe and effective pain management are and remain available for those struggling during this time. *See* 42 U.S.C. § 18022(b)(1); 45 C.F.R. § 156.110.

The federal government should immediately implement a special enrollment period in light of the COVID-19 crisis so that more Americans have access to these services at a time when they may need them most. Indeed, a recent study estimated that over a million Americans could gain comprehensive healthcare coverage, including mental health and substance use disorder treatment, if the Administration were to create a special enrollment period due to the pandemic.[4] Further, the Administration should put its resources behind a national campaign to make Americans aware of coverage options and help.

In States that have performed such outreach and set up special enrollment periods, signups are increasing and people are getting the help they so desperately need during this pandemic. Several of our state-run exchanges have implemented special enrollment periods to allow people who lack healthcare coverage to obtain it. In this way, people can be covered even if they have not experienced a qualifying event such as the loss of employer-provided coverage. In California, 58,000 people have signed up for coverage through Covered California since

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[3] *See, e.g.,* Exec. Order 13,813, *Promoting Healthcare Choice and Competition Across the United States*, 82 Fed. Reg. 48,385 (Oct. 2, 2017).

[4] Charles Gaba, *FOLLOW-UP: How many would likely #GetCovered in YOUR HC.gov state via a #COVID19-specific SEP?*, ACA Signups.net (updated Apr. 16, 2020), http://acasignups.net/20/04/16/follow-how-many-would-likely-getcovered-your-hcgov-state-covid19-specific-sep.

March 20, 2020.[5] Maryland announced on April 16, 2020 that over 21,500 residents had enrolled in coverage during its special enrollment periods; more than 61 percent of residents utilizing the pandemic-SEP enrolled in Medicaid and the remainder in private insurance, with most of the latter qualifying for financial help to lower the cost of the plan.[6] In Connecticut, 2,890 additional households have obtained coverage through the state's special enrollment period. In Vermont, where the uninsured rate was already very low before the COVID-19 crisis, 180 additional households have obtained potentially life-saving coverage through the state's special enrollment period.

These state actions demonstrate that if the Federal government opened and promoted a special enrollment period during the pandemic, working families across the country would benefit, including in States like Hawaii, Georgia, Kentucky, and Michigan that have suffered some of the biggest job losses due to the pandemic.[7] Increased access to comprehensive healthcare not only helps ensure access to mental health and substance abuse treatment, it could also assist with prompt COVID-19 detection, aid with early treatment, diminish spread of the disease, and avoid the consequences of costly hospitalization when the uninsured delay seeking care until their conditions deteriorate.[8]

For these reasons, we have written twice to urge the Administration to immediately establish a special enrollment period for the millions of Americans impacted by the current health and economic crisis.[9] Already, over 200 additional organizations and counting have

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[5] *Covered California Enrolls Tens of Thousands as Impacts of COVID-19 Pandemic Hits California Households*, Covered California (Apr. 14, 2020), https://www.coveredca.com/newsroom/news-releases/2020/04/14/covered-california-enrolls-tens-of-thousands-as-impacts-of-covid-19-pandemic-hits-california-households/.

[6] *More Than 21,500 Marylanders Obtain Health Coverage Through State Special Enrollment Periods*, Maryland Health Benefit Exchange (Apr. 16, 2020), https://www.marylandhbe.com/wp-content/uploads/2020/04/EnrollmentMetricsPressRelease041620.pdf.

[7] Thomas Franck, et al., *This Map Shows the States that Suffered the Biggest Job Losses Last Week Due to Coronavirus*, CNBC (Apr. 9, 2020), https://www.cnbc.com/2020/04/09/this-map-shows-the-states-that-suffered-the-biggest-job-losses-last-week-due-to-coronavirus.html.

[8] Christen Linke Young, et al., *Responding To COVID-19: Using The CARES Act's Hospital Fund To Help The Uninsured, Achieve Other Goals*, Health Affairs (Apr. 11, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200409.207680/full/.

[9] *See* multi-state letter sent on April 3, 2020, that urged the U.S. Department of Health and Human Services to open a special enrollment period to allow all uninsured individuals to obtain coverage due to the unprecedented circumstances of the COVID-19 pandemic, https://www.oag.ca.gov/system/files/attachments/press-docs/CA%20NC%20COVID-19%20healthcare%20exchange%20letter%20plus%20IA.pdf; and multi-state letter sent on April 14, 2020, that requested the Administration to develop and implement an outreach plan to inform the millions of Americans who have already or will lose their employer-sponsored health

likewise appealed to the Administration to create this special enrollment opportunity.[10]The Administration's failure to act was recently highlighted by Facebook's announcement on April 16, 2020, that it will begin directing users to the healthcare exchanges amid rising unemployment.[11] At a time when the Administration is still "scrambling for answers,"[12] this "simple, common-sense step" would help millions of American families immediately secure comprehensive and affordable coverage, and, would assist Americans who have lost employer-sponsored insurance, in obtaining coverage promptly without need for documentation of a qualifying life event.[13]

We urge you to take this "simple common-sense step." The data shows that this concrete action will help millions of Americans weather this crisis, with the added benefit of containing the further spread of this deadly virus so the nation can get back on track sooner.

Sincerely,

Xavier Becerra
California Attorney General

Josh Stein
North Carolina Attorney General

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insurance coverage due to the pandemic of the special enrollment period that is available to them through Healthcare.gov and state-based marketplaces, https://oag.ca.gov/news/press-releases/attorney-general-becerra-co-leads-push-michigan-and-north-carolina-ags-increased.

[10] *200+ Organizations Call for Expansion of Health Insurance Enrollment During Coronavirus Crisis*, Community Catalyst (Mar. 20, 2020), https://www.communitycatalyst.org/news/press-releases/200-organizations-call-for-expansion-of-health-insurance-enrollment-during-coronavirus-crisis.

[11] Cristiano Lima, *Facebook to Direct Users to Obamacare Site Amid Rising Unemployment*, Politico (Apr. 16, 2020), https://subscriber.politicopro.com/article/2020/04/facebook-to-direct-users-to-obamacare-site-amid-rising-unemployment-3979472.

[12] Rachel Roubein and Susannah Luthi, *White House Still Scrambling to Cover Virus Treatment for the Uninsured*, Politico (Apr. 20, 2020), https://www.politico.com/news/2020/04/20/coronavirus-treatment-uninsured-195218.

[13] Charles Gaba and Emily Gee, *How Trump's Policies Have Hurt ACA Marketplace Enrollment,* Center for American Progress (Apr. 16, 2020), https://www.americanprogress.org/issues/healthcare/news/2020/04/16/483362/trumps-policies-hurt-aca-marketplace-enrollment/.

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Colorado Attorney General

William Tong
Connecticut Attorney General

Kathleen Jennings
Delaware Attorney General

Karl A. Racine
Attorney General for the District of Columbia

Claire E. Connors
Hawai'i Attorney General

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Hector Balderas
New Mexico Attorney General

Ellen F. Rosenblum
Oregon Attorney General

Josh Shapiro
Pennsylvania Attorney General

Peter F. Neronha
Rhode Island Attorney General

Thomas J. Donovan, Jr.
Vermont Attorney General

Mark R. Herring
Virginia Attorney General

May 14, 2020

The Honorable Alex Azar
Secretary of Health of Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

Thank you for your continued efforts to mitigate the COVID-19 pandemic and bring an end to our national emergency. We appreciate the Administration's collaboration with states in addressing this national challenge. State insurance regulators are also working to make sure insurance markets meet the immediate and long-term needs of consumers, insurers, and other stakeholders. On behalf of the membership of the National Association of Insurance Commissioners[1], we write to request that you take a number of actions to strengthen health insurance markets, namely providing maximum flexibility on 2021 rate review deadlines; clarifying the financing of surveillance testing; and expediting access in the Federally-facilitated Marketplaces to the already-codified special enrollment period for consumers with declining income.

State regulators will soon begin the process of reviewing insurers' proposed rates for plan year 2021 and carriers are already developing them. As states set their deadlines for submission, posting, review and approval of rates they must balance the need for data and the availability of state resources, and they must comply with various Federal deadlines. We thank you for your recent announcement that the initial filing, posting, and final submission dates have been moved back. This will provide states the flexibility they need as they work closely with their carriers to ensure the most accurate rates for 2021.

Adding to the complexities of setting rates for upcoming years is the recent U.S. Supreme Court ruling in *Maine Community Health Options v. United States* which allows carriers to seek $12 billion in back Risk Corridor payments. How these payments are accounted for and included in the Medical Loss Ratio formula could have significant impact on rates and payments to consumers. We urge your Department to consult with the NAIC and state regulators as the key decisions are made about how these funds are to be handled.

[1] Founded in 1871, the NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

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www.naic.org

Testing for coronavirus infection and exposure is a critical means to understand and control the spread of the pandemic, especially as states begin the process of re-opening businesses. As this testing continues, two key issues have arisen: what tests should be covered and how are these tests to be financed?

We encourage the Department to provide more consistent guidance related to testing protocols and payment. CMS guidance has indicated testing should be covered by insurers when medically necessary, but there are still many questions about the application of medical necessity standards and FDA guidance is less clear about the value of various tests. States, local governments, employers, and carriers would benefit from a consistent and clear message about what tests are approved for what uses and in what circumstances they should be covered by insurers.

On the issue of financing tests, we note that Congress has recognized the need to provide federal resources for testing through the Paycheck Protection Program and Health Care Enhancement Act. Funding has been provided to state or local entities to support a system of testing that makes most sense for that state. We believe that states are the appropriate entities to determine how testing is financed within the parameters set out by the federal government. We are also hopeful that the federal funding made available to states so far will be sufficient to support the testing that is essential to states' ability to reopen their economies but given the major fiscal challenges that states are facing as a result of the coronavirus pandemic, additional federal funding may be necessary.

Finally, as you know, the pandemic is challenging the health and economic security of many Americans and access to comprehensive health insurance can help protect both health and family finances. We encourage you to act quickly to allow more Americans to enroll in comprehensive coverage through Marketplaces on the federal platform using the special enrollment period (SEP) codified at 45 CFR 155.420(d)(6)(v). This SEP allows enrollment of an individual or dependent when he or she was previously enrolled in minimum essential coverage, experiences a decline in income, and is newly determined eligible for premium tax credits. With so many families facing falling incomes, it's particularly important to make this SEP available. Many people who responsibly enrolled in coverage outside of the Marketplace may now have lower income and struggle to afford their premiums—they are the very people Marketplaces and premium tax credits were intended to assist. But even if they are eligible for tax credits, these individuals are unable to access them in Marketplaces on the federal platform because this SEP has not been operationalized. We ask you to make this SEP available as soon as possible.

Thank you for considering these requests from state insurance regulators. Your prompt action in these areas will help keep state health insurance markets stable and allow more Americans to access much-needed coverage. State regulators pledge to continue to work closely with you, your Department, and other federal officials toward to goal of defeating this deadly disease. Please reach out immediately to NAIC staff if there is any additional assistance we can provide in this effort.

Sincerely,

Raymond G. Farmer
NAIC President
Director
South Carolina Department of Insurance

David Altmaier
NAIC President-Elect
Commissioner
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SPECIAL COMMITTEE ON AGING

United States Senate

WASHINGTON, DC 20510-3805

May 18, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

As a result of the current pandemic, upwards of 36 million individuals are newly unemployed.[1] New estimates by the Kaiser Family Foundation find that 27 million Americans may have already lost their employer-based health insurance as a result of this pandemic.[2] During the worst public health crisis this country has experienced in the past century, any barrier to accessing health care services is potentially fatal. I urge you to establish a Special Enrollment Period (SEP) for all Americans during this crisis and to make every American aware of the options for health insurance coverage available as a result of the Affordable Care Act and Medicaid.

Since 2017, the Trump Administration has engaged in the widespread sabotage of the Affordable Care Act (ACA).[3] Now, in the midst of a pandemic that has already cost the lives of over 85,000 Americans, the Administration continues to take steps to dismantle a system that provides affordable health care to millions through litigation to strike down the ACA by arguing that the individual mandate is unconstitutional.[4] Further, while the Administration has chosen to take necessary and unprecedented steps to make accessing care easier for some populations through never before used flexibilities, the Centers for Medicare and Medicaid Services (CMS) continues to refuse to establish a SEP that would allow individuals to sign up for coverage through the Marketplace and has yet to take meaningful steps to make people aware of their coverage options.[5] Since this crisis began, e-mail and text message communication to people who have

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[1] With the number of insured unemployed people reaching a 15.7% rate according to the Dept. of Labor as of May 14, 2020, https://www.dol.gov/ui/data.pdf; Cohen, Patricia, and Tiffany Hsu. "'Rolling Shock' as Job Losses Mount Even With Reopenings." The New York Times. The New York Times, May 14, 2020. https://www.nytimes.com/2020/05/14/business/economy/coronavirus-unemployment-claims.html.

[2] Garfield, Rachel, Gary Claxton, Anthony Damico, and Larry Levitt. "Eligibility for ACA Health Coverage Following Job Loss." The Henry J. Kaiser Family Foundation, May 12, 2020. https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.

[3] U.S. Senator Bob Casey. "The Sabotage of your Health Care, Part III: The Trump Administration's Secret Roadmap to Sabotaging the Affordable Care Act." January 2018. https://www.aging.senate.gov/imo/media/doc/Sabotage%20Report%2001.08.18.pdf

[4] Johns Hopkins Center for Systems Science and Engineering COVID-19 Dashboard. https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6; Carvajal, Nikki. "Trump Says Administration Will Continue Legal Fight to Eliminate Obamacare." CNN, Cable News Network, 6 May 2020, www.cnn.com/2020/05/06/politics/trump-obamacare/index.html; Musumeci, MaryBeth. "Explaining Texas v. U.S.: A Guide to the Case Challenging the ACA." The Henry J. Kaiser Family Foundation, March 10, 2020. https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-case-challenging-the-aca/.; Texas v. U.S., 945 F.3d 355, 2019 U.S. App. LEXIS 37, 567.

[5] Benen, Steve. "White House Balks at New ACA Open-Enrollment Period." MSNBC. NBCUniversal News Group, April 1, 2020. https://www.msnbc.com/rachel-maddow-show/white-house-balks-new-aca-open-enrollment-period-n1173786.

created accounts using HealthCare.gov has been largely dormant; there appears to be no information about coverage options promoted through online platforms, like Facebook and Twitter; and HHS is not using its platform with the press to communicate coverage options to Americans in need of health insurance.[6] This is a total abdication of responsibility on the part of this Administration. Playing politics with health coverage is always dangerous, but during a pandemic, the risk of it proving fatal has skyrocketed.

To help me understand how CMS is conducting outreach to the American people about the resources available under the ACA and, in particular, with HealthCare.gov, I request the following information:

1. How many emails (or text message) alerts have been sent to HealthCare.gov subscribers since March 1, 2020 on the insurance options available under the ACA? Please provide copies of these communications, the number of subscribers they were sent to, and the dates upon which they were sent.

2. What has CMS done to inform the public of the resources available on HealthCare.gov during the COVID-19 pandemic? Please provide copies of any public-facing initiatives, the method of dissemination, the targeted population, and the number of recipients.

3. HealthCare.gov has published blog posts on the resources available to the public during the COVID-19 pandemic, including information on Special Enrollment Period availability and marketplace coverage. What, if any, initiatives are in place to disseminate this information to the public?

4. What other ways has CMS conducted public outreach on the insurance options provided under the ACA during the COVID-19 pandemic? Please describe any initiatives, including their intended audience, the date they were initiated, and any success measures that were included.

Please provide this information as well as a briefing for my staff as soon as possible, but in no event later than June 1, 2020. I look forward to your response.

Sincerely,

Robert P. Casey, Jr.
United States Senator

[6] Keith, Katie. "CMS Could Do More In Light Of The Coronavirus Crisis." CMS Could Do More In Light Of The Coronavirus Crisis | Health Affairs, March 25, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200325.501048/full/.

During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured

May 19, 2020 | **Rachel Schwab**, **Justin Giovannelli**, and **Kevin Lucia**

The economic shutdown due to COVID-19 prompted an unprecedented spike in unemployment, with more than **33 million** people filing claims since mid-March. Alongside this widespread job loss, the health insurance safety net is being stretched to accommodate the rapid increase in people in need of coverage. The Affordable Care Act's (ACA) marketplaces, along with Medicaid, are important tools in covering the **newly uninsured**.

State-Based Marketplaces Work to Enroll the Uninsured

The ACA's marketplaces provide a source of quality health insurance and financial assistance. State-based marketplaces (SBM) have control over call centers, outreach efforts, and eligibility and enrollment platforms. As a result, states with SBMs have **more opportunities** to help consumers during the COVID-19 crisis than states relying on the federally facilitated marketplace.

CREATING NEW OPPORTUNITIES TO ENROLL

The coronavirus pandemic struck shortly after the end of the ACA's annual open-enrollment period, the only time of year when people can sign up for marketplace coverage barring **certain life events**, such as losing employer coverage or other **minimum essential coverage** (MEC), which prompt a special enrollment period (SEP) in every state. There are several SEPs for people seeking coverage during the coronavirus pandemic, but some have been available only in certain states.

Given the need for access to health care and financial protection during the pandemic, **12 of the 13** SBMs — all but Idaho's marketplace — established a new COVID-19 SEP, allowing the uninsured to sign up for coverage outside the annual enrollment period. The federal government **declined to provide** a similar SEP for states relying on the federal marketplace platform, HealthCare.gov, thereby limiting enrollment opportunities in **38 states**.

Additionally, some SBMs offer a reduced-income SEP year-round for people enrolled in MEC outside the marketplace. This includes people who bought private individual coverage directly from an insurer and who become newly eligible for marketplace subsidies because of an income reduction. This SEP has not been implemented on HealthCare.gov, although in every state, marketplace enrollees with an income change can adjust or start receiving subsidies if they qualify based on **eligibility standards**.

Some SBMs also have offered SEPs specific to their state that allow the uninsured to sign up for coverage.

Enrollment Opportunities Available During the Coronavirus Pandemic

Available through every ACA marketplace	
Special enrollment period (SEP)	Details
Loss of minimum essential coverage (MEC)	An existing opportunity to enroll outside of the annual open-enrollment period, triggered by the loss of minimum essential coverage. People who lose employer-sponsored insurance are eligible.[a]

Available only through certain state-based marketplaces		
Special enrollment period (SEP)	Details	State-based marketplaces (SBM) offering SEP
COVID-19	In light of the coronavirus pandemic, the majority of state-based marketplaces (SBM) established an SEP for the uninsured and in some cases those with an off-marketplace plan to enroll in marketplace coverage, and financial assistance if eligible. The SEP's duration varies[b] in each state.	California, Colorado, Connecticut, District of Columbia, Maryland, Massachusetts, Minnesota, Nevada, New York, Rhode Island, Vermont, and Washington
Reduced Income	SEP for people enrolled in off-marketplace MEC who experience an income reduction that makes them newly eligible for marketplace subsidies.	Colorado, Connecticut, District of Columbia, Idaho, Maryland, Minnesota,[c] Rhode Island, Vermont, and Washington[d]
Easy Enrollment Program	In Maryland, residents filing a tax return can check a box indicating that a household member is uninsured and would like to receive information about how to enroll in low- or no-cost insurance through the state health insurance marketplace or Medicaid. If the uninsured person is eligible for a marketplace plan, the marketplace will send a notice and initiate an SEP for coverage. The marketplace plans to implement[e] automatic enrollment in the state Medicaid program for eligible individuals in future plan years.	Maryland
State Individual Mandate Awareness	SEP established in some states for enrollees not aware of the state-level coverage requirement.	California,[f] District of Columbia,[g] and Rhode Island[h]
State Premium Subsidy Awareness	SEP offered to people who were unaware of state-level premium subsidies[i] provided through the marketplace. People enrolled in off-marketplace plans also eligible.	California[j]
ConnectorCare Eligibility	SEP for individuals who are newly eligible for Massachusetts's ConnectorCare program, which provides additional premium and cost-sharing subsidies for individuals with income up to 300% of the federal poverty level.	Massachusetts

Notes: Table displays enrollment opportunities available during common circumstances that arise or are exacerbated during the coronavirus pandemic. This is not an exhaustive list of available SEPs. Some SEPs available through certain SBMs, including the COVID-19 SEPs, the Easy Enrollment Program SEP, the State Individual Mandate Awareness SEP and the State Premium Subsidy Awareness SEP, are limited-time enrollment opportunities that do not necessarily last for the duration of the COVID-19 emergency and may have already expired, depending on the marketplace.

[a] The Loss of MEC SEP is not triggered solely by job loss. Those experiencing job loss must demonstrate loss of MEC, such as employer-sponsored insurance, to qualify for this SEP.

[b] Madeline O'Brien and Sabrina Corlette, "State Action Related to COVID-19 Coverage of Critical Services by Private Insurers," Commonwealth Fund, updated May 15, 2020.

[c] Minnesota began offering this SEP in May 2020. See MNsure, "MNsure Offers Enrollment Opportunity for Minnesotans Newly Eligible for Financial Help Due to Decrease in Income," news release, May 12, 2020.

[d] The New York marketplace plans to offer this SEP starting sometime in May 2020.

[e] Maryland Health Benefit Exchange, "Maryland Easy Enrollment Health Insurance Program Work Group Meeting," presentation, Mar. 9, 2020.

[f] Covered California, "Special Enrollment Period for State Subsidy or Penalty," fact sheet, Feb. 18, 2020.

[g] D.C. Health Benefit Exchange Authority, "Resolution: Executive Board of the District of Columbia Health Benefit Exchange Authority," Jan. 8, 2020.

[h] Health Resource RI, "RI Health Insurance Mandate," n.d.

[i] Covered California, "Lost Your Job? You Can Get Health Coverage!," n.d.

[j] Covered California, "Special Enrollment Period for State Subsidy or Penalty," fact sheet, Feb. 18, 2020.

Data: 45 CFR § 155.420(d); Md. Code, IN §§ 31-201–207; 956 Mass. Code Regs. § 12.10; Madeline O'Brien and Sabrina Corlette, "State Action Related to COVID-19 Coverage of Critical Services by Private Insurers," Commonwealth Fund, updated May 15, 2020; and information provided to authors by SBMs and materials linked above.

Source: Rachel Schwab, Justin Giovannelli, and Kevin Lucia, "During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the

Uninsured," *To the Point* (blog), Commonwealth Fund, May 19, 2020. https://doi.org/10.26099/k7w5-kj74

REACHING THE UNINSURED

In addition to forging new paths to coverage, SBMs have gone to great efforts to broadcast enrollment opportunities. We conducted a survey of SBMs on COVID-19 responses and found that marketplaces have launched various campaigns to reach the uninsured and simplify enrollment.

Several SBMs are announcing SEPs through advertisements. Maryland's marketplace shifted most of its remaining fiscal year marketing budget to its COVID-19 response, and California's marketplace launched a new ad campaign. Numerous marketplaces, including those in Connecticut, the District of Columbia, Massachusetts, Minnesota, Vermont, and Washington, are working with state labor or employment security departments to provide health insurance enrollment information to people filing for unemployment insurance. Similarly, New York's marketplace started an awareness campaign aimed at people at risk of losing job-based coverage. Both the Connecticut and D.C. marketplaces are reaching out to organizations that have announced layoffs to connect employees losing their insurance to coverage options; the D.C., New Mexico, and Oregon marketplaces are conducting additional outreach to small businesses. To streamline enrollment, the D.C., Idaho, and Massachusetts marketplaces are reducing typical SEP paperwork.

SBMs are also tapping consumer assistance networks. Oregon's marketplace surveyed assisters who help with enrollment to ensure that an online search tool reflects assisters who are still available to help consumers. Colorado's marketplace offered assisters supplemental funding to help consumers enroll in coverage. Marketplaces also are bolstering call centers, with the Nevada marketplace adding extra weekend hours to accommodate the surge in inquiries and enrollments.

Efforts are paying off. State marketplaces are reporting thousands and sometimes tens of thousands of enrollments since they instituted a COVID-19 SEP and began outreach efforts.

Marketplace-Reported Enrollment Data During the Coronavirus Pandemic

State-based marketplace (SBM)[a]	COVID-19 special enrollment period (SEP) dates[b]	Special enrollment period (SEP) data[c]
California	March 20–June 30, 2020	As of April 24, 2020, more than 84,000 people[d] signed up for marketplace coverage since the COVID-19 SEP was announced on March 20, a sign-up rate more than 2.5 times the pace of enrollments during the same period in 2019.
Colorado	March 20–April 30, 2020	During the COVID-19 SEP, 14,263 people enrolled in marketplace coverage through the COVID-19 SEP and the Loss of MEC SEP.
Connecticut	March 19–April 17, 2020	During the COVID-19 SEP, 5,629 people signed up for marketplace plans, including 2,209 through the COVID-19 SEP; as of April 10, special enrollments were up[e] more than 70% compared to last year's benchmark.
District of Columbia	Through September 15, 2020[f]	As of April 19, 2020, 2,072 people enrolled in marketplace coverage through an SEP, including the COVID-19 SEP and the Loss of MEC SEP, a 66% increase in enrollments compared to this period in 2019.
Maryland	March 16–June 15, 2020	In March 2020,[g] 4,445 people enrolled in marketplace coverage through the COVID-19 SEP, 3,711 enrolled through the Loss of MEC SEP, and 1,245 enrolled through the Reduced Income SEP.
Massachusetts	March 11–May 25, 2020	On April 28, 2020, the marketplace announced[h] there have been more than 20,000 new marketplace enrollments since the beginning of March, including approximately 8,300[i] individuals who enrolled through the COVID-19 SEP as of April 20.
Minnesota	March 23–April 21, 2020	During the COVID-19 SEP,[j] 6,023 people enrolled in marketplace coverage through the COVID-19 SEP and 3,459 people enrolled through other SEPs, such as the Loss of MEC.
Nevada	March 17–May 15, 2020	From the beginning of March through April 15, 2020, the marketplace saw 2,712 enrollments through the COVID-19 SEP.
Rhode Island	March 14–April 30, 2020	As of April 19, 2020, 1,364 accounts (which may include multiple enrollees) were approved for marketplace enrollment through the COVID-19 SEP; from March 15 to April 22, 2020, 1,169 accounts selected marketplace plans through the Loss of MEC SEP.
Washington	March 10–May 8, 2020	On May 6, the marketplace announced[k] that more than 19,500 people signed up for marketplace coverage since the COVID-19 SEP launched, including 7,000 through the COVID-19 SEP and 12,500 through other SEPs, such as Loss of MEC and Reduced Income.
Vermont	March 20–June 15, 2020	Between March 20 and May 11, 2020, Vermont's marketplace enrolled 888 individuals in marketplace coverage, including 373 who enrolled through the COVID-19 SEP.[l]

[a] Some SBMs with COVID-19 SEPs have not reported enrollment data and are not included in the table.

[b] Some COVID-19 SEPs may be extended beyond current deadline.

[c] Not all data is final; some figures include enrollments through SEPs other than the COVID-19 SEP, as noted; data may not be comparable across states; HealthCare.gov has not released SEP data.

[d] Covered California, "Covered California Continues to See Strong Consumer Interest in Quality Health Care Coverage During the COVID-19 Pandemic," news release, Apr. 28, 2020.

[e] Access Health CT, "Board of Directors: Agenda," Apr. 16, 2020.

[f] In response to the coronavirus pandemic, the D.C. marketplace expanded an existing SEP that launched on February 6, 2020, but later became a COVID-19 SEP that now runs through September 15, 2020.

[g] Maryland Health Benefit Exchange, "COVID-19 Update," Apr. 20, 2020.

[h] Massachusetts Health Connector, "Massachusetts Health Connector Continues Extended Enrollment as Nearly 45,000 People Enroll in New Plans, Update Current Coverage," news release, Apr. 28, 2020.

[i] Massachusetts Health Connector, "Massachusetts Health Connector COVID-19 Special Enrollment Period: Results to Date," May 1, 2020.

[j] MNsure, "More Than 9,400 Minnesotans Enrolled in Private Health Insurance Coverage During MNsure's COVID-19 Emergency Special Enrollment Period," news release, Apr. 22, 2020.

[k] Washington Health Benefit Exchange, "Washington Healthplanfinder Urges Uninsured to Act Fast to Meet Friday, May 8 Deadline," news release, May 6, 2020.

[l] Vermont's total population is lower than most other SBM states at approximately 624,000 people.

Data: Madeline O'Brien and Sabrina Corlette, "State Action Related to COVID-19 Coverage of Critical Services by Private Insurers," Commonwealth Fund, updated May 15, 2020; and authors' analysis of publicly available data, linked above, and information provided to authors by SBMs.

Source:

Several SBMs have found that SEPs are leading to enrollment growth in younger populations, a group that is **more likely** to be uninsured and **important to marketplace stability**. In Maryland and Rhode Island, more than half of reported COVID-19 SEP enrollees are under age 35. In D.C., almost 60 percent of SEP enrollees (as of March 30, 2020) are under age 35. **Massachusetts reported** that COVID-19 SEP enrollees are more likely than existing members to be ages 18 to 34.

Looking Ahead

The ACA's marketplaces were created to expand access to comprehensive, affordable coverage. State marketplaces have responded effectively to the economic crisis caused by COVID-19, providing a port in the storm for those who need health insurance to protect themselves and their families. As the public health emergency and economic shutdown continue, marketplaces have a key role to play.

Publication Details

Publication Date: May 19, 2020

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Topics

COVID-19 Health Insurance Marketplaces

Health Care Coverage and Access

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Congress of the United States
Washington, D.C. 20515

May 19, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar:

As the COVID-19 pandemic continues to displace at least 14 million college students[1] in the United States from their campuses, we urge you to take action to ensure that students are informed about their health care coverage options, so they do not experience unnecessary disruptions in health care.

As a result of the *Affordable Care Act* (ACA)[2], many college and university students under the age of 26 can receive health insurance coverage under their parents' health plans. Additionally, students across the country may receive coverage from student health insurance plans sponsored by their colleges or universities. This coverage is usually in coordination with existing student health centers or university medical centers on campus. Despite this, some students may still lack health insurance coverage and have struggled to receive the information and support they need to find affordable coverage while balancing ever-increasing college costs. Ensuring that all students in higher education have access to health insurance coverage and benefits is a critical part of keeping families and communities safe during the COVID-19 pandemic and reducing the spread of the virus.

Millions of students have been affected by COVID-19. They may not know how their existing coverage is impacted by the pandemic, whether their coverage extends to COVID-19-related benefits, or how to sign up for coverage if they do not already have it. This is particularly true for the many students who now live in a different state and are separated from their student health clinics or normal providers. For those students with chronic health conditions, these problems are particularly urgent. Further, many students living off campus during this pandemic unfortunately may not be able to return to their college or university this fall and may face a break in coverage. It is important to preserve comprehensive health insurance coverage for students at risk of contracting or spreading COVID-19, through student health plans or other affordable, comprehensive options.

To date, the U.S. Department of Health and Human Services (HHS) has declined to create a broader open enrollment period that would allow those in sudden need of coverage to obtain new coverage from the Marketplace. We urge you to reverse this decision. Further, until HHS undertakes a more comprehensive response, HHS should work with the U.S. Department of Education to notify students about their insurance options and that moving away from campus may be a qualifying life event under the ACA that allows students to enroll in individual health insurance plans through a Special Enrollment

[1] Abigail Hess, *How Coronavirus Dramatically Changed College for Over 14 Million Students*, CNBC (Mar. 26, 2020, 2:07 PM), https://www.cnbc.com/2020/03/26/how-coronavirus-changed-college-for-over-14-million-students.html.
[2] 42 U.S.C. 300gg-14.

Period (SEP). SEPs are critically important and students need to understand their options for Marketplace coverage, which provides comprehensive benefits unlike short-term limited duration insurance (STLDI). The U.S. Department of Education has the authority to inform recipients of federal student financial aid of federal and state means-tested benefits, such as Marketplace coverage, pursuant to Section 312 of the *Continuing Appropriations Act, 2019*, and we encourage you to work with Secretary DeVos to ensure that students and their families are fully aware of their options to obtain coverage.

More than 200,000 students[3] currently enrolled in self-funded student health insurance plans may also face additional challenges in understanding their health care coverage and COVID-19-related benefits. As you know, self-funded student health insurance coverage is not coverage that is offered by issuers or group health plans but rather is a type of individual market health insurance coverage offered to students and their dependents under a written agreement between an institution of higher education and an issuer.[4] The *Families First Coronavirus Response Act*[5] requires all group health plans and health insurance coverage to offer free testing for COVID-19. States generally lead in regulation of self-funded student health insurance plans. Given the variety of state regulations, we urge HHS to work closely with states to ensure self-funded student health insurance plans inform covered students about their current COVID-19 testing and treatment coverage.

Informing college students about the full range of available health coverage opportunities during the COVID-19 pandemic is not only of paramount importance to ensuring their health and safety, but also the health and safety of the communities in which they reside during this pandemic. We therefore urge HHS to take any available actions to inform students and their dependents about the comprehensive health insurance options available to them to ensure their continued access to high quality health coverage.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman
House Committee on Education and Labor

PATTY MURRAY
Ranking Member
Senate Committee on Health, Education, Labor and Pensions

Cc: The Honorable Betsy DeVos, Secretary, U.S. Department of Education

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[3] In June 2019, a survey conducted during the American College Health Association's annual meeting showed that about 297,000 students are covered by not-for-profit, self-funded student health plans provided by four-year colleges and universities. Press Release, Lookout Mountain Group, 297,000 Students are Covered by Not-for-profit, Self-funded Student Health Plans Provided by 4-year Colleges (June 25, 2019) *available at* https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Af827c6ec-cdfa-4829-9cf5-594b55fd27c1.

[4] Student Health Insurance Coverage, 77 Fed. Reg. 16,453, 16,455 (Mar. 21, 2012) (to be codifed at 45 C.F.R. Pts. 144, 147, and 158) *available at* https://www.federalregister.gov/documents/2012/03/21/2012-6359/student-health-insurance-coverage.

[5] 42 U.S.C. 1320b-5.

From: "Singh, Jailendra P. " [redacted]
Sent: 5/28/2020 3:16:21 AM +0000
To: "Singh, Jailendra P. " [redacted]
Subject: Some Interesting Reports We Published This Week

I hope you and your family are doing well.

We published few reports over the past few days, which we thought might be of your interest. Below are links to the reports:

- **Conversations with eHealth Management:**
    - A Quick Catch-up with Management on Miscellaneous Topics
    - Quick Thoughts on the Impact of COVID SEP on LTV & Churn Rate

- **Takeaways From Our Virtual Meeting with Dr. Rakesh Mehta, Director of Virtual Health, Memorial Hermann Health System:** Views from a Major Health System's Telehealth Executive

Please let me know if you have any feedback to something we have written.

Regards,

Jailendra

*Please e-mail me if you want to unsubscribe from my distribution list

Jailendra Pratap Singh
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27 May 2020
Equity Research
Americas | United States

eHealth

A Quick Catch-up with Management on Miscellaneous Topics

Healthcare Technology & Distribution | Company Update

EHTH

Target price (12M, US$)
174.00
Outperform[V]

Price (26 May 20, US$)	127.01
52-week price range	146.09 - 53.12
Market cap (US$ m)	3,253.23
Enterprise value (US$ m)	3,132

[V] = Stock Considered Volatile (see Disclosure Appendix)

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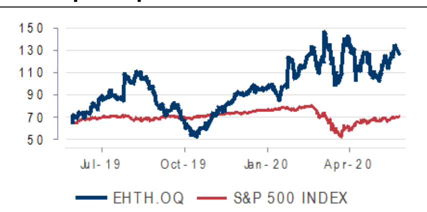
- **SEP Driving Some Enrollment Upside in Q2.** While EHTH did not quantify the benefit, the company notes that it has seen an increase in enrollment since the Special Enrollment Period (SEP) announcement. The SEP, which the company essentially characterized as "an extension of the Open Enrollment Period (OEP)", is available to MA beneficiaries effective 3/1 and runs through 6/30. By way of background, on May 5 the Centers for Medicare and Medicaid Services (CMS) announced the SEP for beneficiaries affected by a FEMA-declared weather-related emergency or other major disaster was applicable for COVID-19 as well. This SEP is particularly for people who missed an opportunity to change their Medicare Advantage and/or Part D plans due to the COVID pandemic. Beneficiaries are allowed to make one election as a result of the COVID-19 SEP.
- **Focused on Improving Recapture Rate & Churn Rate.** eHealth notes that its lower LTV (~$1,000) relative to some of its competitors is likely attributable to its relatively higher churn (36% churn in year one for EHTH versus 30% on an apples-to-apples basis for some of its competitors). While EHTH noted $1,200 as its target LTV at its investor day last year, it basically assumes a flat LTV in its five year plan. However, EHTH is very focused on improving its recapture rate, which will not necessarily help LTV (as the reported LTV is by plan and not by customer) but will improve the company's enrollment volumes & customer acquisition cost. Additionally, another area where EHTH is focused on is improving its churn in the first 90 days. A significant amount of the 36% year one churn happens in the first 90 days, which is largely attributable to plan selection. As a result, the company is working on tying a portion of its agent compensation to the first 90 days' retention, which the company believes could impact the agents' behavior for the better. By way of background, 2-3 years ago, EHTH used to compensate its agents based on submitted polices. However, once the company made the compensation based on approved policies, the company saw a significant improvement in its "approved to submitted" ratio. Notably, eHealth did flag that a wrong plan selection is not always a fault of the broker (sometimes information provided to agents is incorrect or insufficient). EHTH is considering implementing this split broker compensation for the upcoming Annual Enrollment Period (AEP).

Share price performance



On 26-May-2020 the S&P 500 INDEX closed at 2991.77Daily May24, 2019 - May26, 2020, 05/24/19 = US$64.63

Financial and valuation metrics

Year	12/19A	12/20E	12/21E	12/22E
EPS (CS adj.) (US$)	4.37	3.71	4.64	6.07
Prev. EPS (US$)	-	-	-	-
P/E (x)	29.0	34.3	27.4	20.9
EV/SALES	6.4	5.2	4.2	3.4
Revenue (US$ m)	506.2	625.2	781.9	973.5
EBITDA (US$ m)	133.2	134.6	180.8	255.3
EBITDA margin (%)	26.3	21.5	23.1	26.2
EV/EBITDA (current)	23.1	22.9	17.0	12.1
ROIC (%)	19.84	14.80	16.65	19.07
Number of shares (m)	25.61	IC (current, US$ m)		505.89

Source: Company data, Refinitiv, Credit Suisse estimates

Quarterly EPS	Q1	Q2	Q3	Q4
2019A	0.33	0.10	-0.43	4.13
2020E	0.39	-0.15	-0.75	4.17
2021E	-0.01	-0.05	-0.64	5.16

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eHealth (EHTH)

Price (26 May 2020): **US$127.01** Target Price: **174.00**

Analyst: **Jailendra Singh**

Rating: **Outperform [V]**

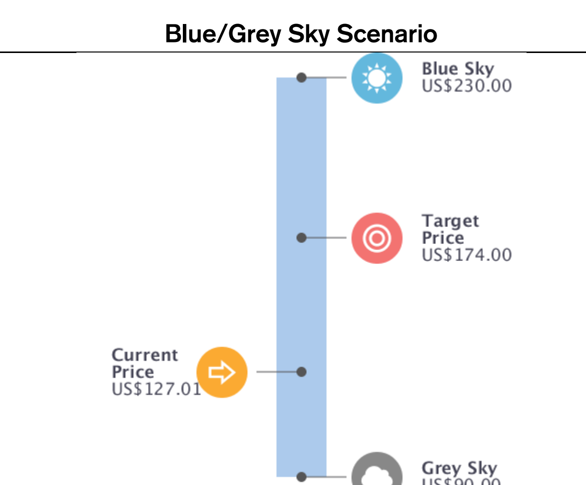
Per share	**12/19A**	**12/20E**	**12/21E**	**12/22E**
No. of shares (EOP)	23	27	30	32
EPS (Credit Suisse) (US$)	**4.37**	**3.71**	**4.64**	**6.07**
Prev. EPS (US$)	-	-	-	-
DPS (US$)	0.00	0.00	0.00	0.00
Book value per share	29.81	36.39	39.91	42.23
Income Statement	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Net written premiums written	-	-	-	-
Pre-tax profit	132.3	133.5	179.6	253.8
Income tax (expense)	30.4	32.0	39.5	58.4
Minority interests (P&L)	-	-	-	-
Adjusted net income (US$)	102.0	101.5	140.1	195.4
Balance Sheet (US$)	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Assets				
Cash & cash equivalents	15	147	199	170
Account receivables	218	296	368	457
Other current assets	11	13	16	20
Total current assets	**243**	**456**	**584**	**647**
Total fixed assets	26	43	62	80
Investment securities	-	-	-	-
Total assets	**746**	**1,095**	**1,368**	**1,603**
Liabilities				
Total current liabilities	**121**	**143**	**175**	**214**
Total liabilities	**251**	**298**	**363**	**442**
Total liabilities and equity	**746**	**1,095**	**1,368**	**1,603**
Net debt	11	(121)	(173)	(144)
Earnings	**12/19A**	**12/20E**	**12/21E**	**12/22E**
P&C net premium growth	-	-	-	-
BVPS growth (%)	0	0	0	0
Net income growth	4	(0)	0	0
EPS	3	(0)	0	0
DPS Growth				
Margins (%)				
P&C combined ratio (%)	-	-	-	-
Profitability (%)				
Return on equity stated	-	-	-	-
ROE (%)	-	-	-	-
Valuation	**12/19A**	**12/20E**	**12/21E**	**12/22E**
PE - stated	29.0	34.3	27.4	20.9
P/E	29.0	34.3	27.4	20.9
Dividend Yield (%)	0.0	0.0	0.0	0.0
Price / NAV	4.3	3.5	3.2	3.0
Price / EV	0.0	0.0	0.0	0.0
Embedded value data	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Group embedded value	-	-	-	-
Embedded value per share	-	-	-	-
Life - APE sales	-	-	-	-
Life - new business values	-	-	-	-
Net interest to EBITDA (x)	0.1	(0.9)	(1.0)	(0.6)
EV ratios	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Return on embedded value (%)	-	-	-	-
EV per share growth	-	-	-	-
APE sales growth	-	-	-	-
New business value growth	-	-	-	-
Life new business margin (%)	-	-	-	-

Source: Company data, Refinitiv, Credit Suisse estimates

Company Background

eHealth owns eHealth.com, a private online health insurance exchange where individuals, families & small businesses can compare health insurance products from brand-name insurers side by side and purchase and enroll in coverage online and over the phone.

Blue/Grey Sky Scenario



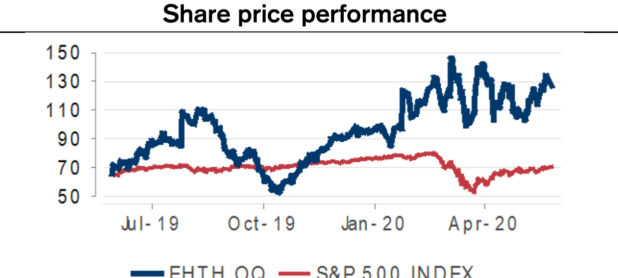
Our Blue Sky Scenario (US$) **230.00**

Our Blue Sky valuation of $230 assumes shares are valued at 8.0x our 2021 revenue estimates under the assumption that the company grows its market share in Medicare market at a pace much faster than currently reflected in our assumptions

Our Grey Sky Scenario (US$) **90.00**

Our Grey Sky valuation of $90 assumes shares are valued at 3x our 2021 revenue estimates under the assumption that the noise around Medicare For All continues and the company grows its market share in Medicare market at a pace slower than currently reflected in our assumptions

Share price performance



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- **Margin Differential and Opportunities.** eHealth invests about 11% of its revenue in digital content/technology investments, which the company notes is significantly higher than some of its competitors and is likely the primary reason for its relatively lower margins. The company is very focused on building the best e-commerce platform, while its competitors have focused more on investing in brokers and call centers. While unassisted online enrollment is still a small percentage of the company's total enrollment, eHealth's goal is to be best positioned in the event the trend towards e-commerce adoption accelerates. eHealth believes, relative to some of its competitors, it spends a little bit less on both customer care & enrollment (CC&E), and marketing. Moving forward, eHealth expects to reinvest all the savings resulting from better than expected CC&E into marketing.
- **Discussions Around the Omni-Channel Strategy**. As part of an omni-channel strategy, EHTH generates enrollments from multiple channels, including 50% through direct mail/TV, 20% through digital (i.e. paid & organic search), and 30% from partner channels (e.g. pharmacy, hospitals, other providers, lead gen sources). EHTH sees the partner channel as an important source of growth, as around half of the enrollees from that channel come at no acquisition cost (though EHTH must still spend money to maintain the channel). On its 1Q20 call, eHealth noted that its pharmacy channel was struggling based on low in-store traffic and hesitation by the pharmacies as they have been focused on managing the COVID-19 crisis, which delayed some of the programs EHTH planned to launch with the pharmacy channel (the pharmacy channel is very profitable for EHTH since there is no revenue share with them). These channels allocate a bulk of their budgets for Q4 since that's when the conversion rates are highest for enrollment. At this point, eHealth expects its partner channel contribution to be back on track in Q4, assuming there is not another spike in the number of COVID cases. By way of background, eHealth has exclusive agreements with the vast majority of the large pharmacies. However, the hospital channel is much more fragmented – though the relationships eHealth has are exclusive.
- **Thoughts on Any Potential Delay in Agents Getting Licensed.** We have recently fielded some investor questions around the impact of COVID-19 on the delay in agents obtaining health insurance licenses and certifications. The pandemic impacted the capacity of health insurance license testing facilities, which likely has resulted in delays in the completion of background checks and fingerprinting requirements. eHealth notes that the company's agent training program runs throughout the year; however, a big ramp heading into the Annual Enrollment Period (AEP) is still expected to be a 3Q event. The company doesn't see any concerns around licensing to have any impact on its ability to have its brokers ready for 4Q20.
- **Churn Improvement in 2Q vs. 1Q.** eHealth notes that it is still too early to have definite clarity on churn trends in the quarter. In fact, management notes that even when Q2 is over, the company will have the enrollment data but it takes 6-8 weeks to have good clarity on the churn rate.

27 May 2020

Companies Mentioned *(Price as of 26-May-2020)*
Change Healthcare (CHNG.OQ, $12.335)
HMS Holdings Corp (HMSY.OQ, $29.05)
Premier Inc (PINC.OQ, $34.02)
Teladoc Health (TDOC.N, $164.47)
Tivity Health (TVTY.OQ, $9.85)
eHealth (EHTH.OQ, $127.01, OUTPERFORM[V], TP $174.0)

Disclosure Appendix

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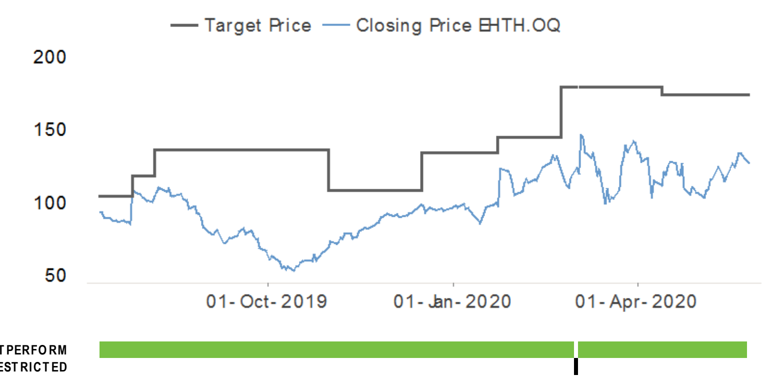
Jailendra Singh, Jermaine Brown and Adam Heussner each certify, with respect to the companies or securities that the individual analyzes, that (1) the views expressed in this report accurately reflect his or her personal views about all of the subject companies and securities and (2) no part of his or her compensation was, is or will be directly or indirectly related to the specific recommendations or views expressed in this report.

3-Year Price and Rating History for eHealth (EHTH.OQ)

EHTH.OQ Date	Closing Price (US$)	Target Price (US$)	Rating
10-Jul-19	93.51	104.00	O
26-Jul-19	108.40	118.00	
06-Aug-19	104.08	136.00	
31-Oct-19	69.04	108.00	
16-Dec-19	98.29	134.00	
23-Jan-20	97.13	145.00	
23-Feb-20	131.52	179.00	
02-Mar-20	123.87		R
04-Mar-20	146.09	179.00	O
13-Apr-20	111.83	174.00	



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Neutral (N) : The stock's total return is expected to be in line with the relevant benchmark* over the next 12 months.
Underperform (U) : The stock's total return is expected to underperform the relevant benchmark* over the next 12 months.

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Neutral/Hold*	38%	(26% banking clients)
Underperform/Sell*	12%	(23% banking clients)
Restricted	1%	

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Target Price and Rating
Valuation Methodology and Risks: (12 months) for eHealth (EHTH.OQ)

Method: Our $174 target price and Outperform rating for EHTH are derived from 6x our 2021 revenue estimate. Our PT multiple reflects some of the potential revenue and earnings upside.

Risk: Risks to our Outperform rating and $174 target price for EHTH are slower than expected market share improvement in Medicare market and slower than expected ramp in margin improvement over the next several years.

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This research report is authored by:

Credit Suisse Securities (USA) LLC...Jailendra Singh ; Jermaine Brown ; Adam Heussner

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27 May 2020
Equity Research
Americas | United States

eHealth

Quick Thoughts on the Impact of COVID SEP on LTV & Churn Rate

Healthcare Technology & Distribution | Comment

EHTH

Target price (12M, US$)
174.00
Outperform[V]

- **Fielding Some Investor Questions Around the Implication of COVID SEP on Churn Rate.** As a follow-up to our note (A Quick Catch-up with Management on Miscellaneous Topics) this morning, we have fielded some investor questions around the impact of the COVID-19 Special Enrollment Period (SEP) on churn rate and LTV. As highlighted in our note this morning, seniors who were unable to switch MA plans during the OEP are allowed to change MA plans during the SEP (which runs through 6/30). Some investors have raised questions if this could lead to a higher churn in Q2. By way of background, in 1Q20, during the OEP, EHTH experienced a higher Y/Y churn. As a majority of churn happens in the first 90 days of enrollment being effective, the churn is expected to decline as the year progresses. Our understanding is that while the COVID-19 SEP could result in slightly higher churn than would otherwise be expected in Q2, it is likely to be still lower than what the company experienced in Q1.
- **Importantly, EHTH's 2020 LTV Outlook & 2Q Expectations Are Conservative.** Despite a 5% Y/Y increase in EHTH's MA LTV in 1Q20, the company continues to forecast its full year 2020 MA LTV to be roughly flat Y/Y. Given the norm that churn likely improves as the year progresses, we believe the company has already taken a conservative view with respect to its LTV projections for the rest of 2020. As highlighted in our note this morning, it takes 6-8 weeks for EHTH to have any clarity on the churn rate. However, the company also notes that it remains very comfortable with its LTV projections for the year, which reflects "a nice cushion vs. its internal expectations." Overall, we believe EHTH's revenue growth outlook of a 20% Y/Y in 2Q20 (versus 55% in 1Q20) is conservative and any unfavorable impact of the COVID SEP on the LTV/churn rate in the quarter is expected to be more than offset by higher sign-ups/enrollment.

Price (26 May 20, US$)	127.01
52-week price range	146.09 - 53.12
Market cap (US$ m)	3,253.23
Enterprise value (US$ m)	3,132

[V] = Stock Considered Volatile (see Disclosure Appendix)

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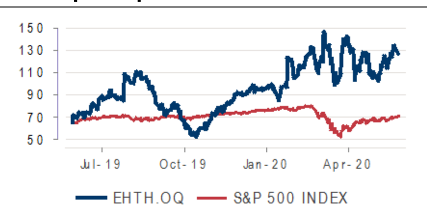
Share price performance



On 26-May-2020 the S&P 500 INDEX closed at 3004.88Daily May28, 2019 - May26, 2020, 05/28/19 = US$66.45

Quarterly EPS	Q1	Q2	Q3	Q4
2019A	0.33	0.10	-0.43	4.13
2020E	0.39	-0.15	-0.75	4.17
2021E	-0.01	-0.05	-0.64	5.16

Financial and valuation metrics

Year	12/19A	12/20E	12/21E	12/22E
EPS (CS adj.) (US$)	4.37	3.71	4.64	6.07
Prev. EPS (US$)	-	-	-	-
P/E (x)	29.0	34.3	27.4	20.9
EV/SALES	6.4	5.2	4.2	3.4
Revenue (US$ m)	506.2	625.2	781.9	973.5
EBITDA (US$ m)	133.2	134.6	180.8	255.3
EBITDA margin (%)	26.3	21.5	23.1	26.2
EV/EBITDA (current)	23.1	22.9	17.0	12.1
ROIC (%)	19.84	14.80	16.65	19.07
Number of shares (m)	25.61	IC (current, US$ m)		505.89

Source: Company data, Refinitiv, Credit Suisse estimates

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eHealth (EHTH)

Price (26 May 2020): **US$127.01** Target Price: **174.00**

Analyst: **Jailendra Singh**

Rating: **Outperform [V]**

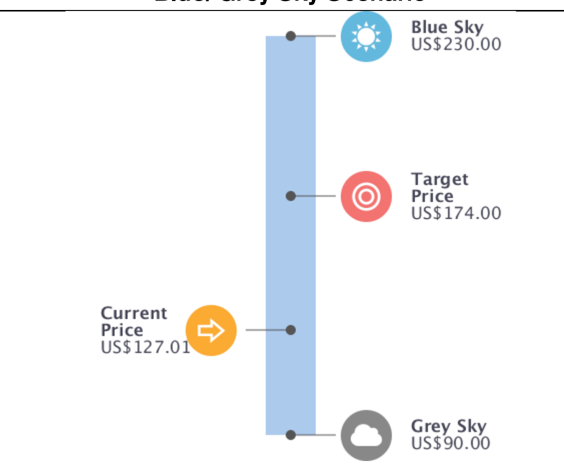
Per share	**12/19A**	**12/20E**	**12/21E**	**12/22E**
No. of shares (EOP)	23	27	30	32
EPS (Credit Suisse) (US$)	**4.37**	**3.71**	**4.64**	**6.07**
Prev. EPS (US$)	-	-	-	-
DPS (US$)	0.00	0.00	0.00	0.00
Book value per share	29.81	36.39	39.91	42.23
Income Statement	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Net written premiums written	-	-	-	-
Pre-tax profit	132.3	133.5	179.6	253.8
Income tax (expense)	30.4	32.0	39.5	58.4
Minority interests (P&L)	-	-	-	-
Adjusted net income (US$)	102.0	101.5	140.1	195.4
Balance Sheet (US$)	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Assets				
Cash & cash equivalents	15	147	199	170
Account receivables	218	296	368	457
Other current assets	11	13	16	20
Total current assets	**243**	**456**	**584**	**647**
Total fixed assets	26	43	62	80
Investment securities	-	-	-	-
Total assets	**746**	**1,095**	**1,368**	**1,603**
Liabilities				
Total current liabilities	**121**	**143**	**175**	**214**
Total liabilities	**251**	**298**	**363**	**442**
Total liabilities and equity	**746**	**1,095**	**1,368**	**1,603**
Net debt	11	(121)	(173)	(144)
Earnings	**12/19A**	**12/20E**	**12/21E**	**12/22E**
P&C net premium growth	-	-	-	-
BVPS growth (%)	0	0	0	0
Net income growth	4	(0)	0	0
EPS	3	(0)	0	0
DPS Growth				
Margins (%)				
P&C combined ratio (%)	-	-	-	-
Profitability (%)				
Return on equity stated	-	-	-	-
ROE (%)	-	-	-	-
Valuation	**12/19A**	**12/20E**	**12/21E**	**12/22E**
PE - stated	29.0	34.3	27.4	20.9
P/E	29.0	34.3	27.4	20.9
Dividend Yield (%)	0.0	0.0	0.0	0.0
Price / NAV	4.3	3.5	3.2	3.0
Price / EV	0.0	0.0	0.0	0.0
Embedded value data	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Group embedded value	-	-	-	-
Embedded value per share	-	-	-	-
Life - APE sales	-	-	-	-
Life - new business values	-	-	-	-
Net interest to EBITDA (x)	0.1	(0.9)	(1.0)	(0.6)
EV ratios	**12/19A**	**12/20E**	**12/21E**	**12/22E**
Return on embedded value (%)	-	-	-	-
EV per share growth	-	-	-	-
APE sales growth	-	-	-	-
New business value growth	-	-	-	-
Life new business margin (%)	-	-	-	-

Source: Company data, Refinitiv, Credit Suisse estimates

Company Background

eHealth owns eHealth.com, a private online health insurance exchange where individuals, families & small businesses can compare health insurance products from brand-name insurers side by side and purchase and enroll in coverage online and over the phone.

Blue/Grey Sky Scenario



Our Blue Sky Scenario (US$) **230.00**

Our Blue Sky valuation of $230 assumes shares are valued at 8.0x our 2021 revenue estimates under the assumption that the company grows its market share in Medicare market at a pace much faster than currently reflected in our assumptions

Our Grey Sky Scenario (US$) **90.00**

Our Grey Sky valuation of $90 assumes shares are valued at 3x our 2021 revenue estimates under the assumption that the noise around Medicare For All continues and the company grows its market share in Medicare market at a pace slower than currently reflected in our assumptions

Share price performance

On 26-May-2020 the S&P 500 INDEX closed at 3004.88
Daily May28, 2019 - May26, 2020, 05/28/19 = US$66.45

Companies Mentioned *(Price as of 26-May-2020)*
eHealth (EHTH.OQ, $127.01, OUTPERFORM[V], TP $174.0)

Disclosure Appendix

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3-Year Price and Rating History for eHealth (EHTH.OQ)

EHTH.OQ Date	Closing Price (US$)	Target Price (US$)	Rating
10-Jul-19	93.51	104.00	O
26-Jul-19	108.40	118.00	
06-Aug-19	104.08	136.00	
31-Oct-19	69.04	108.00	
16-Dec-19	98.29	134.00	
23-Jan-20	97.13	145.00	
23-Feb-20	131.52	179.00	
02-Mar-20	123.87		R
04-Mar-20	146.09	179.00	O
13-Apr-20	111.83	174.00	

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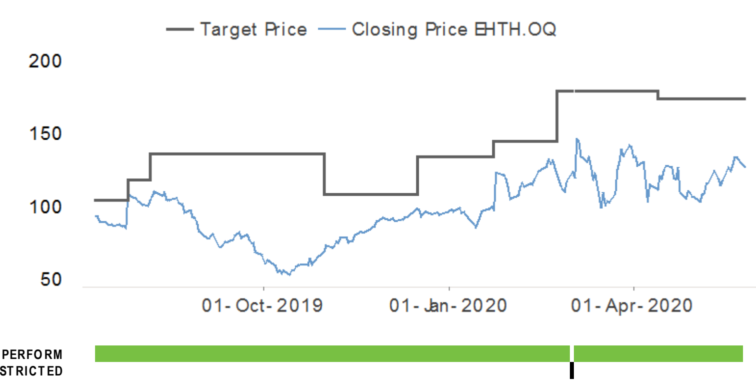

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Neutral (N) : The stock's total return is expected to be in line with the relevant benchmark* over the next 12 months.
Underperform (U) : The stock's total return is expected to underperform the relevant benchmark* over the next 12 months.

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Target Price and Rating
Valuation Methodology and Risks: (12 months) for eHealth (EHTH.OQ)

Method: Our $174 target price and Outperform rating for EHTH are derived from 6x our 2021 revenue estimate. Our PT multiple reflects some of the potential revenue and earnings upside.

Risk: Risks to our Outperform rating and $174 target price for EHTH are slower than expected market share improvement in Medicare market and slower than expected ramp in margin improvement over the next several years.

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This research report is authored by:

Credit Suisse Securities (USA) LLC...Jailendra Singh ; Jermaine Brown ; Adam Heussner

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Congress of the United States
Washington, DC 20515

June 15, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Azar and Administrator Verma:

We write to express our continued concerns regarding the Administration's inaction in responding to the needs of uninsured and underinsured Americans amidst the coronavirus disease of 2019 (COVID-19) pandemic. On April 13, 2020 – two months ago – we wrote to the Departments of Health and Human Services (HHS), Labor, and Treasury requesting information on the steps the Administration would take to ensure robust access to health insurance coverage through the Marketplaces created by the Affordable Care Act (ACA) for millions of American families. Our request for this information, as well as our request for related data, has gone unanswered, which is unacceptable and part of a troubling trend of this Administration ignoring its constitutional obligations to respond to Congressional oversight requests. The Administration's failure to provide this information leaves Congress and the public in the dark as we work to respond to the COVID-19 pandemic.

COVID-19 continues to devastate communities all throughout the country and the health and economic security of millions of Americans has been threatened in recent months. More than 44 million Americans have filed for unemployment benefits since mid-March and this number continues to climb each week.[1] The rapid loss of jobs has resulted in tens of millions of people losing employer-sponsored health insurance, and yet, HHS has provided virtually no support to the uninsured and underinsured during this historic crisis. Estimates show that more than 20 million people who lose employer-sponsored health coverage may become eligible for either Medicaid or Marketplace coverage, and yet this Administration still has not released any data on how many people are enrolling in coverage they are eligible for.[2] We once again

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[1] U.S. Employment and Training Administration, Initial Claims [ICSA], retrieved from FRED, Federal Reserve Bank of St. Louis (fred.stlouisfed.org/series/ICSA) (June 4, 2020).

[2] Kaiser Family Foundation. *As Unemployment Skyrockets, KFF Estimates More than 20 Million People Losing Job-Based Health Coverage Will Become Eligible for ACA Coverage through Medicaid or Marketplace Tax Credits* (May 13, 2020) (www.kff.org/coronavirus-covid-19/press-release/as-unemployment-skyrockets-kff-estimates-more-than-20-million-people-

reiterate our request that the Administration establish a broad Special Enrollment Period (SEP), available to all Americans, in order to help address the ongoing economic and health crisis.

Additionally, HHS has failed to respond to our requests to understand how it is applying existing SEPs for individuals with qualifying life events, such as loss of minimum essential coverage. On April 28, 2020, the Committees requested specific data on SEPs from the Centers for Medicare and Medicaid Services (CMS). We also requested a briefing from CMS Deputy Administrator and Center for Consumer Information and Insurance Oversight (CCIIO) Director Randy Pate and CCIIO Deputy Director for Policy Jeff Wu regarding the implementation of SEPs. In particular, the Committees requested SEP enrollment data for January through April 2020 broken down by SEP category and state, and data related to SEP verification, as well as data for previous plan years 2017-2019.[3] To date, HHS has not provided this data or a valid reason for their delays in providing this data to Congress or the public.

The Administration's failure to take action to increase the awareness of coverage options for American families is disappointing and damaging to the nation's health. At a time when families are facing crises on many fronts, the Administration should make it easier for individuals to access high quality, affordable health insurance. Additionally, HHS' disregard for Congressional oversight may necessitate that we consider additional measures to ensure responsiveness. We request an immediate and complete response to our April 13, 2020, letter, as well as answers to the following questions by Friday, June 19, 2020:

1. Please provide a detailed explanation of the steps the Administration is taking to reduce the burden on applicants seeking to enroll in coverage through HealthCare.gov who may need to provide supporting documentation to prove loss of coverage;

2. For the period from January through May 2020, please provide data on the number of individuals who enrolled in Marketplace coverage due to an SEP. Please provide this data broken down by week and state;

3. For the period from January through May 2020, please provide data on the number of individuals who enrolled in Marketplace coverage by SEP category (*e.g.*, loss of minimum essential coverage). Please provide this data broken down by week and state;

4. For the period from January through May 2020, please provide the percentage of applicants who applied for coverage using an SEP and were required to submit verification documents to prove eligibility for the SEP. Please also provide the

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losing-job-based-health-coverage-will-become-eligible-for-aca-coverage-through-medicaid-or-marketplace-tax-credits/).

[3] Email from Energy and Commerce Majority Committee Staff to Centers for Medicare & Medicaid Services (April 28, 2020).

percentage of individuals who applied for coverage using an SEP and ultimately had enrollment effectuated. Please provide this data broken down by week and state;

5. For calendar years 2017 through 2019, please provide data on the number of individuals who enrolled in Marketplace coverage due to an SEP, including by SEP category. Please provide this data for January through May of each calendar year and by state;

6. Please provide information on the Administration's outreach and enrollment activities on SEPs during COVID-19, including the amount of funding allocated for outreach and enrollment, and specific advertising, marketing, communication and outreach undertaken by CMS to educate consumers regarding the availability of coverage; and

7. Please provide a list of all entities that provided technical support for the Marketplaces from January 2017 to present, and please provide copies of each contract or subcontract. For each contract or subcontract, please also provide a description of the work performed.

Thank you for your urgent attention to this matter.

Sincerely,

Frank Pallone, Jr.
Chairman
Committee on Energy
and Commerce

Robert C. "Bobby" Scott
Chairman
Committee on Education
and Labor

Richard E. Neal
Chairman
Committee on Ways
and Means

Patty Murray
Ranking Member
Committee on Health, Education,
Labor and Pensions

Ron Wyden
Ranking Member
Committee on Finance

June 17, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma:

Thank you for your efforts to respond to the COVID-19 emergency. As this work continues, the undersigned organizations write today to respectfully request several continuations of Medicare enrollment flexibilities that are urgently needed to better facilitate access to coverage and care during this challenging time.

As you know, the older adults and people with disabilities we collectively serve are at high risk of infection, serious illness, and even death from COVID-19.[1] We are concerned that if they do not have health coverage, they may not be able to obtain medical treatment at a time when they need it most—worsening their own and public health outcomes. The enrollment flexibilities that may help some of these individuals connect with their coverage during the emergency period must not end before it does.

We urge you to maintain the following enrollment policies for the duration of the public health emergency, and longer if needed: The Special Enrollment Period for Part C and Part D; Equitable Relief for Premium Part A and Part B; and Time-Limited Equitable Relief for Marketplace Enrollees.

These extensions are necessary to ensure access to coverage during the COVID-19 crisis as well as ongoing compliance with public health guidelines. Local and state ordinances in effect and under consideration, the closure of Social Security field offices, as well as beneficiary experiences with the virus and related complications, may prevent timely Medicare enrollment application submission and processing for an unknown but significant amount of time. Keeping these coverage pathways intact would give older adults, people with disabilities, and their families much-needed peace of mind and access to care.

Special Enrollment Period for Part C and Part D. On May 5, the Centers for Medicare & Medicaid Services (CMS) clarified the availability of a Medicare Advantage (MA) and Part D Special Enrollment Period (SEP) for qualifying individuals affected by the pandemic.[2] This SEP allows people to make changes to their MA or Part D coverage if they were prevented from doing so during and due to COVID-19 emergency. Importantly, access to this SEP is set to end on June 30, 2020—in the face of staggering unemployment and coronavirus infection rates that make it more important than ever.

As a record number of workers continue to experience employment changes and the loss of job-based health coverage, an ever-growing share of the Medicare-eligible population is likely to qualify for a Part B SEP. Many of these individuals may be overwhelmed by their own or a family member's

[1] Centers for Disease Control and Prevention, "If You Are at Higher Risk" https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html.
[2] CMS, "Special Enrollment Period (SEP) for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Other Major Disaster: Applicable for COVID-19" https://www.cms.gov/files/document/special-enrollment-period-sep-individuals-affected-fema-declared-weather-related-or-other-major.pdf.

illness or distracted by the general state of the outbreak and its economic fallout. These circumstances may leave them uniquely susceptible to Medicare enrollment errors and missteps. To ensure these individuals can access needed coverage in a timely manner, we urge CMS to maintain this SEP while the emergency declarations are in place, at a minimum.

We also support making this SEP more effective by broadening eligibility to include people who have discovered, as a result of the pandemic, that their plan is not a good fit. While, as always, these enrollees can file an appeal if their plan will not cover a necessary medication or service, that is their only recourse. They are currently unable to make a coverage change, even if they need to do so because of the coronavirus emergency. Given the unprecedented nature of this crisis and urgent, shifting health care needs, we encourage you to adopt this flexibility without delay.

Equitable Relief for Premium Part A and Part B. Also recently unveiled, CMS acknowledges this application of equitable relief will help "ensure beneficiaries have access to the critical healthcare coverage they need in the wake of the Coronavirus Disease (COVID-19) outbreak."[3] We appreciate this recognition, and that the solutions available to the agency are limited. Unlike with MA and Part D, CMS does not have the statutory authority to establish an emergency-specific SEP for Premium Part A and Part B.[4] As a result, the agency is forced to rely on equitable relief to facilitate these enrollments.

Despite this lack of parity, equitable relief will undoubtedly help some Medicare-eligible individuals connect with needed coverage.[5] Troublingly, the policy has serious limitations that may dilute its efficacy. Announced just last month, it is only set to be in effect from March 17 to June 17, and enrollees are required to file their request within that timeframe. Based on our experience helping Medicare beneficiaries understand and navigate the equitable relief process, that is unlikely to be enough time for people to realize the need for and availability of this relief, or to obtain, complete, and submit the necessary paperwork. This restrictive timeline also excludes people who make or discover mistakes after mid-June, for whom access to coverage will be no less urgent. Absent changes, these constraints may prevent CMS from realizing its stated goal of improved access to Medicare.

As the COVID-19 pandemic and its risk to older adults and people with disabilities continues, so does the need for enrollment relief across the Medicare program. We urge CMS to keep this equitable relief eligibility window open for the duration of the public health emergency, at a minimum, and to strengthen the policy by allowing all who are eligible to access it at any time in the future.

Time-Limited Equitable Relief for Marketplace Enrollees. Time-limited equitable relief (TLER) helps some Medicare-eligible individuals with Marketplace coverage enroll in Part B without penalty. We understand that under the current policy, all who qualify for TLER through June 30, 2020 will be able to access it going forward. However, we are concerned that the pool of those newly needing this

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[3] CMS, "Medicare Part A and Part B Enrollment Equitable Relief for the COVID-19 Pandemic-Related National Emergency" https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index.

[4] SSA 1860D-1(b)(3)(C]

[5] CMS, "Medicare Part A and Part B Enrollment Equitable Relief for the COVID-19 Pandemic-Related National Emergency" https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index.

relief may continue to grow after that cutoff date. In particular, in the current environment, CMS communications targeted to Medicare-eligible Marketplace enrollees may be less impactful and more confusing than they would have been otherwise. At a time when access to affordable care is more important than ever, we urge CMS to maintain this pathway to coverage alongside the emergency declarations.

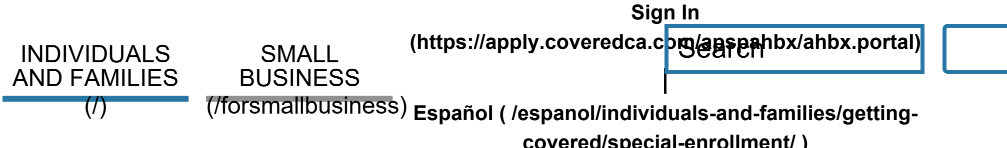
Thank you for your leadership, time, and consideration. We look forward to working together to ensure all people with Medicare have accessible and affordable health care and prescription drug coverage, during the COVID-19 crisis and beyond.

Sincerely,

AARP
AFL-CIO
AFSCME
Aging Life Care Association
Alliance for Aging Research
Alliance for Retired Americans
American Association on Health and Disability
American Geriatrics Society
American Kidney Fund
California Health Advocates
Caring Across Generations
Center for Medicare Advocacy
Center for Public Representation
Children's Aid
Disability Policy Consortium
Every Texan
Families USA
Gerontological Society of America
GLMA: Health Professionals Advancing LGBTQ Equality
The Jewish Federations of North America
Justice in Aging
Lakeshore Foundation
Medicare Rights Center
NAACP
National Adult Day Services Association (NADSA)
National Adult Protective Services Association
National Alliance on Mental Illness
National Association of Area Agencies on Aging (n4a)
National Association of Councils on Developmental Disabilities
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Social Workers (NASW)
National Association of State Long-Term Care Ombudsman Programs (NASOP)
National Consumer Voice for Quality Long-Term Care
National Council of Jewish Women

National Council on Aging (NCOA)
National Grange
National Health Law Program
National Partnership for Women & Families
Service Employees International Union (SEIU)
Union for Reform Judaism
Whitman-Walker Health

cc:
Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director, Center for Medicare
Jerry Mulcahy, Director, Medicare Enrollment and Appeals Group, Center for Medicare



Special-Enrollment Period Due to Coronavirus Now Available

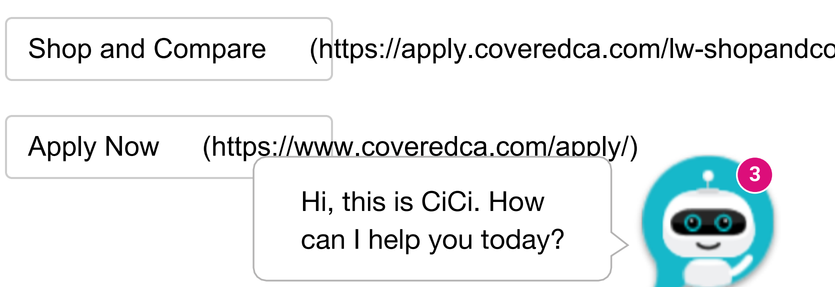
Having health insurance is critical — now more than ever. During this time of national emergency, we know there are thousands of people affected by income changes, reduced hours and layoffs leaving many Californians without health insurance coverage. If you've been affected use the Shop and Compare Tool (https://apply.coveredca.com/lw-shopandcompare/) and Apply Now (https://www.coveredca.com/apply/) to see if you're eligible. You have until July 31, 2020, to enroll.

What is special enrollment?

People who experience a qualifying life event can newly enroll in a health plan through Covered California even outside the open-enrollment period. People who already have a plan through Covered California who experience a qualifying life event can change their coverage or choose a new plan.

Get Help Applying

You can apply online (https://www.coveredca.com/apply/apply-online/) or call a Certified Insurance Agent, Navigator or our service center. (https://www.coveredca.com/find-help/) You may experience longer than normal wait times due to the current circumstances, but we're encouraging consumers to call and not seek in-person help.

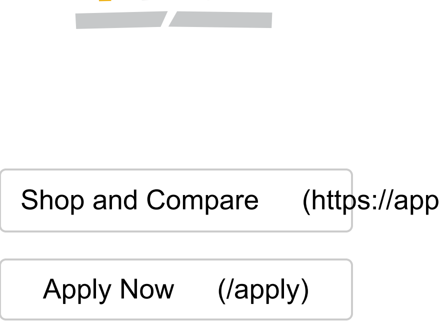


Other Qualifying Life Events

Lost Coverage **Moved** **Just Married** **Had a Baby**

You recently lost or will soon lose your coverage.

- You lose Medi-Cal coverage.
- You lose your employer-sponsored coverage.
- Your COBRA coverage is exhausted. (Note: Not paying your COBRA premium is not considered loss of coverage.)
- You are no longer eligible for student health coverage.
- You turn 19 years old and are no longer eligible for a child-only plan.
- You turn 26 years old and are no longer eligible for a parent's plan. If your parent has coverage through Covered California, you can stay in their plan until coverage ends on Dec. 31, even if you turn 26 mid-year. If your parent has a job-based plan, you qualify for a special-enrollment period to buy health insurance. Your special-enrollment period starts 60 days before you lose coverage and ends 60 days after.



Shop and Compare (https://app

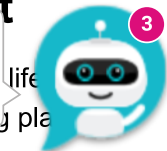
Apply Now (/apply)

These are just some of the more common qualifying life events. Read more about special enrollment and qualifying life events (/individuals-and-families/getting-covered/special-enrollment/qualifying-life-events/).

Covered California can also determine, on a case-by-case basis, that you experienced an exceptional circumstance that could allow for a special-enrollment period.

Deadlines to Enroll After a Qualifying Life Event

Hi, this is CiCi. How can I help you today?



For most qualifying life events, you have 60 days from the[...] life happens to enroll in a Covered California health insuranc[...] pla

If 60 days pass and you do not sign up for health coverage, you will have to wait until the next open-

enrollment period.

How to Enroll After a Qualifying Life Event

For many qualifying life events, you can enroll online. You can also call the Covered California service center at (800) 300-1506. Service center representatives can answer any questions you have about a qualifying life event and can help you enroll in or change health insurance plans. Visit the Find Help page for more resources including certified agents and Navigators. (https://www.coveredca.com/find-help/)

Start Dates and Avoiding Gaps in Coverage

Your coverage start date will depend on your qualifying life event.

For these life events, coverage will start on the first day of the month following enrollment:

- Needing coverage due to COVID-19.
- Losing Medi-Cal or job-based coverage.
- Marriage or registered domestic partnership.

For the birth or adoption of a child, or acceptance of a child into foster care, your coverage starts on the first day of the month following the birth, adoption, or placement in foster care but you can choose to have coverage start on the date of the birth, adoption, or placement in foster care, or on the first day of the month following enrollment.

For most other qualifying life events, the start date for coverage depends on the date of enrollment. If you enroll by the 15th day of the month, coverage will start on the first day of the next month. If you enroll after the 15th day of the month, coverage will start on the first day of the second month. For example, if you enroll on April 10, coverage will start on May 1. If you enroll on April 16, coverage will start on June 1.

Documents to Verify a Qualifying Life Event

Some consumers who apply for Covered California coverage in a special-enrollment period are asked to submit verification of their qualifying life event. If you receive a letter asking you to submit documents for your qualifying life event, check the Special Enrollment Acceptable Document List (/PDFs/SEP-Acceptable-Documents.pdf) to select the right document to send to us.

Coverage Basics (/individuals-and-families/getting-covered/coverage-basics)

Special Circumstances (/individuals-and-families/special-circumstances)

Eligibility and Immigration (/individuals-and-families/getting-covered/immigrants/)

Careers (http://hbex.coveredca.com/jobs/)

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Hi, this is CiCi. How can I help you today?

Health Insurance Providers Respond To Coronavirus (COVID-19)

posted by AHIP
on July 13, 2020

The health and well-being of millions of Americans remains our highest priority. Health insurance providers are committed to help prevent the spread of COVID-19. We are activating emergency plans to ensure that Americans have access to the prevention, testing, and treatment needed to handle the current situation. Click here for a one-pager to learn how we're protecting Americans.

Here are some ways health insurance providers are taking action:

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

A

Aetna

Aetna will waive co-pays for all diagnostic testing related to COVID-19, according to **CVS Health**. That includes all member costs associated with diagnostic testing for Commercial, Medicare, and Medicaid lines of business. Self-insured plan sponsors will be able to opt-out of the program at their discretion. Aetna is also offering zero co-pay telemedicine visits for any reason, and it is extending its Medicare Advantage virtual evaluation and monitoring visit benefit to all fully insured members. People diagnosed with COVID-19 will receive a care package. CVS Health is also offering several programs to help people address associated anxiety and stress.

Aetna, a CVS Health company, will waive member cost-sharing for inpatient admissions at all in-network facilities for treatment of COVID-19 or health complications associated with COVID-19. This policy applies to all Aetna-insured commercial plan sponsors and is effective immediately for any such admission through June 1, 2020.

Aetna is also waiving member cost-sharing for inpatient admissions at all in-network and out-of-network facilities for treatment of COVID-19 or health complications associated with COVID-19. This policy applies to all Aetna Individual and Group Medicare Advantage members and is effective March 25, 2020 for any such admission through June 1, 2020.

Aetna is also offering its Resources For Living®, its employee assistance program, to individuals and organizations who have been impacted by COVID-19, whether or not they have RFL included as part of their benefits.

Aetna is working closely with partner hospitals to help transfer and discharge members with issues unrelated to COVID-19 from hospitals to safe and clinically appropriate care settings where they can continue to have their needs addressed. This will help hospitals and emergency rooms make room for more patients, especially those suffering from COVID-19.

Aetna, a CVS Health company, is streamlining its provider credentialing process so there can be more health care professionals caring for patients.

Aetna is also paying the amount of the cost-sharing the member would have ordinarily paid related to COVID-19 testing or inpatient treatment so there is no financial impact on the provider.

Additionally, Aetna is reimbursing all providers for telemedicine at the same rate as in-person visits for applicable telehealth codes, including for mental health care services.

The Aetna Foundation is donating $500,000 to the Americares COVID-19 Mental Health and Psychosocial Support project to help frontline health care workers, particularly those who serve low-income populations, improve their mental health awareness, knowledge and resiliency, and understand the mental health concerns impacting their patients.

The Aetna Foundation is also making a $300,000 grant to the Crisis Text Line, which provides 24/7 confidential direct mental health support for those on the frontlines, including health care workers dealing with the stress, anxiety, fear, depression and/or isolation associated with COVID-19.

Aetna is extending all member cost-sharing and co-pay waivers for inpatient admissions for treatment of COVID-19 or health complications associated with COVID-19. Additionally, given the escalating mental health crisis resulting from or amplified by the pandemic, Aetna is extending all member cost-sharing waivers for in-network telemedicine visits for outpatient behavioral and mental health counseling services. These actions, which were scheduled to expire on June 1, 2020, have been extended through September 30, 2020. Aetna will continue working with self-funded plan sponsors to provide options.

Aetna is also taking additional steps to eliminate out-of-pocket costs for primary care services for Medicare Advantage members. Effective from May 13, 2020 through September 30, 2020, Aetna is waiving member out-of-pocket costs for all in-network primary care visits, whether done in-office and via telehealth, for any reason, and encourages members to continue seeking essential preventive and primary care during the pandemic.

Aetna has also extended the following actions, which were scheduled to expire on May 15, 2020, through September 30, 2020:

- Waiving early refill limits on 30-day prescription maintenance medications for all members with pharmacy benefits administered through CVS Caremark.
- Continuing to encourage all members of Commercial, Medicare and Medicaid plans to take advantage of plan benefits for 90-day maintenance medication prescriptions.

Aetna, a CVS Health company, will waive out-of-pocket costs for in-network primary care and specialist telehealth visits for all Individual and Group Medicare Advantage plan members through September 30, 2020.

AFLAC

AFLAC has made a $5 million donation to two organizations that are providing assistance for health care workers on the front lines of the COVID-19 pandemic.

AFLAC is donating $2 million to the Global Center for Medical Innovation (GCMI), a comprehensive innovation center using innovative 3D printing to help support medical device shortages, particularly as it relates to ventilators and protective masks. GCMI works in collaboration with Children's Healthcare of Atlanta Pediatric Technology Center.

The additional $3 million is going to Direct Relief, a humanitarian aid organization providing personal protective equipment (PPE) and essential medical items to health workers responding to the coronavirus. Direct Relief is active in all 50 states.

AFLAC is making a $1 million donation to Crisis Text Line, a global, not-for-profit organization that specializes in mental health intervention. Crisis Text Line provides free, 24/7, confidential support to people in crisis via SMS texting. Aflac's donation will help fund the organization's new campaign, For the Frontlines, aimed at helping individuals battling the COVID-19 crisis in the U.S.

Alignment Healthcare

Alignment Healthcare has launched two signature programs to address critical medical and social challenges Americans are now facing. The first is the AVA™ Personalized COVID-19 Risk Assessment tool, which provides personalized results and is now available to the public at www.alignmenthealthcare.com. The other is a crisis meal delivery program, providing two weeks of meals to members who cannot otherwise access food.

Alignment is also waiving Alignment Health Plan member cost-sharing (including, but not limited to, copays, deductibles or coinsurance) to zero for medically necessary screening and testing for COVID-19. Members may receive medically necessary services from any available Medicare-certified provider or facility without prior authorization from their medical group or Alignment Health Plan.

Alignment is making sure plan benefits are available to its members from their homes such as mail-order delivery of prescription drugs. Members with a monthly over-the-counter allowance can order their items for mail delivery by phone or online.

Alignment expanded access to certain telehealth services so members can connect with a doctor by phone or video in the safety and comfort of their own home.

Additionally, Alignment offers a variety of at-home video workouts through Peerfit Move at no extra cost to its Alignment Health Plan members. Additional resources and information are available for members at www.alignmenthealthplan.com.

AllWays Health Partners

AllWays Health Partners is removing cost-sharing (copayments, deductibles, or coinsurance) for testing and copayments for treatment at in-network facilities; ensuring access to out-of-network providers for the initial COVID-19 test or treatment when no in-network providers are available; and removing all cost-sharing for telemedicine services, including virtual visits with primary care providers and specialists, and through Partners HealthCare On Demand, to enable members to seek COVID-19-related care without the need to go to medical offices.

AlohaCare

AlohaCare will fully cover medically-necessary diagnostic tests for COVID-19, according to the Centers for Disease Control and Prevention (CDC) guidelines.

Prior authorization is not needed for diagnostic tests and covered services that are medically-necessary and follow COVID-19 CDC guidelines.

AlohaCare is donating $150,000 to local non-profit organizations that are helping at-risk families and individuals impacted by the COVID-19 pandemic. The donation includes monetary contributions to food banks across the state; 28,800 KN95 masks for health care workers at community health centers; and a grant for a new online platform to help identify areas of need in Hawaii.

AmeriHealth Caritas

AmeriHealth Caritas will cover and waive cost-sharing for testing and in-network, inpatient, acute care treatment of COVID-19.

AmeriHealth Caritas has also expanded access to telehealth services by video and phone. In several markets, to aid in the enhancement of telemedicine visits, AmeriHealth Caritas plans are also providing blood pressure monitors to persons diagnosed with hypertension, including expectant mothers.

AmeriHealth Caritas is focused on improving the health and wellbeing of underserved communities at this time of crisis and is conducting “well-check” outreach to vulnerable members and helping connect them to their providers and community resources. In select communities, AmeriHealth Cartas has also expanded the delivery of medically tailored and ready-to-eat meals and groceries to the homes of members who have been confirmed to have COVID-19 and to members at highest risk for COVID-19 complications.

AmeriHealth New Jersey

AmeriHealth New Jersey will waive cost-sharing for COVID-19 testing performed at a hospital or approved laboratory. This includes members in fully insured, employer-sponsored plans and the individual and family plans available through the Affordable Care Act. Self-funded plans will be able to opt-out of the program. The company is also waiving cost-sharing for telemedicine visits available through members' plans for the next 90 days.

AmeriHealth New Jersey is expanding its temporary suspension of prior authorization for acute in-network from the emergency department to include all diagnoses (including COVID-19) and for in-network transfers and transportation between facilities.

The prior authorization expansion will stay in place until June 4.

AmeriHealth New Jersey is also offering members free access to Stop, Breathe & Think, an emotional wellness app. The free access will run until June 14.

AmeriHealth New Jersey will waive members' cost for in-network, acute in-patient treatment of COVID-19 through December 31, 2020[2]. Cost sharing will be applied to post-acute care (e.g. skilled nursing, rehabilitation and long-term acute care facilities), outpatient treatment, prescription drugs, ambulance transportation to a post-acute setting, and out of network care.

Pre-authorization is currently not required for acute, in-network, in-patient admissions from the emergency department. Pre-authorization is also being waived for transfers from an in-patient facility to long-term ambulatory care, rehabilitation, or skilled nursing facilities, and transportation between facilities. These temporary changes to our pre-authorization policy are in effect until July 31, 2020. Facilities are still required to notify AmeriHealth New Jersey.

Anthem

Anthem will cover the cost of coronavirus testing with no out-of-pocket cost. Anthem also confirms that prior authorization is not required for diagnostic services related to COVID-19 testing. The company recommends using telehealth when possible to help prevent the spread of a virus. It is also encouraging its members to talk to their doctor about whether it is appropriate for them to change from a 30-day supply of their regular medications to a 90-day supply.

On March 17, Anthem also announced new resources for its members. First, it is working to accelerate the availability of a Coronavirus Assessment tool on the Sydney Care mobile app, which members can download at no cost. Second, Anthem's affiliated plans will continue to waive copays, coinsurance and deductibles for diagnostic tests for COVID-19, and extending this to include waiver of copays, coinsurance, and deductibles for visits associated with in-network COVID-19 testing, whether the care is received in a doctor's office, urgent care center or emergency department. Third, Anthem is relaxing early prescription refill limits for members who wish to receive a 30-day supply of most maintenance medications, where permissible. Fourth, for 90 days, Anthem plans will waive any cost sharing for telehealth visits, including visits for mental health care, for fully insured employer plans, individual plans, Medicare plans, and Medicaid plans, where permissible. This includes visits using Anthem's telemedicine service, as well as care received from other telehealth providers delivering virtual care.

The Anthem Foundation continues to support the Red Cross, Direct Relief, Americares, and Feeding America, and has committed $50 million for COVID-19 response and recovery efforts to help areas of greatest need, including care provider safety, food insecurity, and mental and behavioral health resources. The company is also matching employee donations to the Anthem Foundation's program.

Anthem is increasing physician availability through its telemedicine service, LiveHealth Online (LHO), including encouraging in-network doctors to join the platform, given the surge in demand. LHO is a safe and helpful way to use Anthem benefits to see a doctor and receive health guidance related to COVID-19, without leaving home or work.

Anthem is contributing $1 million to the Rapid Response Loan Fund, which was established by the Indy Chamber. The loan fund is intended to help the roughly 43,000 small business in central Indiana.

Anthem has also launched the Anthem Medical Associate Volunteer Program, which is designed to allow associates with professional medical training volunteer and assist in their local community's response to COVID-19.

In addition, Anthem suspended prior authorization requirements for patient transfers as well as for the use of medical equipment critical to COVID-19 treatment.

Anthem is waiving cost sharing payments for COVID-19 treatment. The expansion covers the waiver of cost share for COVID-19 treatment received through May 31, 2020.

Anthem's affiliated health plans and Beacon Health Options have joined with Psych Hub, mental health advocates and other national health insurers to develop a free digital resource site to help individuals and care providers address behavioral health needs resulting from the COVID-19 pandemic. This COVID-19 Mental Health Resource Hub provides a range of resources designed to help people, their families and care providers cope with pandemic-related stress brought on by social isolation, job loss and other challenges.

Anthem has also partnered with Aunt Bertha, a leading social care network, which helps connect individuals and families to free and reduced-cost social services in their communities. These programs include COVID-19-specific assistance, such as food delivery and help paying for bills. All consumers can access the more than 350,000 programs, which are available in every zip code across the U.S.

Anthem has donated $200,000 to United Way and Feeding America, two organizations that are crucial frontline responders to the coronavirus pandemic in California. Funds will be cascaded to food banks, shelters and other resource centers across the state that are helping struggling individuals and families access necessities amid the pandemic.

- Anthem Blue Cross's $100,000 contribution to the Feeding America COVID -19 Response Fund is helping Feeding America's network of 17 food banks throughout California to secure resources, meet increased demand and implement extra social distancing precautions as they continue to serve the most vulnerable members of the community. This includes families

dealing with school closures, those experiencing job disruptions, the elderly and disabled, people with low-incomes, those struggling with homelessness and other challenges.

- Anthem Blue Cross's $100,000 contribution to the United Way's COVID-19 Response Fund is supporting California's low income and vulnerable populations by ensuring families stay fed and housed amid the economic shutdown. Contributions are being used to provide food assistance, cash to pay for necessities such as rent and utilities, and even broadband access to help school children continue their education from home. Funds are also supporting the United Way's 2-1-1 programs, which connect people with needed resources and supports. Additionally, the fund is helping many of the state's agricultural workers, many of whom are undocumented and not eligible for federal financial relief or other resources to support their families.

The Anthem Foundation has distributed more than $200,000 to local organizations across Georgia that are responding to the COVID-19 crisis.

These contributions are part of a nearly $2 million commitment recently made by the Foundation as Anthem continues to support relief efforts for communities and families as they respond to the many emerging challenges associated with this public health emergency.

The Foundation has also made $260,000 in grants to Ohio-based Boys & Girls Clubs, Feeding America organizations and the Children's Hunger Alliance to address food insecurity in the wake of COVID-19.

Anthem has launched a virtual dental care program through a partnership with The TeleDentist, an in-network provider of virtual dental services from board-licensed dentists. The partnership provides consumers with timely access to dental care that is available 24/7, 365 days a year in the event of an emergency, with virtual exams covered at 100% with no deductibles, copays, paperwork, or claims to file through June 30.

Anthem launched Ortho@Home, a teledentistry and at-home orthodontia program. The services are part of Anthem's continuing commitment to providing access to affordable services that meet a person's whole health needs, while also providing safe, remote-care during this pandemic.

The service integrates seamlessly with orthodontic network provider options and includes discounts of up to $200 off retail pricing.

Anthem is providing $2.5 billion of financial assistance to ease the burden COVID-19 is placing on affiliated health plans' consumers and employer customers, care providers and nonprofit partners across the country.

Anthem affiliated health plans are supporting customers by providing a one-month premium credit to members enrolled in select Individual plans and fully insured employer customers ranging from 10 to 15%. In addition, individuals in stand-alone and group dental plans will also receive a 50% credit.

Consumers and employer customers will receive the premium credit in July. Anthem's health plan affiliates are also working with some employer groups on special payment arrangements as a bridge to continue to provide insurance for their employees during this difficult time.

Anthem's health plan affiliates will continue to waive cost sharing for in-network COVID-19 related treatment for members enrolled in fully insured employer plans, Individual plans and Medicare Advantage plans through December 31, 2020. Self-insured employers who previously chose to adopt cost sharing waivers for treatment can choose to extend the waivers.

Until September 30, 2020, Anthem's health plan affiliates will continue to allow expanded telehealth coverage, including some physical, occupational and speech therapy, and will continue to waive cost shares for in-network telehealth visits, including telephonic visits, for medical and mental health or substance abuse disorders, for fully insured employer plans, Individual plans, Medicare Advantage plans, group retiree plans and Medicaid plans, where permissible. This will also include waiving cost shares when utilizing TeleDentists®, an in-network provider with Anthem offering online and mobile-app enabled teledentistry solutions for dental care.

Anthem and its affiliated health plans are working with state partners to accelerate funds to care providers who treat the most vulnerable, particularly those with chronic conditions, behavioral health, and other special healthcare needs. Anthem's health plan affiliates are also reaching out to Medicaid beneficiaries to facilitate connections with state and social services, helping newly eligible and at risk members enroll in the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Health plan affiliates are directly contacting hundreds of thousands of Medicare Advantage and Medicaid consumers to make sure they have necessary medications on hand, their nutritional needs are being met and critical health needs are addressed during this time of social distancing and isolation.

Anthem will continue to make a difference in improving health across the nation, including addressing health disparities facing minority and underserved communities disproportionally impacted by this pandemic and other health inequities. Anthem is focused on empowering individuals to understand and take action on the health risks that affect them, including racial and ethnic risk factors, social drivers of health and pre-existing conditions. Through efforts to collaborate with care providers, health advocates and community leaders Anthem is working to address gaps in care and provide data and resources to effect positive health outcomes for members and communities at large.

Anthem is providing funding to support care providers' telehealth capabilities, quality-based programs and PPE, and extending additional funding to provide critical support to targeted independent primary care physician organizations and multispecialty groups who are facing financial pressure during this crisis. Additionally, Anthem is actively working with care providers to accelerate claims processing for outstanding accounts receivables, resolving claims where possible and appropriate, as well as accelerating payments to support state specific Medicaid programs.

Anthem will provide in-network dental providers a PPE Credit of $10 per patient, per visit, from June 15th through the end of August.

Anthem is simplifying access to care by temporarily suspending prior authorization requirements for respiratory services and medical equipment critical to COVID-19 treatment including Durable Medical Equipment such as oxygen supplies, respiratory devices, continuous positive airway pressure, or CPAP devices, non-invasive ventilators, and multi-function ventilators.

Anthem's health plan affiliates are temporarily extending prior authorizations on elective inpatient and outpatient procedures, issued before May 30, 2020. This will allow more flexibility in scheduling these procedures.

Anthem has launched a suite of digital tools that provide in-depth, trusted, and aggregated information for multiple stakeholders to use in making informed, data-driven decisions during the COVID-19 crisis. Led by Anthem, Inc.'s new C19 Explorer and C19 Navigator, these decision support tools are also designed to assist public health officials and business leaders as they plan for re-opening and returning to the office.

Arkansas Blue Cross and Blue Shield and Health Advantage

Arkansas Blue Cross and Blue Shield and Health Advantage are covering any illness related to the coronavirus that results in a need for standard covered medical treatment. There will be no prior authorizations for COVID-19 diagnostic tests and for covered services that meet primary coverage criteria and are consistent with CDC guidance. They will cover COVID-19 diagnostic testing and testing services at no cost to members. They are waiving early medication refill limits on 30-day prescription maintenance medications and encouraging members to use their 90-day mail-order benefit. Arkansas Blue Cross will also ensure formulary flexibility if there are shortages or access issues. Members are encouraged to use virtual health and nurse/provider hotlines.

Arkansas Blue Cross and Blue Shield and Health Advantage are waiving costs their fully insured members would normally have to pay for telehealth services related to physical and/or behavioral health when received from an in-network provider.

The waivers will be in place through at least May 15, 2020.

The Blue & You Foundation for a Healthier Arkansas is donating $500,000 in support of immediate needs around food insecurity in the state and opening the "Rapid-Response COVID Relief" grant process to award up to $1.7 million in grants supporting nonprofit organizations that have experienced the consequences of COVID-19.

The Rapid-Response COVID Relief Grants program is designed to help eligible organizations lessen the impact of the Covid-19 virus on the individuals, families and communities they serve.

Arkansas Blue Cross and Blue Shield and Health Advantage has extended the waiver on telehealth out-of-pocket costs through July 25, 2020. The waiver for cost-sharing payments for medical services for fully insured members whose primary diagnosis is COVID-19 has also been extended to July 25, 2020.

Aspire Health Plan

Aspire Health Plan is waiving all co-pays related to COVID-19 testing. Aspire is also making its telehealth benefit available for no copay.

Avera Health Plans

Avera Health Plans is waiving member costs for all telehealth benefits through June 14.

Avera is also waiving early refill limits on maintenance drugs to allow access to an additional 30-day supply.

Avera Health Plans will waive members' cost-share related to the treatment of COVID-19 (co-pay, coinsurance and deductible) when seeking care from an in-network provider through June 30, 2020.

Avera Health Plans is waiving the member cost for all applicable telehealth services through December 31, 2020. Members receiving applicable telehealth services from participating providers during this period will have their normal cost-share waived regardless if the telehealth visit is directly related to COVID-19 or not.

Avera Health Plans has extended its waiver of member cost-share payments related to COVID-19 treatment when seeking care from an in-network provider through Sept. 30, 2020.

AvMed

AvMed will cover diagnostic testing for COVID-19 at no cost-sharing if it is determined that test is needed. AvMed, in partnership with CVS Health, will also be waiving early refill limits on 30-day prescriptions for maintenance medications and providing home delivery of all prescription medications free of charge. It is also encouraging the use of telehealth services.

AvMed is waiving out-of-pocket costs for COVID-19 treatments for its fully-insured commercial and Medicare Advantage members through May 31, 2020. In addition, AvMed will continue to provide its members with zero-dollar diagnostic testing, zero-dollar virtual visits, including behavioral health, and waiver of specialist referral requirements.

AvMed is extending COVID-19 benefits and coverage until July 31, 2020. That includes zero-cost diagnostic testing, zero-cost treatment, and zero-cost virtual visits

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Blue Cross Blue Shield Association

Blue Cross Blue Shield Association announced that its network of 36 independent and locally operated Blue Cross and Blue Shield companies will waive prior authorizations for diagnostic tests and covered services for COVID-19, cover those tests at no cost share to members, waive prescription refill limits on maintenance medications, and expand access to telehealth and

nurse/provider hotlines. This applies to fully insured, individual, and Medicare Advantage plan members, and plans are working with state Medicaid and CHIP agencies to ensure people have access to needed testing and services.

All 36 independent and locally operated Blue Cross and Blue Shield companies are also waiving cost sharing for telehealth services for fully insured members for the next 90 days.

Independent and locally-operated Blue Cross Blue Shield companies across the country and the BCBS Federal Employee Program® (FEP®) have decided to waive cost-sharing for treatment of COVID-19 through May 31. This includes coverage for testing and treatment administered, including for inpatient hospital stays.

Blue Cross Blue Shield Association's network of 36 independent and locally-operated Blue Cross and Blue Shield companies and the Blue Cross and Blue Shield Federal Employee Program® have committed nearly $3 billion to date in support of members, health care workers and local communities to aid in the ongoing fight against COVID-19.

Blue Cross Blue Shield of Massachusetts

Blue Cross Blue Shield of Massachusetts will cover the costs of diagnostic testing for COVID-19 for fully insured members. Self-funded groups will have the ability to opt-in. The company will also cover the cost of a COVID-19 vaccine when it is available, and will waive co-payments for COVID-19 treatment at doctor's offices, emergency rooms and urgent care centers. It is removing administrative barriers such as prior authorizations and referrals, waiving copays for its telehealth platform, and allowing early access to refills of prescription medications.

Blue Cross Blue Shield of Massachusetts has also donated $100,000 to the Boston Resiliency Fund and an additional $150,000 to relief efforts across Massachusetts.

Blue Cross Blue Shield of Massachusetts has removed prior authorization requirements and moved to a notification-only requirement for inpatient levels of care including Acute, Long Term Acute (LTAC), Acute and Subacute Rehabilitation (Rehab), and Skilled Nursing Facility (SNF) admissions. Medical necessity reviews will not be performed for these inpatient levels of care through June 23, 2020. Notifications by facilities will allow Blue Cross nurses to assist members during their care transitions, including to the home.

Blue Cross and Blue Shield of Massachusetts is reallocating more than $1.75 million in community investments and strategic sponsorships to expedite unrestricted cash to help nonprofits meet operational challenges, including:

- Committing $550,000in relief grants to nonprofits providing frontline aid including access to food, basic needs and critical support for first responders, health care and retail workers;
- Lifting funding restrictions on $520,000of committed funds to ensure nonprofits have the flexibility to address critical challenges; and

- Leveraging a $300,000commitment to Blue Cross' Healthy Living Collaborative partners, including Codman Square Health Center and East Boston Neighborhood Health Center, to meet pressing community health challenges.

Blue Cross Blue Shield of Massachusetts has processed 180,000 telehealth claims since changing its policy to both expand coverage for telephone and virtual visits and reimburse them at the same rate as in-person visits during the COVID-19 state of emergency. The March telehealth claims figure is a 3600% increase over February and a 5100% increase over the monthly average for 2019.

In March Blue Cross made payments of nearly $800 million to physician and hospitals, including more than 50,000 new claims for COVID-19 testing and care, totaling approximately $10 million.

Additionally, Blue Cross is accelerating payments to provider groups participating in its Alternative Quality Contract (AQC). Under normal circumstances, these incentive payments would have been made in late 2020 or early 2021. This direct financial support is intended to assist providers with the financial pressures associated with the COVID-19 public health emergency.

Blue Cross has also developed a new expedited credentialing and enrollment process for practitioners, designed to speed health plan approval within 72 hours. The Public Health Emergency Provider Credentialing and Enrollment Process includes a simplified, one-page application and essential documentation requirements consistent with conditions for licensure with the Massachusetts Board of Registration in Medicine. Approval under this expedited process is time-limited and in effect for the duration of the Massachusetts public health emergency.

Blue Cross Blue Shield of Massachusetts has launched "We Are Mighty, Massachusetts," a campaign that celebrates our Commonwealth's resiliency and unity in the fight against COVID-19.

#WeAreMightyMA launches today with a video that shares an inspiring message of collective action across Massachusetts and celebrates the innumerable ways individuals have shown resolve and solidarity since the onset of the coronavirus pandemic. Blue Cross also invites individuals to shine a spotlight on those making a difference across the Commonwealth by sharing "mighty" stories and unsung efforts using the hashtag #WeAreMightyMA across social media channels.

Blue Cross Blue Shield of Massachusetts is re-deploying a portion of its employees to work with the Community Tracing Collaborative and Boston Hope field hospital, two key elements of the state's COVID-19 response.

More than 100 Blue Cross employees will be temporarily re-deployed as contact tracers for the Boston-based global health nonprofit Partners in Health at the collaborative. Contact tracers will call Massachusetts residents who have been in contact with people infected with COVID-19 and support them through quarantine.

Fifteen Blue Cross registered nurses are supporting the care of patients at the Boston Hope field hospital seven days a week, from 7 a.m. to 7 p.m. The facility, now operating in the Boston Convention and Exhibition Center, provides care to low acuity COVID-19 patients to ensure beds in Boston hospitals are available for the most serious coronavirus cases and other critical patients.

Blue Cross and Blue Shield of Massachusetts has processed more than one million telehealth claims in the nine weeks since changing its policy to expand coverage for telephone and virtual visits at no cost to members during the COVID-19 crisis. In February 2020, Blue Cross received approximately 200 telehealth claims per day. Now, the health plan is receiving more than 38,000 per day. Blue Cross is reimbursing telehealth services at the same rate as in-person visits for the duration of the Massachusetts public health emergency.

Nearly half the telehealth visits since the crisis began have been for mental health services, including psychotherapy. To help meet this unprecedented demand, Blue Cross has added more than 400 new mental health clinicians to its network since March 1 via its expedited emergency credentialing and enrollment process. This brings the total number of psychologists, psychiatrists, social workers, family therapists and other mental health clinicians – most of whom are now offering telehealth services – to nearly 15,000.

Blue Cross Blue Shield of Massachusetts is expanding access to an innovative online program for stress, anxiety and depression.

The program, called Learn to Live, helps members address their mild to moderate anxiety, depression, insomnia or substance use and improve their overall emotional health. Previously, Learn to Live was available to members whose employers purchased the benefit. Now, Blue Cross is making the program available to all fully insured customers and members.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan will waive prior authorizations for diagnostic tests and covered services for COVID-19, cover those tests at no cost share to members, waive prescription refill limits on maintenance medications, and expand access to telehealth and nurse/provider hotlines. This applies to fully insured and Medicare Advantage plan members. Blue Cross Blue Shield of Michigan will also work to support self-insured customers who choose to take similar actions.

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan will further expand access to prescription drug refills for members in order to comply with an executive order issued by Gov. Gretchen Whitmer to expand access to prescription drug refills during the COVID-19 public health crisis. Governor Whitmer's executive order expands BCBSM and BCN efforts by requiring all insurance providers to waive any limits on early refills, so Michigan residents can obtain a 90-day supply of prescription drugs necessary to manage their medical conditions during the COVID-19 crisis.

Blue Cross Blue Shield of Michigan and Blue Care Network are waiving all member copays, deductibles and coinsurance for COVID-19 testing and treatment. The coverage applies to commercial PPO, Medicare Advantage PPO and HMO plans.

Blue Cross Blue Shield of Michigan is accelerating payments to Michigan-based physician organizations and practices to support their efforts for treating patients with COVID-19. Additionally, BCBSM is relaxing some of its administrative requirements to allow Michigan's physician organizations and health systems to spend more time treating patients and hasten their diagnoses and treatment.

The accelerated funding is available to the more than 40 physician organizations that are a part of Blue Cross' Physician Group Incentive Program (PGIP), including over 20,000 primary care and specialist physicians throughout Michigan.

Blue Cross Blue Shield of Michigan is offering full salary and benefits to employees with medical backgrounds who volunteer to work in the coronavirus field hospital being constructed at the TCF Center in Detroit.

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan will waive cost-sharing for Medicare Advantage members through December 31 for certain specific services that enable seniors to consult with their doctors and therapists about their health needs, both in-person and virtually. Members in BCBSM and BCN Medicare Advantage plans will be assured of no copays, coinsurance or deductibles for the following in-network services, from May 1 through Dec. 31, 2020:

- In-person primary care services
- Behavioral health office visits
- Telehealth services for both medical and behavioral health

Blue Cross Blue Shield of Michigan and Blue Care Network are also launching new telehealth programs with behavioral health providers, so Blue members who are interested in participating in group sessions to discuss the impacts of the COVID-19 pandemic on their mental health can share their experiences with others under the guidance of a trained therapist. The programs are available for free to members with Blue Cross and Blue Care Network behavioral health coverage through June 30.

Blue Cross Blue Shield of Michigan and Blue Care Network will be returning more than $100 million to many fully insured customers this year. The refunds are in addition to $494 million that BCBSM has invested in expanding the availability of no-cost benefits for members and to support health providers in response to COVID-19 – bringing the BCBSM enterprise's commitment in response to the crisis to nearly $600 million.

BCBSM will be providing the following relief to customers and members with Blue Cross and Blue Care Network health plans:

- Fully insured small group customers with 50 or fewer employees will receive a 30% credit on their July premium invoice. All told, BCBSM is providing about $37 million back to small group customers for their medical plans.

- Low rate adjustments for small group customers. BCBSM filed 2021 small group rates last week with state regulators that average 0.9% more for PPO plans and 1.95% more for HMO plans.

- Blue Dental and Blue Vision employer group customers will be sharing a total refund of about $10.5 million. All fully insured groups with dental and vision coverage will receive a one-month premium refund to be credited on their July invoice. BCBSM also will not increase rates for fully insured customers renewing dental and vision plans for 2021.

- Individual health plan members from 2019 will receive a one-time rebate resulting from lower than expected health care claims. Altogether, about $45 million will be paid directly to these 2019 individual plan subscribers in September. Rebates are determined based on each subscriber's plan and premiums paid in 2019. Rebate amounts will vary by subscriber.

- Medigap (Medicare Supplement) and individual Medicare Advantage members in a plan with a premium above $0 will receive a 15% premium refund for the months of March and April to be applied to their July premium bill. This refund totals about $15 million to Medigap and Individual Medicare Advantage members. For Individual Medicare Advantage members this includes their Optional Supplemental Buy-up (if applicable).

BCBSM is also providing $494 million in additional support to members and providers:

- Medicare Advantage member cost share waivers will be provided through December 31 for BCBSM and BCN Medicare Advantage members. On May 7, BCBSM became the first health plan in Michigan to announce that it would waive cost sharing for Medicare Advantage members for all services provided during in-person primary care visits, for in-person behavioral health services and for telemedicine access. The projected value of these no-cost services will save BCBSM and BCN Medicare Advantage members $10 million.

- COVID-19 testing and treatment cost share waivers and no-cost telehealth services will continue to be provided through June 30 to enable free access to physician-directed COVID-19 testing and treatment for commercially insured members. The projected value of these no-cost services will save members $97 million. BCBSM was the first health plan in Michigan to announce testing and treatment for COVID-19 at no cost, along with no-cost telehealth access for both medical and behavioral health services during the first wave of the pandemic period.

- Advance funding for health providers. BCBSM pulled forward $87 million in earned incentive payments to Michigan physicians to enable them to operate, purchase testing supplies, enhance treatment services for COVID-19 patients and expand telehealth services. BCBSM also decided to continue planned payments to health systems, totaling about $300 million, despite disruptions in claim volume. This enabled Michigan health systems to continue operating with a stable revenue stream during a time of significant disruption in their ability to deliver services.

Blue Cross Blue Shield of Michigan and Blue Care Network will provide their members no-cost treatment for COVID-19 disease through Dec. 31, 2020. The cost share waivers apply to members in fully insured commercial PPO and HMO plans, as well as individuals in fully insured Medicare Advantage plans. BCBSM will work with employer group customers that are self-insured to make decisions regarding their own benefits.

BCBSM estimates that it will spend between $23 million to $43 million in providing these additional benefits – bringing the company's total investment in additional benefits for members to nearly $150 million during the pandemic.

Blue Cross Blue Shield of Wyoming

Blue Cross and Blue Shield of Wyoming is waiving members' coinsurance, copayments and deductibles for COVID-19 medical treatments through June 30, 2020. Cost sharing payments for COVID-19 testing and related services, including office visits, urgent care or emergency department, have also been waived.

Blue Cross Blue Shield of Wyoming is also temporarily waiving member cost-share for services provided through telemedicine by phone, video or other means.

Blue Cross Blue Shield of Wyoming has also waived the early refill limitation for prescription drugs and waived the prior authorization requirement for refill.

Blue Cross Blue Shield of Wyoming has donated $100,000 to support local anti-hunger programs throughout the state.

Blue Cross Blue Shield of Wyoming has extended its waiver of out-of-pocket costs for telemedicine services and necessary treatment for COVID-19. Extended benefits apply to fully insured groups and individuals but is optional for self-funded groups.

Blue Cross and Blue Shield of Alabama

Blue Cross and Blue Shield of Alabama is expanding telehealth coverage. This expansion allows physicians, physician assistants, nurse practitioners and behavioral health practitioners to provide medically necessary services via telephone consultation.

Blue Cross and Blue Shield of Alabama is also waiving prior authorizations for diagnostic tests and covered services that are medically necessary and consistent with CDC guidance for members diagnosed with COVID-19.

Blue Cross and Blue Shield of Alabama is covering medically necessary COVID-19 diagnostic tests at no cost to members with fully insured, individual, employer-based, Federal Employee Program, and Medicare Advantage plans.

Blue Cross and Blue Shield of Illinois

Blue Cross and Blue Shield of Illinois is temporarily lifting cost sharing payments for medically necessary health services delivered through telehealth. This applies to all fully insured members whose benefit plan included telehealth benefits. Blue Cross and Blue Shield of Illinois has also added 18 additional telehealth procedure codes that health care providers may use when billing Blue Cross and Blue Shield of Illinois for medically necessary health care services, including codes for behavioral health therapy.

Blue Cross and Blue Shield of Illinois also launched a dedicated microsite with information for members, providers on COVID-19.

Blue Cross and Blue Shield of Illinois has opened a $1.5 million funding program to support community-based organizations with missions focused on access to health care, hunger and shelter. The BCBSIL COVID-19 Community Collaboration Fund will release $20,000 grants to organizations around the state. The program is designed to distribute the funds quickly to respond to the current health crisis.

BCBSIL is also supporting non-profit organizations that serve our most vulnerable neighbors through a $1 million donation to Governor J.B. Pritzker's Illinois COVID-19 Response Fund and $500,000 to the Chicago Community COVID-19 Response Fund.

BCBSIL has also purchased and donated 150,000 KN95 masks, to meet the urgent need for personal protective equipment. The masks were donated to the Illinois Emergency Management Agency for distribution to providers most in need.

Blue Cross and Blue Shield of Illinois has selected 75 organizations to receive $1.5 million in funding as part of the BCBSIL COVID-19 Community Collaboration Fund. The Fund supports organizations that are providing critical services in the areas of access to health care, hunger and shelter.

Of the 75 grant recipients, 25 represent and address each focus area: hunger, shelter and access to health care.

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Kansas will expand coverage for telehealth services, which includes waiving cost-sharing for all telehealth services for members.

Blue Cross and Blue Shield of Kansas will continue waiving member cost sharing, including co-pays and deductibles, until June 30 for the following services:

- Telehealth services for any visit that is medically reasonable to be done using this technology. This includes, but is not limited to, medical visits, physical therapy, occupational therapy, and speech therapy. The visit does not have to be specific to COVID-19 testing. The use of telehealth will help to lower the spread of germs while allowing members to continue to get the care they need.

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Early refills on prescription medications will be allowed until June 30; however, they will still be subject to co-pays and deductibles.

- Treatment of COVID-19, which includes coverage for testing and treatment administered at a doctor's office, urgent care facility and emergency room, as well as inpatient hospital stays. This only applies to fully insured members, along with those who receive their insurance through Medicare Advantage plans.

Blue Cross and Blue Shield of Kansas will also continue covering the following services with no member cost sharing for the duration of the COVID-19 public health emergency:

- Medically necessary diagnostic tests related to COVID-19 and the cost of the visit to doctor's office, urgent care, telehealth, and emergency room used for diagnostic testing of COVID-19.
- Related services (flu tests, respiratory illness tests) provided during urgent care, emergency room, or in-person or telehealth provider visits that result in an order for or administration of a covered diagnostic test for COVID-19.

Blue Cross and Blue Shield of Kansas City

Blue Cross and Blue Shield of Kansas City will waive cost-sharing for COVID-19 testing and eliminate prior authorizations for COVID-19 services. The company is waiving refill limits for 30-day maintenance medications, as well as fees for urgent/sick virtual care visits. It is offering same- or next-day therapy appointments to help ease anxiety about coronavirus.

Blue Cross and Blue Shield of Kansas City is waiving all member cost sharing and copayments for inpatient hospital admissions due to the diagnosis of COVID-19. This policy will remain in place through June 30, 2020 and applies to insured Blue KC plans.

Blue Cross and Blue Shield of Kansas City has partnered with The Battle Within to provide Kansas City healthcare providers, first responders, and military veterans with cost-free virtual or in-person behavioral healthcare through the Frontline Therapy Network.

The Frontline Therapy Network's licensed providers are qualified to provide care to the Kansas City medical personnel, first responders, and veterans on the trauma, stress, discomfort, grief, or other mental health concerns they are experiencing on the frontlines of the COVID-19 response.

Blue Cross and Blue Shield of Kansas City has committed nearly $18 million in financial relief to support employer groups, members, and providers experiencing unexpected financial hardships due to the COVID-19 pandemic. This financial support supplements the measures Blue KC has put in place to ensure its members are able to receive the care they need during the COVID-19 emergency period.

Blue KC will be working with broker partners to deploy a suite of financial assistance programs for eligible employers that will include credits of certain health care premiums. Programs will be introduced starting August 2020, with others spanning into the summer of 2021 to provide more long-term relief.

Blue KC will also advance August and September 2020 value-based payments to health care providers who participate in Blue KC's Advanced Primary Care Program. These advanced payments, which will be made in July 2020, are aimed at helping these specific provider groups as they recover from the financial burden experienced during the height of the COVID-19 outbreak.

Blue KC is also continuing to waive member cost sharing for in-network primary care physician and specialty visits for Medicare Advantage members through December 31, 2020.

Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is making medical or behavioral health online visits with BlueCare, the insurer's signature telehealth platform, available for $0.

Blue Cross and Blue Shield of Louisiana data and analytics team members have worked closely with the Louisiana Department of Health to aggregate, analyze and model diverse data for Blue Cross members and members of state Medicaid plans, representing two out of three Louisianans. This lets them make projections about rates of hospitalization and death, healthcare facilities' capacity and proper allocation of crucial medical resources. This information is shared with state officials to assist in planning COVID-19 mitigation measures.

Blue Cross and Blue Shield of Louisiana has made more than $3.1 million in grants to 70 non-profit organizations since mid-March.

The grants have included:

- $1 million for providing food to kids, financially insecure families and seniors
- $160,000 to support healthcare needs, including securing critical supplies for providers, connecting individuals to care and mental health resources
- $780,000 to provide support for direct economic support funds, housing assistance and keeping families financially stable
- $630,000 for regional groups organizing disaster response in communities across Louisiana, and support of nonprofits through community relief funds operated by local community foundations

Blue Cross and Blue Shield of Louisiana has created an online, multimedia toolkit for Louisiana employers to address common questions about returning to work and share information from medical directors and others.

Blue Cross and Blue Shield of Louisiana Foundation has granted more than $4 million to 95 nonprofits across the state working to meet the needs of communities in response to COVID-19 since mid-March.

Efforts supported through Foundation grant funding include:

- Providing food to kids, financially insecure families and seniors
- Supporting healthcare needs, including securing critical supplies for providers, connecting individuals to care and mental health resources
- Funding direct economic support , housing assistance and keeping families financially stable
- Sustaining essential services disproportionately affected by stay-at-home orders, such as sober housing, services for sexual assault victims and a limited scope of education-related services
- Supporting regional groups organizing disaster response in communities across Louisiana, and supporting nonprofits through community relief funds operated by local community foundations

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota will waive prior authorizations for diagnostic tests and covered services for COVID-19, cover those tests at no cost share to members, waive prescription refill limits on maintenance medications, and expand access to telehealth and nurse/provider hotlines. This applies to fully insured employer, individual and Medicare members. Self-insured employers will have the flexibility to apply the same no-cost structure.

Blue Cross and Blue Shield of Minnesota announced a new community-based initiative with Allina Health to enable skilled volunteers to assist with the shortage of personal protective equipment for health care workers. This initiative asks skilled volunteers throughout the state to sew CDC-approved reusable face masks that health workers can use as they treat patients.

Blue Cross and Blue Shield of Minnesota is waiving all patient costs related to in-network COVID-19 treatment and care, including hospitalization. The treatment cost waiver applies to all members in fully insured commercial plans, Minnesotans who purchase Blue Cross coverage on their own, and seniors enrolled in Medicare. The waiver will be in effect through May 31, 2020.

Blue Cross and Blue Shield of Minnesota has joined with North Memorial Health to create mask covers made of surgical wrap material that can be worn over N95 masks. One sheet of wrap can make 24 mask covers, and thousands of mask covers will be sewn for this campaign.

Blue Cross and Blue Shield of Minnesota Foundation has granted more than $825,000 to community organizations through its COVID-19 rapid response fund, on top of earlier efforts that include contributing $100,000 to both the Minnesota Disaster Recovery Fund and the Headwaters

Foundation for Justice's Communities First Fund, $100,000 to the Coalition of Asian-American Leaders (CAAL) as part of their anti-racism campaign and $15,000 to both the Minneapolis American Indian Center and NorthPoint Health and Wellness for their emergency food shelf efforts.

Blue Cross and Blue Shield of Minnesota announced partnerships with WellShare International and the Minnesota Community Health Worker Alliance designed to strengthen and extend the community health work infrastructure in Minnesota communities, reduce health disparities, and bridge cultural and language barriers in efforts to limit the spread of COVID-19.

Blue Cross and Blue Shield of Minnesota is reducing barriers to care for Medicare Advantage members by waiving member cost-sharing for in-network primary care, mental health and substance use office visits for the duration of the public health emergency in 2020. Additionally, Medicare Advantage members will have expanded access to in-home wellness care and home test kits for some preventive screenings.

Blue Cross and Blue Shield of Minnesota has become the first health insurer to join the state's latest public health initiative to slow the spread of COVID-19. More than 140 Blue Cross associates from across Blue Cross will volunteer as contact tracers for the Minnesota Department of Health.

Blue Cross volunteer investigators will interview individuals who have been diagnosed with COVID-19 in order to determine who among their social contacts may also have been exposed to the virus. The investigator will then reach out to those identified contacts and relay the state's suggested policies and procedures for self-quarantine and testing.

Blue Cross and Blue Shield of Minnesota and Blue Plus has committed $60,000 in funding to support the Arrowhead Health Alliance (AHA), a collaboration between the Health and Human Services agencies of Carlton, Cook, Lake, Koochiching and St. Louis counties in northeastern Minnesota. The funding will support the AHA's Arrowhead Telepresence Coalition, enabling the organization to purchase and distribute Internet devices and hardware to individuals in the region who are most in need of access to telehealth services. The AHA is anticipating as many as 300 to 400 new telehealth users due to COVID-19 related concerns about in-person visits to health care clinics and hospitals.

Blue Cross and Blue Shield of Mississippi

Blue Cross and Blue Shield of Mississippi is covering medically necessary diagnostic tests consistent with CDC guidance related to COVID-19 at no cost share (deductible, copay, coinsurance) to members.

Blue Cross and Blue Shield of Mississippi is also waiving member cost sharing for medically necessary covered services for COVID-19 treatment through May 31, 2020.

Medically necessary covered telemedicine services are also being provided with no member cost sharing payments.

Blue Cross and Blue Shield of Nebraska

Blue Cross and Blue Shield of Nebraska will cover testing for COVID-19 with no cost-sharing and is waiving early refill limits on 30-day prescription medications. It will also cover the cost of all telehealth visits with no cost-sharing for all members.

Blue Cross and Blue Shield of Nebraska is extending the waiver of member cost shares for in-network COVID-19 testing and inpatient/outpatient treatment, including telehealth, through Sept. 30, 2020. During the pandemic, the company has seen a significant increase in telehealth usage. BCBSNE began waiving member cost shares for telehealth in early March.

Telehealth claims among BCBSNE members were up 963% in March, and 3612% in April, compared to February 2020. Over half of these telehealth visits – 53% – were for behavioral health.

Blue Cross and Blue Shield of Nebraska has also donated $20,000 to the Open Door Mission. The donation will support the nonprofit in providing shelter and care for men, women and children experiencing homelessness during the COVID-19 crisis.

Blue Cross and Blue Shield of New Mexico

Blue Cross and Blue Shield of New Mexico will waive co-pays and deductibles for COVID-19 testing and will not require prior authorization. It is working with self-insured plans on their decisions.

Blue Cross and Blue Shield of New Mexico also launched a dedicated microsite with information for members, providers on COVID-19.

Blue Cross and Blue Shield of New Mexico is contributing $1 million to address the needs of New Mexicans impacted by the COVID-19 pandemic.

The BCBSNM COVID-19 Community Collaborative Grant Fund will help support the health and wellness of our communities by focusing on areas where communities need it the most, including aid for food security, child and senior care, providers, and health care access.

Blue Cross and Blue Shield of Oklahoma

Blue Cross and Blue Shield of Oklahoma will waive co-pays and deductibles for COVID-19 testing and will not require prior authorization.

Blue Cross and Blue Shield of Oklahoma has partnered with DispatchHealth, a mobile medical care unit, to deliver on-demand health care services at members' homes. The service is intended to prevent overcrowding at emergency rooms and other health care facilities during the COVID-19 pandemic.

Blue Cross and Blue Shield of Oklahoma will temporarily lift cost-sharing for medically necessary medical and behavioral health services delivered via telemedicine in response to the COVID-19 public health emergency.

Blue Cross and Blue Shield of Oklahoma also launched a dedicated microsite with information for members, providers on COVID-19.

Blue Cross and Blue Shield of Oklahoma will authorize any member who was receiving treatment outside of Oklahoma prior to March 15 to continue receiving care closer to home if they prefer not to travel during the COVID-19 crisis. Members can transition to an in-network provider in Oklahoma, or BCBSOK will cover the costs to see an out-of-network provider in Oklahoma at the in-network rate.

MyHealth Access Network is providing its secure health records portal to all qualified providers in Oklahoma. These services are being made available to all qualified Oklahoma providers through September 1, 2020, thanks to a grant from Blue Cross and Blue Shield of Oklahoma. The new program will enable front line health care providers to use MyHealth to reference patient health data, including any test results for COVID-19, in real-time.

Qualified providers for this program will include the first responders, doctors, hospitals, agencies and long-term care providers who come into contact with patients before their COVID-19 status is known or who may encounter these patients later and need to verify testing status.

Blue Cross and Blue Shield of Oklahoma will authorize any member who was receiving treatment outside of Oklahoma prior to March 15 to continue receiving care closer to home if they prefer not to travel during the COVID-19 crisis through July 31. This date is an extension from the original end date of June 30. Members can transition to an in-network provider in Oklahoma or BCBSOK will cover the costs to see an out-of-network provider in Oklahoma at the in-network rate.

Blue Cross and Blue Shield of Texas

Blue Cross and Blue Shield of Texas will not apply co-pays or deductibles for testing to diagnose COVID-19, and will not require preauthorization.

Blue Cross and Blue Shield of Texas as is temporarily lifting cost sharing for medically necessary medical and behavioral health services delivered through telemedicine. This applies to all fully insured members who receive covered in-network telemedicine services.

Blue Cross and Blue Shield of Texas also launched a dedicated microsite with information for members and providers on COVID-19.

Blue Cross and Blue Shield of Texas will offer a special enrollment period (SEP) for its insured group customers. Employees of fully insured group customers who did not opt in for coverage during the regular enrollment period will have an opportunity to get coverage for their health care needs.

The SEP launched April 1 and will conclude April 30, 2020.

Blue Cross and Blue Shield of Texas is also waiving member cost-sharing, including deductibles, copayments and coinsurance, related to treatment for COVID-19. The waiver applies to costs associated with COVID-19 treatment at in-network facilities and treatment for out-of-network emergencies. The policy is effective for treatment received April 1 through May 31, 2020.

Blue Cross and Blue Shield of Texas has made a $1 million donation to the Communities Foundation of Texas to help with COVID-19 relief efforts. The donation will support nonprofits statewide providing critical services such as: personal protective equipment (PPE) for first responders, childcare for first responders and healthcare professionals, and services for senior adults, including meal and grocery delivery.

Blue Cross and Blue Shield of Texas made a $1 million grant to the Texas Restaurant Association's TX Restaurant Relief Fund. Established in response to the COVID-19 pandemic, the TX Restaurant Relief Fund provides immediate financial support to Texas' independent restauranteurs and their employees.

This grant will be used to keep restaurant operations open and employees working, while also providing first responders across Texas with meals to show appreciation for all they are doing during this unprecedented crisis.

In addition to providing more than 150,000 meals to first responders, the BCBSTX grant will provide support to more than 100 independently owned restaurants, 670 Whataburger, and more than 220 Chipotle stores across Texas.

Blue Cross Blue Shield of Arizona (BCBSAZ)

Blue Cross Blue Shield of Arizona (BCBSAZ) will waive prior authorizations for medically necessary covered services for members diagnosed with COVID-19. Members will pay no cost-share for medically necessary diagnostic tests related to COVID-19. It will waive the member cost share for telehealth sessions, and expand access to telehealth and nurse/provider hotlines. It will increase access to prescription medications by waiving early medication refill limits on 30-day prescription maintenance medications (consistent with a member's benefit plan) and/or encouraging members to use their 90-day mail order benefit. BCBSAZ will also work with members to find alternative covered medications if there are shortages or access issues. Patients will not be liable for additional cost share for a non-preferred medication if the preferred medication is not available due to shortage or access issues.

BCBSAZ will waive cost sharing for insured members who receive care for COVID-19 related treatment from in-network providers through May 2020. This impacts BCBSAZ fully insured groups, individual policies, and Medicare members.

More than 20 medically qualified Blue Cross Blue Shield of Arizona employees have volunteered to assist in providing care and treatment to COVID-19 patients in healthcare facilities. The company will support trained healthcare specialists from BCBSAZ and its subsidiary, Health Choice Arizona, in returning to practice as physicians, nurses, and pharmacists to care for those in need.

Blue Cross Blue Shield of Arizona along with Phoenix Suns Charities, donated $80,000 to purchase 5,000 COVID-19 antibody test kits for first responders.

The antibody tests are designed to help determine if first responders have been exposed to COVID-19 and developed antibodies for the disease, even if they have not experienced any symptoms. The test results will give first responders yet another piece of critical information to help them understand more about their exposure and risks of spreading the virus.

Blue Cross Blue Shield of Arizona has announced a new program to support primary care providers across the state during the COVID-19 pandemic. PCPs participating in the BCBSAZ Patient Centered Medical Home program can now receive partial prepayment of their estimated annual quality incentive payment. These advances will help BCBSAZ PCMH providers cover monetary shortfalls due to the COVID-19 crisis.

Blue Cross Blue Shield of Arizona and Sharecare are collaborating to help all Arizonans better manage stress, anxiety, and burnout. With an estimated 230% increase in worry among Americans due to the pandemic, BCBSAZ is providing all Arizonans with 90 days of free access to Sharecare's Unwinding Anxiety, which is clinically proven to decrease anxiety within three months.

Blue Cross Blue Shield of Arizona is launching a loan program for healthcare providers, including qualifying hospitals and physicians across Arizona who have been impacted by COVID-19. The Claim Payment Advance program will allow certain providers to receive a three-month loan to help ease the strain on cash flow so they can continue to provide medical care to Arizonans.

As BCBSAZ analyzed claims payments in 2020 and compared them to the same period last year, claims costs in aggregate were actually running higher until just last week, when the first year-over-year reduction was experienced. Even though elective surgeries were down, the reduction in claims costs wasn't immediately evident due to increased costs in other areas, including:

- 33% increase in behavioral health visits
- 3,200% spike in telemedicine visits
- 22% increase in prescription costs
- Enhanced benefit payments at 100% for telehealth and COVID-19 claims

Physician specialists are the hardest hit, with revenue declines down nearly 6%. To help stabilize the Arizona healthcare system, up to $10 million in loans will be made available to Arizona medical physicians and hospitals. Among the qualifications for the Claim Payment Advance program, providers must be in the BCBSAZ network, have experienced at least a 33% reduction in claims for fully insured plans, and be in good standing with professional licensing boards, and with BCBSAZ.

Blue Cross Blue Shield of Arizona has contributed $10,000 to assist the Navajo Nation in Arizona in its efforts to slow the spread of coronavirus. The funds will help the tribe purchase critical medical supplies and personal protective equipment (PPE) that can help prevent the continued spread of COVID-19.

The reservation has one of the highest per-capita rates of COVID-19 infections in the country, with more than 4,000 confirmed cases in Arizona. Funds provided by BCBSAZ will directly benefit the Navajo Nation's Dikos Ntsaaígíí-19 (COVID-19) relief efforts as tribal leaders continue working to reduce infection rates.

BlueCross BlueShield of Montana

BlueCross BlueShield of Montana will waive co-pays and deductibles for COVID-19 testing and will not require prior authorization. This applies to all members except those in self-insured plans; those plans are making their own coverage decisions.Blue Cross and Blue Shield of Montana is temporarily expanding its telemedicine visit coverage to include phone calls and eliminating cost sharing for clinically appropriate, covered medical and behavioral health services delivered through telemedicine in response to the COVID-19 pandemic.The expansion is effective through April 30, 2020.

BlueCross and BlueShield of Montana also launched a dedicated microsite with information for members, providers on COVID-19.

BlueCross BlueShield of North Carolina

BlueCross BlueShield of North Carolina will cover members' cost for COVID-19 testing and will not require prior approval for COVID-19 testing. The company is also expanding virtual access to doctors and will waive early medication refill limits. These changes apply to fully insured, Medicare Advantage and Federal Employee Program members. Self-funded employer groups will be given the option to apply these changes to their employees' plans.

BlueCross BlueShield of North Carolina also announced that it will cover virtual doctor visits, including those done by phone, the same as face-to-face visits according to a member's health plan. This is an expansion of the telehealth benefits Blue Cross NC has previously offered.

BlueCross and BlueShield of North Carolina is waiving member cost-sharing – including deductibles, co-payments, and coinsurance – for treatments related to COVID-19 if a member is diagnosed with the virus.

Blue Cross NC will waive member cost-sharing for COVID-19 related treatments for both in-network and out-of-network providers.

Blue Cross and Blue Shield of North Carolina will speed up payments to providers as they deal with potential short-term cash flow challenges from COVID-19. The company is also fast-tracking proactive steps to support hospitals, physicians, nurses and thousands of other health care providers across North Carolina.

Blue Cross NC is enhancing claims payment processes to speed payments to providers to help alleviate revenue and potential short-term cash flow challenges during the pandemic. These measures mean that 90 percent of claims will be paid within 14 days. A significant portion of these will be paid in seven days or less.

Blue Cross NC is also speeding up its credentialling process to help meet the demand for clinicians related to the COVID-19 pandemic. Blue Cross NC will credential physicians and physician assistants applying due to COVID-19 treatment needs within 72 hours of receipt of the necessary application, consistent with the North Carolina Medical Board's processes.

Commitments made by Blue Cross and Blue Shield of North Carolina to provide financial support to members, employers, providers, and community organizations to address the COVID-19 pandemic are projected to reach up to $593 million with $318 million in projected costs to improve access to care and $275 million projected to address cash flow challenges facing members, employers and providers.

Blue Cross and Blue Shield of North Carolina is expanding its support of primary care by creating Accelerate to Value, a program to help independently owned primary care physician practices remain financially viable and move to value-based care. The program helps ensure long-term access to high-quality care for Blue Cross NC members while enabling primary care practices across the state to weather the financial crisis created by the COVID-19 pandemic.

The program, open to independently owned primary care practices in North Carolina, includes:

- Financial stabilization: Blue Cross NC will provide significant financial support by making payments to participating practices, based on 2019 revenue, to improve financial stability in 2020 and 2021. These payments will begin by September.
- Transition to value-based care: Participating practices will commit to joining Blue Premier, Blue Cross NC's value-based care program, by the end of 2020. Practices will have the option of joining an existing accountable care organization through a Blue Premier clinically integrated network or through Aledade, a company that helps primary care practices move to value-based care. Blue Premier jointly holds providers and Blue Cross NC accountable for meeting quality and cost standards.
- Capitated payments: Under a payment model known as capitation, beginning in 2022 the practices will be eligible to receive fixed monthly payments for meeting the health needs of their entire patient population. This replaces the fee-for-service method of getting paid for each patient encounter. Capitation encourages doctors to spend as much time as they need with each patient, helping them to improve their health.

BlueCross BlueShield of North Dakota

BlueCross BlueShield of North Dakota is allowing customers to have 62 days to pay their premiums (which is an extension from the current 31-day requirement) for all members with individual plans or small group coverage (businesses with under 50 employees).

BlueCross BlueShield of North Dakota is waiving out-of-pocket costs for the treatment of COVID-19, including hospital stays and outpatient treatment. This applies to BCBSND members on fully insured employer sponsored plans and individual plans.

BlueCross BlueShield of North Dakota Caring Foundation has given $150,000 to nonprofits working to address the COVID-19 crisis. $75,000 will go to the eight United Way agencies across the state of North Dakota, as well as $75,000 to nonprofits dedicated to serving homeless populations, feeding families, providing childcare, and offering other basic needs to individuals most affected by the novel coronavirus.

Blue Cross and Blue Shield of Rhode Island

Blue Cross and Blue Shield of Rhode Island waived all member cost sharing (copays and deductibles) for telehealth whether provided by an in-network provider or through the Doctors Online telehealth platform.

Blue Cross and Blue Shield of Rhode Island has also waived member copays and cost sharing for diagnostic testing related to COVID-19 consistent with CDC guidelines, and has removed administrative barriers by waiving prior authorization and referral requirements for testing and medically appropriate treatment of COVID-19.

Blue Cross and Blue Shield of Rhode Island has awarded $500,000 to nine local organizations committed to improving access to affordable housing. This is in addition to $200,000 BCBSRI awarded to five housing-related agencies at the end of 2019.

The organizations receiving funding in 2020 are each finding creative ways to make healthy and affordable housing a reality for those most in need, as well as helping them to become self-sufficient, whether through building vocational skills, learning how to negotiate with a landlord and understand tenant rights, or, in the case of formerly incarcerated individuals, receiving case management assistance and reentry support.

Blue Cross and Blue Shield of Rhode Island is streaming virtual fitness classes every weekday at 10 a.m. as a way to meet Rhode Islanders where they are during the COVID-19 pandemic. The classes, which are typically offered only to BCBSRI members at Your Blue Store locations, include balance and strength, core, strength and tone, stretch and relax, and cardio dance.

Blue Cross and Blue Shield of Rhode Island is providing a 25% dental premium credit for fully insured customers and is extending teledentistry services with in-network dentists through July 31, 2020.

The dental premium credit will cover March, April and May 2020 and will appear as a one-time credit on July invoices. This applies to employers and individuals who purchase dental coverage directly from BCBSRI. For employers and individuals who purchase BCBSRI dental coverage through HealthSource RI, they will receive a check directly from BCBSRI in July.

BlueCross and BlueShield of South Carolina

BlueCross and BlueShield of South Carolina is waiving all out-of-pocket costs related to in-network COVID-19 medical treatment for members, through June 1.

BlueCross and BlueShield of South Carolina and the BlueCross BlueShield of South Carolina Foundation have joined together with Senior Resources to provide emergency food assistance beginning now into early summer in counties throughout the state.

The health insurer and its foundation are combining resources and providing nearly $1.6 million to expand Senior Resources' emergency senior nutrition program, which is giving five free meals weekly to eligible homebound elderly. The contribution is anticipated to provide 245,000 meals.

BlueCross and BlueShield of South Carolina and Charleston County Medical Society have joined together to bring 300,000 PPE supplies to independent physicians in South Carolina.

BlueCross and BlueShield of South Carolina, the South Carolina Hospital Association and the South Carolina Medical Association are joining together in an effort to persuade the public to limit potential exposure to COVID-19.

The groups are also looking to support South Carolina-based physicians by providing free access to an online continuing medical education module with updates on the most current COVID-19 treatment information. This effort is being supported in part through K2P, a Maryland-based company dedicated to using digital technology to personalize on-demand learning that measurably improves clinical judgment, critical thinking and patient care. The company is donating nearly $1 million worth of online, COVID-specific educational material.

BlueCross BlueShield of Western New York

BlueCross BlueShield of Western New York is eliminating any and all costs for our members related to COVID-19 testing and treatment. The policy is effective April 1 through May 31, 2020.

BlueCross BlueShield of Western New York has also donated $100,000 to the Western New York COVID-19 Community Response Fund to address the most critical and immediate community needs related to the coronavirus as well as other efforts.

BlueCross BlueShield of Western New York is sending healthy snack-packs and meals from local companies, Buffalo Strive and Jakes Cafe, to 1,500 Western New York heroes, on behalf of their 1,500 employees— a symbolic effort to support the dedicated individuals who are on the frontlines serving our community during the COVID 19 pandemic.

BlueCross BlueShield of Western New York is also offering members free access to a digital behavioral health app, myStrength.

The app empowers users to combat anxiety, stress, depression, chronic pain and sleep challenges. The app features modules that can help manage heightened stress and feelings of social isolation due to COVID-19, as well as manage their overall health.

BlueCross BlueShield of Western New York 's Blue Fund has made a corporate donation of $900,000 to the WNY COVID-19 Community Response Fund, bringing the Blue Fund's total investment to $1 million.

As a founding corporate funder of the WNY COVID-19 Community Response Fund, BlueCross BlueShield's initial $100,000 contribution helped launched the fund in March 2020— in collaboration with other philanthropic organizations—to address the most immediate community needs. Now, as the crisis continues to unfold, BlueCross BlueShield of Western New York is pivoting its traditional 2020 Blue Fund grant cycle to support recovery and rebuilding efforts in Buffalo-Niagara through an additional $900,000 donation to the WNY COVID-19 Community Response Fund.

BlueCross BlueShield of Tennessee

BlueCross BlueShield of Tennessee is offering enhanced support for its members by:

- Waiving all member cost-sharing for COVID-19 treatments, including hospitalizations, from in-network providers through May 31, 2020
- Waiving member costs for any appropriate, FDA-aligned COVID-19 testing
- Adapting prior authorization requirements and billing processes for emergency care through May 31, 2020
- Allowing early prescription refills and 90-day prescriptions to avoid increased risk of exposure
- Expanding access to telehealth services by making PhysicianNow visits available at no cost and by covering virtual visits with other network providers for many services
- Sharing key public health information, such as promoting social distancingand warning of potential scam activity
- Working with community news partners to help educate on and address health care disparities

In addition, the BlueCross BlueShield of Tennessee Foundation donated a total of $3.25 million to six food banks across the state to help them meet increased community needs. And the foundation has provided grants to support testing for uninsured residents in partnership with local governments.

BlueCross has also made donations of personal protective equipment (PPE) to some Tennessee health systems.

BlueCross BlueShield of Tennessee has made permanent its coverage of virtual visits with in-network providers.

BlueCross BlueShield of Tennessee began covering telephone and video visits with in-network providers in March. The change initially included primary care providers, specialists and behavioral health providers and was later expanded to include occupational, physical and speech therapy as well as ABA therapy services. All of these services will now be covered on an ongoing basis.

BlueCross BlueShield of Tennessee will waive Medicare Advantage member costs for doctor's office and virtual visits to in-network primary care and behavioral health care providers from May 19 through September 30, 2020.

BlueCross BlueShield of Vermont

BlueCross BlueShield of Vermont opened an emergency COVID-19 special enrollment period starting on March 20, 2020 for the uninsured to enroll in health plan coverage. This special enrollment period is for all qualified health plans offered through the exchange and will be for 30 days until April 17, 2020.

BlueCross BlueShield of Vermont is also covering COVID-19 testing performed by the Centers for Disease Control, the Vermont covered COVID-19 testing performed by the Centers for Disease Control (CDC), the Vermont Department of Health (VDH), or a laboratory approved by CDC or VDH, with no co-payment, coinsurance, or deductible requirements.

This coverage includes telephone triage, office visits with your provider, or urgent care visits and emergency service visits to test for COVID-19.

Blue Cross of Idaho

Blue Cross of Idaho has waived all cost-sharing for doctor's office and urgent care visits related to testing for COVID-19. This decision applies to individual and fully insured members on employer plans.Blue Cross of Idaho has also expanded access to MDLIVE, the company's telehealth partner. The new telehealth benefits are being offered at no additional premium cost to those members.

Blue Cross of Idaho has created a program to allow independent providers, such as private-practice physician groups, an opportunity to receive advance payments to cover monetary shortfalls due to the COVID-19 pandemic. Blue Cross of Idaho will make advance payments to the provider once per month in April, May and June. The company will recover the interest-free payments during the fourth quarter of 2020.

Blue Cross of Idaho is also waiving all member cost-sharing for treatment of COVID-19. Members will not pay anything out-of-pocket – including copays, deductibles or coinsurance – for testing for COVID-19, for the medical visits related to testing, or treatment of COVID-19. Waiving of cost-sharing for coverage of treatment for COVID-19 applies through June 30, 2020.

Blue Cross of Idaho is extending telehealth services for its members throughout the state until December 31, 2020. Members may continue to receive telehealth services via phone or video call from all in-network providers throughout Idaho.

Additionally, Blue Cross of Idaho members can access MDLIVE, the company's telehealth partner. MDLIVE provides a primary care platform via mobile device or computer for Blue Cross of Idaho members to access convenient, secure and cost-effective options for accessing preventive, chronic and other primary care services.

Blue Cross of Idaho has processed more than 90,500 telehealth claims since expanding telehealth access on March 19, 2020. During the week of January 27-February 2, 2020, Blue Cross of Idaho processed 108 telehealth claims. That number increased to 10,718 telehealth claims between April 6-April 19, 2020 – 118 times more than the weekly average for the first 3 months of the year.

Blue Shield of California

Blue Shield of California will waive all cost-sharing and any prior approval for COVID-19 testing for fully insured commercial and Medi-Cal plans. This includes cost-sharing for hospital, urgent care, emergency room, and office visits where the visit is to screen or test for the virus. Blue Shield also will not require prior authorization for medically necessary emergency care. Blue Shield is working closely with self-funded plan sponsors to confirm coverage levels for their employees. Blue Shield is closely monitoring impact to prescription drug supply and will take immediate steps to ensure members have access to medications. It is encouraging use of telehealth services.

Blue Shield of California also announced it will waive out-of-pocket costs for most members to use Teladoc Health's virtual care service. Costs will be waived until May 31 in Individual & Family and employer-sponsored plans that offer Teladoc. Members enrolled in Blue Shield's Trio, Tandem and Medicare Advantage plans, plus Blue Shield of California Promise Health Plan enrollees, already enjoy $0 out-of-pocket costs for Teladoc Health services.

Blue Shield of California will cover members' coinsurance, copayments and deductibles for COVID-19 medical treatments through May 31, 2020.

Blue Shield of California is providing up to $200 million in direct support to health care providers and hospitals through financing guarantees, advance payments, and restructuring of contracts.

Blue Shield is working with two financial institutions to help providers with guaranteed loans and to make advanced payments to them on anticipated healthcare costs. The plan is to offer favorable repayment terms to help providers get through the next six months.

Blue Shield of California is providing $100,000 support to MedShare, a San Francisco Bay area nonprofit organization that donates personal protective equipment (PPE) supplies to nonprofit community healthcare providers.

Blue Shield of California is offering a digital tool at no additional cost for its nearly 350 in-network hospitals to help them triage the influx of patients seeking advice on coronavirus or other medical care via their websites.

Blue Shield is also donating $500,000 to the Oakland COVID-19 Relief Fund to support, among its projects, pop-up coronavirus testing sites organized by Brown & Toland Physicians that will prioritize medical providers and first responders.

Blue Shield of California Promise Health Plan, which serves Medi-Cal and Medicare beneficiaries, is giving $100,000 sponsorship funds to community health providers in Los Angeles and San Diego counties.

Blue Shield of California has teamed up with DoSomething.org, the largest organization for young people and social change in the nation, to develop a first-of-its-kind mental health guide to help youth cope with stress and anxiety during the COVID-19 crisis.

The three-month digital campaign, will include text, email, and social media activations to DoSomething.org's millions of members, encouraging young people across the U.S. to share their tips to help combat anxiety, especially during COVID-19.The idea is to reduce stigma, raise awareness, and encourage youth to seek help.

The campaign is in addition to the resources developed and offered by Blue Shield of California's BlueSky initiative, a multi-year effort to enhance awareness, advocacy, and access to mental health support for middle and high school students in California and beyond.

Blue Shield of California has provided $300,000 in grants to nonprofit organizations providing mental health supports in San Diego and Alameda counties. This builds on the company's multi-year, $10 million investment in youth mental health.

The $300,000 will be divided into 18 different grants – nine each in Alameda and San Diego counties.

Blue Shield of California is extending its commitment to waive co-payments, coinsurance, and deductibles for treatment for COVID-19. It will also continue to cover costs for virtual care (medical and behavioral) services provided by Teladoc Health through Sept. 30, 2020. The plan will also continue to waive cost-sharing for COVID-19 screening and testing in accordance with applicable state and federal law.

BlueShield of Northeastern New York

BlueShield of Northeastern New York is offering its members free access to a digital behavioral health app, myStrength. MyStrength, powered by Livongo®, is a highly interactive application that empowers users to combat anxiety, stress, depression, chronic pain and sleep challenges. The app features modules that can help manage heightened stress and feelings of social isolation due to COVID-19, as well as manage their overall health.

BlueShield of Northeastern New York is targeting at-risk New Yorkers for wellness check-ins, increasing engagement and support during the COVID-19 crisis.

The COVID-19 Member Well-being Outreach Program provides members with personalized outreach calls offering telehealth support, assistance with online prescriptions, education, and additional resources focused on improving their health as members continue following stay-at-home guidance.

Bright Health

Bright Health will cover COVID-19 diagnostic test and associated office as a preventive care service, so it is available at no cost to members, regardless of network. The company is also authorizing early medication refills for members who might be impacted by the outbreak. Non-emergency transportation is being made available to all members, and ride limits are being waived for non-emergency visits to and from their doctor. All telehealth services (online and virtual care) obtained in connection with COVID-19 testing and diagnosis is now covered, at no cost to members.

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CalOptima

CalOptima has committed more than $629,000 in a grant for a new program that improves infection control training. The Orange County Nursing Home COVID-19 Prevention Team program is a collaborative effort by UC Irvine, the Orange County Health Care Agency (HCA) and CalOptima.

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The new COVID-19 program will operate concurrently with other infection control efforts by HCA and CalOptima. HCA's public health team responds with a targeted intervention when a cluster of COVID-19 cases is identified in a nursing home. Separately, CalOptima's Post-Acute Infection Prevention Quality Initiative (PIPQI) reduces the impact of multi-drug resistant organisms, such as MRSA, among nursing home residents.

Cambia

Cambia is fully covering the cost of testing and associated office visits for COVID-19, and also covering the cost of COVID-19 treatment at no cost to members through June 30.

Cambia is also supporting early refills of needed medication and ensuring that care related to COVID-19 is not restricted by preauthorization requirements.

Cambia is promoting telehealth options, and in-network providers can provide telehealth services at the same cost as an in-person visit.

Cambia Health Foundation has invested more than $3 million to meet emerging needs created by the COVID-19 crisis. The investments will go to four community health associations that support the work of Federally Qualified Health Centers across Idaho, Oregon, Utah, and Washington. The new funding also supports the development of tools and resources for health care providers on the front-lines of the pandemic.

Cambia has extended coverage for COVID-19 treatment without any out-of-pocket costs for fully insured Asuris Health Northwest members through Dec. 31, 2020. In addition, Asuris will continue paying providers for virtual care services at the same rate as in-person visits through Sept. 2020 to help ease member access and support providers experiencing financial challenges. Diagnostic testing also remains covered at no cost to members.

Capital BlueCross

Capital BlueCross will waive cost-sharing for COVID-19 testing, as well as prior authorization for COVID-19 testing and services. It is also waiving early refill limits on 30-day maintenance medications and encouraging members to use telehealth services.

Capital BlueCross is waiving member cost sharing for telehealth visits with in-network providers through April 15.

Capital BlueCross is waiving member cost share (copays, coinsurance, and deductibles) through May 1 for in-network, inpatient hospital treatment for COVID-19. This cost waiver applies to Medicare and fully insured individual and commercial group members. (Large, self-insured groups may choose to offer this waiver for their employees.)

BlueCross Dental plans will cover in-network teledentistry consultations with no member cost share through May 15. During this time, frequency limits for eligible evaluations will be waived and covered teledentistry exams will not count toward a member’s annual oral exam frequency allowance. BlueCross Dental members may use teledentistry to consult with a dentist through video conference or by sending images for review about pain, an abscess or other urgent issues.

Capital BlueCross is increasing funding to food banks and other community organizations—as well as providing meals to healthcare workers, first responders, and nursing home staff and residents—as part of its efforts to help communities and front line workers during the COVID-19 pandemic.

The Central Pennsylvania Food Bank, the Second Harvest Food Bank serving Lehigh and Northampton counties, and the Helping Harvest Food Bank serving Berks and Schuylkill counties have all received funds. These food banks collectively provide more than 45 million meals annually.

Capital BlueCross is offering advance payments to independent health care providers in an effort to address the financial strain some providers face due to the COVID-19 pandemic.

Under Capital BlueCross’ program, advance payments are available to eligible health care providers who had at least a 40% decrease in average payments for services provided to Capital BlueCross members during March and April, 2020. These providers can receive funding advances based on their average monthly payments from 2019.

Capital BlueCross is making advance payments available through July 15. Providers can apply by contacting the insurer directly.

Capital BlueCross is waiving member costs for in-network, inpatient hospital treatment for COVID-19 through July 31, 2020.

Capital District Physicians' Health Plan

Capital District Physicians' Health Plan is waiving cost sharing (copays, coinsurance, and deductibles) for all coronavirus (COVID-19) related treatment with in-network providers. This change is retroactive for all COVID-19 treatment, including hospitalizations, testing, and office visits with in-network providers.

Capital District Physicians' Health Plan is also providing members access to telemedicine services with no cost sharing. Members have access to ER Anywhere and Doctor on Demand.

Capital District Physicians' Health Plan Patient Care Team, which moved into a virtual setting as a result of the COVID-19 pandemic, is reaching out to patients and their family members to assist with the following:

- Providing emotional support to members, families, and caregivers;
- Providing daily communication updates between hospital staff, patients, and families;
- Collaborating with hospital care teams to customize discharge planning;
- Identifying any barriers to care, such as access to food, medication, and transportation;
- Identifying any community resources/support services needed post-discharge; and
- Facilitating post-discharge phone calls and support.

Capital District Physicians' Health Plan has partnered with Brook Health to offer the Brook Personal Health Companion to members and non-members for free during the COVID-19 crisis. The Health Companion is a smartphone app that can provide patient support in areas including healthy meal ideas, blood pressure management, and sleep support.

Capital District Physicians' Health Plan, MVP Health Care, CDPHP, and Quick Response have partnered to provide the cities of Albany, Schenectady, and Troy with essential sanitation equipment to protect local first responders from COVID-19. Each city will receive two Defense Soap Cordless Electrostatic Hand or Backpack Sprayers for use by the police and fire departments. Each sprayer provides up to 23,000 square feet of disinfectant in a single tank.

CareFirst

CareFirst is waiving cost sharing for in-network or out-of-network visits to a provider's office, lab fees or treatments related to COVID-19. It is eliminating prior authorization requirements for medically necessary diagnostic tests and covered services related to COVID-19 diagnosis. It is also waiving early medication refill limits on 30-day maintenance medications, encouraging the use of its 24/7

nurse phone line, and encouraging the use of telemedicine and virtual sites of care. For telemedicine accessed through a CareFirst Video Visit, copays, coinsurance, and deductibles will be waived for the duration of this public health emergency—including behavioral health, lactation support, nutrition counseling and urgent care services. CareFirst has also rapidly expanded the scope of its contracted lab partners to support access to testing as it becomes available.

CareFirst BlueCross BlueShield

CareFirst BlueCross BlueShield will waive prior authorizations for diagnostic tests and covered services for COVID-19, cover those tests at no cost share to members, waive early medication refill limits, and encourage alternative sites of care if a member's primary care doctor is not available.

CareFirst BlueCross BlueShield is offering employees who are licensed nurses and behavioral health practitioners the opportunity to volunteer their time, resources and expertise during the COVID-19 pandemic.

CareFirst BlueCross BlueShield is offering financial flexibility for members and groups that are experiencing economic hardship. Customers can request a deferral of up to two months of premium with due amounts carried forward with no interest or penalty. The deferred premium would be satisfied over time through scheduled periodic payments.

CareFirst also created a volunteer program available for the company's licensed clinicians in response to the coronavirus (COVID-19) pandemic. This initiative offers CareFirst employees, who are licensed nurses and behavioral health practitioners, the opportunity to volunteer their time, resources and expertise during this public health crisis.

CareFirst BlueCross BlueShield will offer a new accelerated payment program to an array of healthcare providers experiencing financial strain due to the coronavirus (COVID-19) pandemic. This initiative is part of CareFirst's ongoing commitment to support the communities it serves as they navigate the complexities of this public health crisis. CareFirst's combined provider-focused efforts will result in over $170 million in direct support of the healthcare delivery system during the pandemic.

CareFirst is accelerating funds that would otherwise not be available during the pandemic or have been paid later in 2020 and 2021. CareFirst will offer a combination of:

- Advance lump-sum payments, increased fee schedules and monthly cash advances for qualifying PCMH panels;
- Monthly cash advances for pediatricians and rural primary care physicians who need additional assistance, independent practices in certain specialty areas, and dentists; and,
- Cash advances to select hospitals demonstrating need in Maryland, the District of Columbia, and Northern Virginia.

CareFirst and the Maryland State Medical Society (MedChi) also announced a partnership to provide MedChi independent physician practices with five or fewer members, a year of complimentary access to DrFirst's Backline Telehealth platform for physicians who enroll between March 1st and December 31st of 2020. DrFirst is a Maryland-based company that offers secure telehealth services. This partnership will equip additional Maryland physicians with the technology they need to provide needed virtual care during the COVID-19 pandemic and beyond.

CareFirst will provide premium credits to many fully insured customers as a result of treatment disruptions related to the COVID-19 crisis, extend the waiver of cost sharing for telehealth services and COVID-19 testing and treatment, and return rebates from 2019 as a result of lower than expected use of medical care by its members. These latest benefits, combined with other relief CareFirst has offered, result in over $300 million made available to CareFirst's members, providers, and communities during the COVID-19 crisis.

CareFirst will provide the following relief:

- Premium credits totaling $25 million for fully insured small and large group customers, to be reflected on their August premium invoice;
- Premium credits totaling over $4 million for small and large group fully insured dental customers, to be reflected on each group's August premium invoice;
- Rebates totaling over $80 million for individual members and fully insured small and large group customers who had CareFirst coverage in 2019 due to lower utilization of medical care than anticipated; and,
- Extension of waiver for cost share expenses related to telehealth services to July 24, 2020, and extension of waiver for cost share expenses related to COVID-19 testing and treatment through September 30, 2020, reflecting in total an anticipated $45 million commitment to our members.

CareFirst BlueCross BlueShield has launched a $5 million public-private sector philanthropic endeavor, "Care, delivered", that will distribute personal protective equipment at no-cost to healthcare and social service organizations on the front lines of the pandemic. This initiative is part of CareFirst's ongoing commitment to support the communities it serves as they navigate the complexities of this public health crisis.

CareFirst will distribute 1.6 million gowns, gloves, masks and face shields to community-based organizations, federally qualified health centers and independent primary care providers in Maryland, the District of Columbia, and Northern Virginia who are on the front lines of the COVID-19 crisis.

CareFirst Community Health Plan of DC

Trusted Health Plan will cover all medically necessary services required to facilitate testing and treatment of COVID-19 for its eligible enrollees, in accordance with federal and state guidance. No prior authorization is required for COVID-19 testing.

CareOregon

CareOregon is strategically reallocating $1.5 million of funding through its Community Giving Grant program to assist local organizations and help them continue to offer food security, shelter and rental assistance to our communities.

CareOregon is also expediting approvals for temporary housing support for members suspected to have COVID-19, including helping secure hotel/motel stays for houseless members who are at risk for virus transmission.

CareOregon is also working with providers to supply flip phones and simple smartphones to members. With many providers moving to delivery of services via telehealth, CareOregon wants to ensure that members have access to a phone so they can still get the care they need.

CareOregon is also taking actions to support providers during the COVID-19 crisis, expediting $25 million in payments to support provider operations including:

- Offsetting lost revenue by paying providers a lump sum advance for visits that would have been conducted in March, April, May and June 2020.
- Releasing the majority of state incentive payments earlier than normal to give clinics needed access to money for COVID-19 mitigation.
- Delaying the implementation of new alternative payment methodology (APM) contracts and maintaining PMPM payments at current respective clinic levels.

CareSource

CareSource is partnering with The Foodbank, Inc., as part of its response to COVID-19. CareSource is committing up to $128,000 to allow The Foodbank to prepare 1,200 supplemental food boxes to distribute to seniors who live with an income below 200% of the poverty line. Each home will be provided with a 14-day supply of food, covering three meals per day for a total of 50,400 meals.

CenCal Health

CenCal Health has procured and is now in the process of delivering 100,000 disposable face masks, 100,000 disposable gloves and 20,000 protective gowns in order to protect and support local healthcare workers during the COVID-19 public health emergency.

Centene

Centene will cover COVID-19 testing and screening services for Medicaid, Medicare and Marketplace members and is waiving all associated member cost share amounts for COVID-19 testing and screening. The company will not require prior authorization, prior certification, prior notification or step therapy protocols for these services.

Centene will cover the cost of COVID-19-related treatments for Medicare, Medicaid and Marketplace members. Centene is also eliminating the need for providers to collect co-pays and removing authorization requirements for COVID-19 related treatment.

Centene is creating a Medical Reserve Leave policy to support clinical staff who want to join a medical reserve force and serve their communities during the COVID-19 pandemic. The new policy will provide paid leave and benefits for up to 3 months of volunteer service.

Centene has created a provider support program to assist its network providers who are seeking benefits from the Small Business Administration (SBA) through the CARES Act. As part of the provider program, the company has launched a dedicated online portal where providers can research benefits they may be eligible for and work directly with experts to apply for them.

The company will provide resources to aid providers in grant writing and business loan applications, among other key activities. The program will help providers apply for various benefits, including small business loans, a paycheck protection plan and various grants for which they may be eligible.

Centene has also created a comprehensive financial aid package in response to the unprecedented needs of safety net providers including Federally Qualified Healthcare Centers, behavioral health providers and community-based behavioral health organizations, and long-term service and support organizations operating on the front lines of the pandemic.

Centene has created a provider support program to assist its network providers who are seeking benefits from the Small Business Administration (SBA) through the CARES Act. As part of the provider program, the company has launched a dedicated online portal where providers can research benefits they may be eligible for and work directly with experts to apply for them. The company will provide resources to aid providers in grant writing and business loan applications, among other key activities.

The program will help providers apply for various benefits including small business loans, a paycheck protection plan and various grants they may be eligible for. In addition to the online portal, the Company will provide partners with access to webinars and one-on-one consulting with key experts.

Centene has also made a series of investments to address the social determinants of health for vulnerable populations during the COVID-19 crisis. Centene is partnering with Feeding America's network of food banks to donate1 million meals a month for 12 months to feed communities all over the country.

Centene is also purchasing 50,000 gift cards for use on essential items. The cards will be delivered to local providers and other community resources for distribution to individuals in need. The gift cards, which will have $35 of value each, can be used to purchase essential healthcare and educational items including diapers, over-the counter medicines, cleaning supplies, and books.

Centene has released resources on improving health care access for people with disabilities during the COVID-19 pandemic, as well as maintaining their access to personal attendants.

Centene is supporting the disability community affected by the COVID-19 pandemic by:

- Establishing an emergency registry for members with long-term services and supports. Centers for Independent Living partners will recruit, train, and deploy a specialized emergency in-home care workforce for members with disabilities who self-direct their personal attendants.
- Establishing onsite disability liaisons at COVID-19 super sites. Disability liaisons provided by local CILs within treatment facilities will advocate for and assist with functionality for patients with physical disabilities.
- Addressing social determinants of health to support the unique needs of members with disabilities by:
    - Augmenting service coordination activities through peer supports and skills training for members with disabilities provided by the CILs. Supports include personal protective equipment distribution, multiple weekly contacts for problem solving, and sourcing
    - Providing grants to Area Agencies on Aging for groceries and meal deliveries for members with disabilities who have had a disruption of natural supports
    - Matching funds in partnership with organizations, such as, workforce development boards and other safety net organizations, to train the direct care workforce and support unemployed individuals by preparing them for a career in health care
    - Offering access to the Provider Accessibility Initiative COVID-19 Web Series to provide timely recommendations from experts with disabilities on how providers and organizations can deliver disability-competent care during the pandemic and future emergencies

Centene has created a Medicaid Telehealth Partnership with the National Association of Community Health Centers to help Federally Qualified Health Centers quickly ramp-up their capacity to provide telehealth solutions to meet the needs created by the COVID-19 crisis.

Centene is dedicating $5 million to the partnership’s efforts, which will be used to purchase equipment and provide training and technical assistance to FQHCs. Centene has expanded membership access via Telehealth and has been supportive of provider practices to ensure care continuity during the COVID-19 crisis.

Centene is collaborating with Quest Diagnostics to increase access to real-time reverse transcription polymerase chain reaction (rRT-PCR) COVID-19 testing in critical areas of need across the country. Through this collaboration, Centene will facilitate the distribution of 25,000 Quest COVID-19 test kits each week to Federally Qualified Health Centers in ten states or districts across the country.

Centene is making three investments to support communities that are experiencing elevated levels of stress and mental strain caused by an increase in grief, loss, economic pressure, unemployment and social isolation due to the COVID-19 crisis.

Centene is partnering with Allegheny Health Network and the CARES Institute at Rowan University to fund 25 virtual Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training cohorts, which will enable up to 600 clinicians nationally to receive this highly effective training. TF-CBT is an evidence-based treatment for the impact of traumatic experience on child and adolescent mental health.

Centene is also directing funds to the Crisis Text Line to support their 'For the Frontlines' initiative. For the Frontlines provides fast, free, text-based crisis support to individuals on the frontlines of the COVID-19 pandemic response, including doctors, nurses, pharmacists, and other essential workers.

Additionally, Centene is partnering with peer warmlines, which are dedicated call centers for mild to moderate behavioral health needs, in states hardest hit by COVID-19, including California, Michigan, New York, New Jersey, Louisiana, Illinois, and Florida. As part of this partnership, Centene will allocate funds to assist warmlines in meeting the demand for increased capacity brought on by the pandemic.

Centene is also donating to the National Council for Behavioral Health's COVID-19 Relief Fund, specifically for the provision of Mental Health First Aid. Mental Health First Aid teaches citizens to recognize signs that someone might be experiencing a mental health crisis, suicidal thinking, or abusing substances.

Advancing States, in collaboration with Centene, is releasing www.ConnectToCareJobs.com for wide dissemination and use in all 56 states and territories. This new website serves as a tool to solve the critical problem many healthcare facilities face during the COVID-19 crisis – how to fill critical staffing gaps in a timely fashion.

The first release allows nursing homes, assisted living facilities, residential care facilities, and long-term acute care hospitals to identify gaps in specific staffing needs they have on particular days. At the same time, healthcare professionals who are licensed and/or trained for the various roles needed by these facilities can register their availability and willingness to fill shifts. An algorithm then matches the workers to the facilities – in real time. States and territories have the ability to manage which facilities are included (to enable preference for those in crisis) as well as to monitor the matching process.

Centene has convened a group of medical, non-profit and community leaders to form the Centene Health Disparities Task Force. The task force will further enhance Centene's leadership and commitment to ensuring underserved populations have access to quality health care.

The Task Force will meet on a regular basis to provide advice and recommendations to Centene through the pandemic and beyond.

Centene is waiving all cost sharing for in-network primary care, behavioral health, and telehealth

visits for the remainder of the calendar year for Medicare Advantage members.

Medicare Advantage members may also be eligible for the following expanded benefits for the remainder of 2020:

- Extended Meal Benefits – Members eligible for meal benefits due to a chronic condition or recent discharge may receive an additional 14 meals delivered to their home at no cost.
- Annual Wellness Visit Incentives – Members will be eligible for an increased incentive for completing their Annual Wellness Visits, a benefit offered at no cost to the member.
- Additional Over-The-Counter (OTC) Benefits – Plans with an OTC benefit may now receive additional allowance dollars in monthly or quarterly increments, adding up to as much as $150 for the remainder of 2020, depending on plan.

Centene has donated $500,000 to the National Domestic Violence Hotline, which aims to support and advocate for those affected by relationship abuse. The shelter-in-place orders across the country during the COVID-19 crisis have led to an increase in incidents of domestic violence.

Centene has formed a research partnership with the National Minority Quality Forum to assess the impact of COVID-19 on racial minorities and underserved communities across the country. The Minority and Rural Health Coronavirus Study will examine the risk factors associated with the disproportionate impact that coronavirus is having on racial minorities and rural communities.

Cigna

Cigna is covering the cost of coronavirus testing, waiving all co-pays or cost-shares for fully insured plans, including employer-provided coverage, Medicare Advantage, Medicaid, and individual market plans available through the Affordable Care Act. Organizations that offer Administrative Services Only (ASO) plans will also have the option to include coronavirus testing as a preventive benefit. Recognizing that health outbreaks can increase feelings of stress, anxiety and sleeplessness and sometimes loss. Cigna is also staffing a second phone line for customers.

Cigna also announced it will waive customers' out-of-pocket costs for COVID-19 testing-related visits with in-network providers, whether at a doctor's office, urgent care clinic, emergency room or via telehealth, through May 31, 2020. This includes customers in the United States who are covered under Cigna employer/union sponsored group insurance plans, globally mobile plans, Medicare Advantage, Medicaid and the Individual and Family plans. Employers and other entities that sponsor self-insured plans administered by Cigna will be given the opportunity to adopt a similar coverage policy. The company is making it easier for customers with immunosuppression, chronic conditions or who are experiencing transportation challenges to be treated virtually by in-network physicians with those capabilities, through May 31, 2020. Cigna's Express Scripts Pharmacy offers free home delivery of up to 90-day supplies of prescription maintenance medications. Additionally, Cigna will offer a webinar to the general public raising awareness about tools and techniques for stress management and building resiliency, along with the ability to join telephonic mindfulness sessions.

Cigna will waive prior authorizations for the transfer of its non-COVID-19 customers from acute inpatient hospitals to in-network long term acute care hospitals to help manage the demands of increasingly high volumes of COVID-19 patients.

Cigna is waiving customer cost-sharing and co-payments for COVID-19 treatment through May 31. The policy applies to customers in the U.S. who are covered under Cigna's employer/union sponsored insured group health plans, insured plans for U.S. based globally mobile individuals, Medicare Advantage, and Individual and Family Plans. Cigna will also administer the waiver to self-insured group health plans.

Cigna and Express Scripts are working with Buoy Health to provide an early intervention screening tool to help customers and members understand their personal risks for COVID-19. The digital tool immediately triages symptoms and recommends next steps for care, while also relieving demand on an over-burdened health care system.

Cigna is launching a pilot program to increase social connectivity among its Medicare Advantage (MA) customers during the COVID-19 pandemic.

Through the pilot, Cigna is reaching out proactively to many of its Medicare customers to monitor their general health and well-being as well as daily needs during COVID-19, including food, housing and transportation. Customers will be able to opt-in to receive follow-up calls from the same Cigna representative to help cultivate meaningful connections. Cigna will also leverage its comprehensive data and analytics to identify MA customers who may be at higher risk for health issues and complications for additional proactive outreach to help answer questions about COVID-19, conduct regular health checks and triage care to a medical professional, if necessary. The pilot program will initially reach 24,000 customers with plans for rapid expansion.

Cigna is also providing medications to Washington University School of Medicine in St. Louis to initiate a clinical trial that will evaluate antimalarial and antibiotic treatments for COVID-19. The researchers plan to enroll 500 patients, over the course of the study, hospitalized with the novel coronavirus at Barnes – Jewish Hospital in St. Louis, MO.

Cigna has launched Dental Virtual Care, which will be available through Cigna's growing network of dental providers who offer teledentistry.

Cigna Dental Virtual Care will be available this month to over 16 million dental customers enrolled in Cigna's employer-sponsored insurance plans at no cost through May 31, 2020.

Cigna is also partnering with The TeleDentists, a national virtual care dental provider with more than 300 dentists. Through a video consultation, licensed dentists can triage urgent situations such as pain, infection, and swelling and guide the customer on next steps. If necessary, the dentist will prescribe medications, such as antibiotics and non-narcotic pain relievers.

Cigna Foundation and New York Life Foundation have partnered to launch the Brave of Heart Fund to help the spouses, domestic partners, children, and parents of the frontline healthcare workers who gave their lives in the fight against COVID-19. Cigna Foundation and New York Life Foundation will make initial seed contributions of $25 million each and both CEOs will work to garner additional support from other corporate and private citizens.

In addition to the financial assistance, Cigna will provide behavioral and emotional health support to the families to help them cope. These offerings are an expansion of Cigna's efforts to support both front-line healthcare workers and the general public during the ongoing COVID-19 outbreak.

Cigna is expanding its digital capabilities to help customers with COVID-19 by providing real-time, personalized support. These new virtual solutions will help rapidly identify and assist Cigna customers who arrive in emergency room settings with COVID-19 symptoms, and support those who are actively recovering at home.

Cigna has partnered with Collective Medical to identify customers, in real-time, checking into emergency care settings with COVID-19 symptoms. With this information, Cigna Care Advocates can quickly engage these customers and connect them with programs to support whole person health, such as care management, remote patient monitoring and behavioral health support.

Customers with mild to moderate COVID-19 symptoms can now access an interactive digital tool while they safely shelter and recover at home. Cigna has partnered with Medocity to create a simple solution, Medocity for Cigna, which allows customers to track their symptoms, connect with care advocates and access behavioral and emotional supportive resources.

Cigna is adding Talkspace to its behavioral provider network for customers seeking a more convenient therapy option. With private messaging (text, voice, and video), Talkspace connects Cigna customers to dedicated licensed therapists who engage daily through a secure app. Customers can also schedule live video sessions based on personal preference.

Cigna has launched the Cigna Care Card to help clients provide financial assistance to keep employees healthy and supported during the COVID-19 crisis. The new offering will make it easier for employers to support the well-being and peace of mind of employees and their families by designating a tax-free dollar amount to cover expenses incurred as a result of COVID-19.

The Cigna Care Card is a debit card powered by Alegeus that allows clients to pre-load funds that employees can use for qualified disaster relief payments, such as medical payments, groceries, child care, and wellness services.[2] Payments are tax-free to employees and fully deductible to the employer.

Cigna is expanding its support for customers during the COVID-19 crisis by eliminating cost-sharing for all primary care, specialty care and behavioral health care in-office or telehealth visits for COVID-19 and non-COVID-19 care. This expansion applies to all U.S. customers enrolled in Cigna's Medicare Advantage and Individual and Family Plans, including those sold on the Individual

Marketplace. Additionally, Cigna is making enhancements to its Medicare Advantage meal plan benefits to further protect customers during the crisis and underscore the company's continued commitment to enabling access to simple, affordable and predictable health care.

The Cigna Foundation is inviting nonprofits working to create greater access to mental health services to apply for funding through its Healthier Kids For Our Future[SM] grant program. The program will provide up to a total of $5 million in grants to community organizations over the next year.

Healthier Kids For Our Future[SM] is a five-year, $25 million global initiative to improve the health and well-being of children that launched in 2019. Phase I focused on reducing childhood hunger and improving nutrition, awarding more than $4.5 million in grants to-date. In Phase II, the program will add an additional focus area, addressing the mental health and well-being of children. Nonprofits working to improve childhood hunger can still apply as well.

Many families across the country are facing increased stress and anxiety right now. Prior to COVID-19, up to 20 percent of children and adolescents worldwide experienced mental illness, and the crisis is shedding light on a worsening mental health crisis – as both children and adults are struggling with anxiety, loneliness, and isolation.

Cigna Dental will reimburse contracted network dentists for PPE when providing dental services for Cigna customers.

In addition, Cigna is helping dental providers overcome the stress and anxiety of returning to work by offering mental health resources and support for in-network dental office employees. Network dentists and office staff can speak to a qualified representative 24 hours a day, seven days a week through July 31 by calling 1.855.287.8400.

Cigna group dental clients will also receive a one-month premium credit applied in July for clients who were active in May 2020. The employer can pass through the premium credit to employees if they are responsible for their dental premiums. No action is required by clients to receive this credit.

In addition to the one-month premium credit for eligible clients and customers, Cigna Dental has implemented dental care solutions to assist employers and their employees during the COVID-19 pandemic, including no-cost virtual dental care for employees through July 31, 2020.

ConnectiCare

ConnectiCare is covering telehealth visits for covered medical and mental health services at no cost through May 31, 2020.

ConnectiCare has launched a "Peace of Mind" initiative to provide members with additional support during the coronavirus pandemic. ConnectiCare nurse care managers are calling members who may be more vulnerable to the coronavirus due to medical conditions or their age and giving them critical information to help keep them safe. ConnectiCare's service team is making similar calls to members that have previously visited a ConnectiCare center.

The initiative has led to calls to nearly 10,000 members who may be at heightened risk for COVID-19 and has assisted with a variety of needs ranging from prescription drugs to billing questions and telemedicine services to dealing with stress and anxiety caused by the member's current situation.

CommunityCare

CommunityCare is covering all allowable costs for treatment of COVID-19 for our fully insured employer groups, Medicare Advantage, and individual/family members. This policy will waive all copays, coinsurance and deductibles to cover treatment of COVID-19 through May 31, 2020.

CommunityCare members also have 100% coverage when accessing their in-network providers who are participating in providing telemedicine services and will not be subject to any copayment, coinsurance or deductible.

CVS Health

CVS Health is re-purposing a portion of its three-year, $40 million commitment to invest in California's health care delivery system. Nearly $1.5 million in grants will immediately help four local nonprofit organizations expand access to telehealth services, address food insecurity among California's most vulnerable populations, and support the state's paramedics and EMTs.

CVS Health and the American Lung Association have launched a campaign at CVS Pharmacy locations to support the Lung Association's COVID-19 Action Initiative, which will expand COVID-19 research and fund the development of new vaccines, detection tests and treatment to defend against future respiratory viruses.

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Dean Health Plan

Dean Health Plan is waiving in-network cost-sharing, including copayments, coinsurance and deductibles, for COVID-19 diagnostic testing. Dean Health Plan will cover the test and doctor visit at no cost to members when the basis for the visit is related to testing for COVID-19.

Dean Health Plan is covering in-network hospitalizations for COVID-19 treatment with no member cost sharing.

Delta Dental

Delta Dental of Iowa and the Delta Dental of Iowa Foundation have committed $10.5 million in grants to COVID-19 relief programs to help Iowa dentists and nonprofits.

Delta Dental of Arizona

Delta Dental of Arizona is offering claims advances to network dentists affected by the novel coronavirus (COVID-19). The newly launched Advance Claim Payment Program will allow Arizona dental offices to receive an advance of up to $50,000 from the dental insurance company.

Delta Dental of Arizona plans to provide a 25% premium credit to its fully-insured group dental clients. The move provides more than $3 million in relief to more than 2,900 companies statewide. Delta Dental of Arizona has also frozen rates for clients with 2-199 enrolled employees that renew PPO dental and/or vision plans May 1 through August 1, 2020. As a result, approximately, 650 small- to medium-sized businesses will not get an increase in rates and will continue to benefit from the same competitive premium rate for another 12 months.

Delta Dental Plan of Arizona, through its foundation, is donating $500,000 to the 23 federally qualified health centers (FQHCs) across the state.

Delta Dental of Arizona's Interim PPE Support Program is designed to help offset the cost of PPE supplies, equipment and technology needed to safely reopen and scale up practices to provide dental services to Delta Dental of Arizona members amid COVID-19.

A $10 PPE support payment will be calculated for all Delta Dental of Arizona member claims paid to a dental office from April 1 through July 31, 2020, with a maximum of one PPE support payment per patient per day.

PPE support payments will be made as separate, monthly lump-sum payments that reflect the total number of Delta Dental of Arizona claims paid to the dental office for the period. Claims paid during the timeframe of the program are the only claims eligible for the PPE support payment.

Delta Dental of Arizona has also partnered with the Arizona Department of Administration to provide 30,000 toothbrushes and 30,000 tubes of toothpaste to homeless shelters and organizations serving vulnerable populations.

Delta Dental of Arkansas

Delta Dental of Arkansas has committed a total of $6.5 million in emergency financial assistance to dental practices in Arkansas. The new program – the Delta Dental of Arkansas Advance Receipts Program – will provide financial support to dental practices, who are limited to providing only emergency services during the COVID-19 outbreak. In addition, the Delta Dental of Arkansas Foundation, which is the organization's charitable giving arm, will offer a total of $500,000 in grants to community organizations for projects directly related to COVID-19.

Delta Dental of Arkansas is providing financial assistance to its business clients and network dentists as Arkansans continue to feel the impact of COVID-19 on their businesses. The Pandemic Relief Credit gives a credit in the amount equal to 100% of the monthly premium billed to Delta Dental's commercial business clients with dental and/or vision insurance. This premium "holiday" amounts to almost $15 million in credits to over 4,000 Arkansas business clients.

Delta Dental of California

Delta Dental Community Care Foundation is making $5 million in funding available to organizations across its 15-state service area that are at the forefront of helping the communities most impacted by COVID-19. Funds will support a variety of response activities for at risk populations.

Of the $5 million total, $3.5 million will support increasing access to care across the Foundation's 15-state area. The majority will be provided to federally qualified health centers, which are government-funded clinics that provide primary care services in underserved areas and must offer a sliding fee scale based on a patient's ability to pay, and other community health centers that serve on the front lines of this public health crisis and are working tirelessly to protect and treat those affected by the COVID-19 virus.

The Delta Dental Community Care Foundation will make $1 million of this funding available to organizations responding to the unparalleled public health emergency and to current partners experiencing significant increases in expenses and/or budget shortfalls as a result of the COVID-19 pandemic.

The Delta Dental Community Care Foundation will also be providing $500,000 in disaster response funding to California organizations that provide assistance to seniors, those living with food insecurity, those experiencing homelessness and homebound individuals.

Delta Dental of California is establishing a $200 million loan program to provide economic assistance and post-COVID-19 pandemic relief for its independent provider network across 15 U.S. states and the District of Columbia. As part of this aid, Delta Dental's co-sponsored loan program will include interest subsidies, principal deferment and enable providers to refinance other business loans and get working capital.

Delta Dental Community Care Foundation is providing $2 million funding for organizations in New York state helping vulnerable populations affected by COVID-19. The funding will be in the form of unrestricted grants for organizations that provide critical services to underserved individuals, including medical clinics and community service organizations.

Delta Dental of Colorado

Delta Dental of Colorado and the Delta Dental of Colorado Foundation (DDCOF), have collectively committed $30 million in the form of billing and premium credits, loans, relief funds, and grants to customers, oral health care providers, and local community organizations.

Delta Dental of Illinois

The Delta Dental of Illinois Foundation has provided $1.5 million to help ensure Illinoisans continue to receive vital health services during the COVID-19 pandemic. The Foundation has provided $500,000 to support the Illinois State Dental Society Foundation and is also launching a $1 million emergency grants program to Federally Qualified Health Centers in Illinois.

Delta Dental of Iowa

Delta Dental of Iowa will provide a 25% premium relief credit for employer customers offering fully-insured dental and vision plans. The credit will cover April and May premiums and be applied to July premiums.

A $10 payment will also be applied to claims for Delta Dental of Iowa members who have services between May 1 through August 31, 2020. In total, more than $4 million in additional support has been dedicated to Delta Dental network dentists through this program.

Delta Dental of Iowa DeltaVision members with individual and family plans will also receive a 25% premium relief credit for April and May premiums. Members can choose to donate their premium relief credit to the Iowa Food Bank Association, which serves food banks in all 99 Iowa counties and Delta Dental will match members' donations up to $250,000.

Delta Dental of Kentucky

Delta Dental of Kentucky's new Provider Advance Payment Program is making approximately $5 million available to help supplement Kentucky dental practices that have lost income following Gov. Andy Beshear's March 18 executive order stopping all non-emergency medical and dental procedures.

Delta Dental of Massachusetts

Delta Dental of Massachusetts has made three contributions totaling $200,000 to support Massachusetts non-profits in their response to community needs during the COVID-19 outbreak.

Delta Dental of Massachusetts will provide a 30% credit on premiums paid for April and May coverage, following approval by the Massachusetts Division of Insurance for individual subscribers who signed up directly and through the Massachusetts Health Connector.

Additionally, DDMA will provide free access to its Delta Dental Patient Direct® card discount plan from June 1 through the end of the year for employees of DDMA's clients, who have been furloughed or laid-off and lost their dental insurance coverage.

For patients who choose to return to the dentist for preventive cleanings, DDMA will provide each member of a fully insured group plan who completes a preventive cleaning visit between June 1 and August 31 with a free electronic toothbrush.

Delta Dental of Massachusetts has donated $2 million to the Massachusetts Dental Society Foundation COVID-19 Recovery Fund, established to support the continued viability of community dental offices and dentists across the state following the extended COVID-19 shutdown.

Delta Dental of Michigan, Ohio, and Indiana

Delta Dental of Michigan, Ohio, and Indiana will provide every licensed dentist in the three-state region a $1,000 credit for dental products and services beginning May 26, 2020 so they can maintain care and keep their communities healthy as patients begin seeing their dentists again.

Since March, Delta Dental of Michigan, Ohio, and Indiana along with the Delta Dental Foundation, the philanthropic arm of the company, have committed about $88 million to assist local communities and partners through the pandemic.

Delta Dental of Missouri

Delta Dental of Missouri is donating $500,000 to organizations providing COVID-19 relief efforts in Missouri, and in South Carolina, where the company does business as Delta Dental of South Carolina.

Delta Dental of Tennessee

Delta Dental of Tennessee made a $50,000 commitment to support COVID-19 relief efforts across Tennessee through The Salvation Army Nashville Area Command and Second Harvest Food Bank of Middle Tennessee. The nonprofits will receive $25,000 each to distribute across the state based on need.

Delta Dental of Tennessee also announced a commitment of more than $3.3 million for Operation #SmilesMatter, a grant program to help Tennessee dentists acquire much-needed supplies, equipment, and technology as they prepare to reopen their practices following COVID-19-related closures. Delta Dental will be funding a $1,000 “allowance” or credit available to all dentists in Tennessee, regardless of whether they participate in Delta Dental’s network, to purchase dental products.

Delta Dental of Virginia

Delta Dental of Virginia has made a $1 million contribution to support Virginia’s dental practices and their patients, provide financial assistance for safety net dental clinics, and support local non-profits working to meet needs in their communities.

Delta Dental of Wisconsin

The Delta Dental of Wisconsin Foundation has provided $800,000 in grants to safety-net clinics in Wisconsin as well as an additional $100,000 for food security programs.

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EmblemHealth

EmblemHealth is partnering with Medly Pharmacy to provide direct, at-home delivery of prescriptions to members, as part of its COVID-19 response.

EmblemHealth is waiving cost sharing for all COVID-19 diagnostic tests and associated office, urgent, or emergent visits for both in and out of network providers, and has also waived prior authorization and concurrent review for all inpatient admissions.

EmblemHealth is also waiving prescription refill limits on maintenance medicines, helping members convert to 90-day mail order prescriptions, and entering into a new partnership to provide same day home-delivery of prescriptions providing access to pharmacists seven days a week and servicing customers in more than a dozen languages. EmblemHealth has provided special training to associates to ensure that consumers are aware of the Special Enrollment Period and informed about how to obtain coverage during this uncertain time.

EmblemHealth also has expanded telemedicine benefits for members, waiving all cost sharing for telehealth services and expanding services available via telehealth.

In addition to extending the Grace Period for non-payment of premium, EmblemHealth Neighborhood Care has been connecting members to social supports like food pantries, unemployment benefits and housing assistance. The plan launched a comprehensive effort to support small business owners to assist any displaced employees. EmblemHealth has launched an outreach campaign to its most vulnerable members, offering a human connection to those who may be suffering from extended periods alone and anxious for and to offer assistance with accessing care. EmblemHealth is supporting the local food banks it partners with through Neighborhood Care through donations and has amended its paid time off policy for clinically trained qualified employees to answer the state's call to serve.

EmblemHealth has extended the waiver on prior authorization and concurrent review for all inpatient admissions to Medicare, covering all hospital admissions.

EmblemHealth has also taken internal steps to expedite payments to ensure that revenue is moving to hospitals on the frontline as quickly as possible.

Empire BlueCross BlueShield

The Empire BlueCross BlueShield Foundation has committed more than $200,000 to organizations on the frontlines of providing New Yorkers with critical access to food during the ongoing COVID-19 pandemic. Of the $200,000 dedicated to fighting food insecurity, Empire has made contributions of $50,000 each to City Harvest and Food Bank for New York City, which will support local families during the COVID-19 outbreak.

Empire BlueCross BlueShield has launched Ortho@Home, a teledentistry and at-home orthodontia program. The services is part of Empire's continuing commitment to providing access to affordable services that meet a person's whole health needs, while also providing safe, remote-care during the COVID-19 crisis.

Consumers with orthodontic benefits will have access to at-home clear aligner therapy, remote oversight of care, teeth whitening, and retainers at completion of treatment with an average cost up to 60% less than traditional orthodontia and three times faster. This offering helps improve member access to orthodontic care – especially in rural areas where over half of the counties in the United States do not have access to orthodontists' offices.

Excellus BlueCross BlueShield

Member out-of-pocket costs such as copayments, co-insurance and deductibles have been waived on all COVID-19 related testing and diagnosis where medically necessary and consistent with federal guidelines. This includes the cost share for the office visit, urgent care visit or emergency room visit.

The member out-of-pocket expense is also being waived for all telemedicine visits during the state of emergency for plans that have a telemedicine benefit. Telemedicine is alternative way to access care if a person can't reach their physician.

Excellus has also waived preauthorization requirements for diagnostic tests and for covered services that are medically necessary and consistent with CDC guidance for members diagnosed with COVID-19.

Excellus BlueCross BlueShield estimates that New Yorkers used telehealth benefits about 290,000 times last year. In the first four months of 2020, a time period marked by the global spread of COVID-19, the number skyrocketed to an estimated 2.6 million times. According to Excellus BCBS's claims-based review of services delivered, more than one-third of telehealth visits are for mental health services.

Excellus BlueCross BlueShield will continue to waive out of pocket costs for COVID-19 diagnosis and treatment for its fully insured employer groups, individual market qualified health plans and Medicare Advantage members **through September 7, 2020**. This waives the member's copayment or cost share for diagnosis and treatment, even if that treatment is delivered in the hospital. Excellus also provides coverage in full for medically appropriate COVID-19 testing.

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Fallon Health

Fallon Health is relaxing administrative procedures, such as prior authorizations and out-of-network requirements, for medically necessary care, waiving copayments for medically appropriate coronavirus treatment, and waiving early refill limits on non-scheduled control drug prescriptions for all Fallon members who fill their maintenance medications at any in-network pharmacy.

Fallon Health has waived cost-sharing for all COVID-19 and non-COVID-19 related medically necessary telehealth services for all members. This will also be effective while Massachusetts is under a state of emergency.

Fallon Health has converted one of its senior care facilities in Worcester into a residential coronavirus care center. Nine patients have been admitted to the center so far for COVID-19 care and treatment.

Florida Blue

Florida Blue will waive all copays and deductibles for the medical testing for COVID-19 for members who are part of its commercial insurance plans, including the Affordable Care Act (ACA) Individual and Medicare Advantage plans. The company is waiving early medication refill limits on 30-day prescriptions, is encouraging the use of virtual care, and is offering mental health support for experiencing stress from COVID-19.

Florida Blue is adding a free-to-member virtual care partner, Teladoc, for seniors and others on its Medicare Advantage plans, and waiving the virtual care copay for many commercial and Affordable Care Act members to encourage use of Teladoc if it is offered as part of their plan. Additionally, during this pandemic, Florida Blue's network of primary care doctors and specialists will be able to treat patients virtually at their normal office visit rates.

Florida Blue is allowing groups and individual members more time to pay through May 31, 2020 for customers unable to pay premiums as a result of the COVID-19 health crisis that would otherwise have been subject to termination of coverage.

Florida Blue will waive cost-sharing through June 1 for its members who must undergo treatment for COVID-19, including in-patient hospital admissions. The announcement impacts all Florida Blue members with Affordable Care Act, Medicare Advantage (excluding Part D drug plans) and other individual plans, as well as all fully insured employer group health plans.

Florida Blue is offering a dedicated COVID-19 virtual assistant on its public websites at www.FloridaBlue.com and www.FloridaBlue.com/COVID19, free and available to anyone.

The assessment function of the new virtual assistant pops up automatically on the websites, and guides users through educational content or through a series of questions to check for COVID-19 symptoms and related risk factors. Based on the assessment results, the tool directs users to contact their primary care provider for next steps, to the Florida Blue Center nurses for answers to commonly asked questions about COVID-19 and connection to community resources, or to immediate care options as needed.

Florida Blue is extending the premium due date through the end of June for customers who needed extra time to pay premiums as a result of the COVID-19 health crisis and would otherwise have been subject to termination of coverage. The payment extension applies to Individual – Affordable Care Act (ACA) and non-ACA – plans, Fully Insured Employer Group health plans and Medicare Supplement plans.

Additionally, all member cost sharing payments for in-network primary care office and telehealth visits, as well as behavioral health-related office, outpatient and telehealth visits, will be waived for Florida Blue's Medicare Advantage plan members through December 2020.

Florida Blue will also waive cost-sharing for its members who must undergo testing and treatment for COVID-19, including in-patient hospital admissions, through August 1, 2020.

Florida Blue is more than tripling its COVID-19 community investments to over $7 million. In March, the insurer provided an initial $2 million to organizations across the state to address urgent health and safety needs. Florida Blue will invest an additional $2.5 million to provide access to testing and health care, food security and other essential needs for Floridians. Additionally, the insurer plans to contribute more than $2.6 million to United Way organizations across Florida.

More than $1 million of the additional funding is dedicated to providing COVID-19 testing and access to health care for underserved Floridians. Florida Blue will work with its partners at organizations such as the Florida Association of Free and Charitable Clinics, Federally Qualified Health Centers and others to identify opportunities across the state to address areas in need.

A three-year grant of $220,000 to UF Health will help provide necessary technology for the development of a model for COVID-19 diagnostic tests called pooled testing. The model allows more people to be tested at a substantially reduced cost and will be exportable to other labs with similar technology.

Over $1.3 million will also address food security for seniors, children and disadvantaged families, support the mental health of those impacted by the COVID-19 crisis and provide essential needs to those struggling due to the pandemic.

Fidelis Care

Fidelis Care has expanded access to telehealth services, covering virtual visits with providers from the safety, comfort, and convenience of a member's home for a $0 copay.

Members have access to telehealth through network providers or specialists, or through Teladoc.

Fidelis Care has also waived allCOVID–19 related prior authorization requirements, and member cost sharing for related screening, testing, and treatment – including telehealth visits.

First Choice Health

First Choice Health is covering the cost of telehealth services for its self-funded employer customers via on-demand primary care service 98point6. First Choice Health will provide its employer customers complimentary access to 98point6 for 60 days.

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Gateway Health

Gateway Health is waiving all member co-payments, co-insurance and deductibles associated with COVID-19 testing and medical treatment. This applies to in-network and out-of-network inpatient, outpatient and emergency department services related to COVID-19 treatment. The decision to waive member cost-sharing affects all Gateway members participating in Pennsylvania Medicaid HealthChoices and Medicare Assured Part C plans.

Gateway Health is committing more than $1 million to support non-profit organizations, community partners and social determinants of health causes in 2020.

Many of the areas where Gateway Health members live have been hit especially hard by the economic challenges associated with COVID-19, including food insecurities. Gateway Health's donation to this important relief effort will assist communities across Pennsylvania. They will be able to expand access to much needed heathy food options in light of the ongoing COVID-19 crisis. The donation also supports ongoing nutrition education and resources in these areas.

Geisinger Health Plan

Geisinger Health Plan will waive out-of-pocket costs for COVID-19 testing, and is not requiring prior authorization for diagnostic services related to these tests. We are relaxing refill quantity and frequency restrictions to offer 90-day maintenance medication prescriptions for Commercial and Medicare members and allowing members to refill their prescriptions early. Its large TPA groups may opt out of these programs at their discretion.

Geisinger is also making telehealth services available for all members at no cost through June 15. Services are provided via Teladoc online or by phone, and may be used for any routine medical need.

Geisinger has partnered with the Central Pennsylvania Food Bank, Harrisburg, and Weinberg Northeast Food Bank, Pittston, to distribute emergency food boxes to health plan members, patients and those in need in the community. These boxes are being delivered from Geisinger's Fresh Food Farmacy locations and include shelf stable supplies, recipes, educational information and other resources. Geisinger is targeting food insecure health plan members, however, any patient or community member in need is eligible. To ensure the safety of the community and prevent potential exposure to COVID-19, staff will be doing curbside or front porch deliveries.

Geisinger Health Plan is waiving all out-of-pocket costs for members receiving in-network, inpatient treatment for COVID-19.

Geisinger Health Plan has expanded telemedicine services to include primary care and 70 other specialties. The service allows patients to speak to providers in real-time about colds, the flu, rashes, diabetes, mental health conditions, neurological conditions, and much more- providing necessary care while maintaining social distancing.

Geisinger Health Plan is offering new virtual and telephonic services to members. These include health coaching, population health programs, behavioral health services, and online health resources.

Geisinger is also providing tools, information and guides to help employers keep their staff and patrons safe and healthy.

This online resources center is available at go.geisinger.org/businessresources and includes frequently asked questions, best practices, guidance for screening employees, signage kits promoting handwashing and social distancing at the workplace, and more. Virtual consultations are also available upon request.

Geisinger Health Plan has launched a new mobile app to connect patients with their care providers and monitor their symptoms as they recover from COVID-19 at home.

Through Epic's MyChart Care Companion, patients report their symptoms, temperature, and oxygen levels twice a day to a team of nurses. If symptoms worsen, an automated alert is sent, and the patient is quickly contacted by a clinical nurse for further evaluation and a video encounter with a physician if needed. The clinical team can help get patients who have particularly concerning findings to the emergency room.

Gold Coast Health Plan

Gold Coast Health Plan has launched a 24/7 emergency hotline for members to consult a medical professional about COVID-19 or other health issues. The service is available to Medi-Cal beneficiaries and will help them to decide if they need urgent medical care or can take care of symptoms at home.

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Harvard Pilgrim Health Care

Harvard Pilgrim Health Care will cover the costs of diagnostic testing for COVID-19, waive cost sharing for all telemedicine visits and allow early refills for prescription medications. Self-insured groups will have the ability to opt-in at their discretion.

Harvard Pilgrim has also donated over $3 million to COVID-19 relief efforts by supporting community organizations in Connecticut, Maine, Massachusetts, and New Hampshire. The money will help select restaurants throughout the region to provide and deliver take-out meals to families in need and help to put people back to work. Additionally, these resources will assist communities in facilitating access to COVID-19 testing.

Harvard Pilgrim Health Care is waiving member cost-sharing related to treatment for COVID-19. The waiver applies to medical costs associated with COVID-19 treatment at in-network facilities and out-of-network emergencies.

Harvard Pilgrim Health Care Foundation and Convenient MD have partnered to open a drive-thru COVID-19 testing site at Harvard Pilgrim Health Care's Quincy headquarters' parking lot, located at 1600 Colony Drive.

Harvard Pilgrim Health Care will be providing $32 million in premium credits to all its fully-insured employer groups, as well as to Medicare Supplement members. Harvard Pilgrim is awaiting regulatory approval for this action in Connecticut which it expects to receive shortly. Additionally, the nonprofit health plan announced it will provide $3 million in financial support to independent primary care physicians, $3 million to support community health centers, and the insurer will waive all primary care and specialty care copays for office visits for Medicare Advantage members through the end of the year.

Harvard Pilgrim will be providing the following relief and support to members, customers, independent primary care physicians and community health centers:

- Fully-insured Employer Groups regardless of size or location, will receive a 15% credit on their September premium invoice ($30 million total).
- Medicare Supplement Members will receive a 15% credit on their September invoice ($2 million total).
- Medicare Advantage members copays for all primary and specialty care office visits will be waived starting July 1st until the end of 2020.
- Independent Primary Care Practices will have access to $3 million in financial support to assist with aspects of reopening their practices. To support the provider community, Harvard Pilgrim provided over $40 million in financial advances to providers throughout the region.
- Community Health Centers, focusing on those providing care to predominately black and brown communities, as well as centers that provide care for vulnerable populations, will receive $3 million to support equity and equality in accessing health care, and address health disparities.
- COVID-19 testing and treatment cost-share waiving and no out-of-pocket expense for telehealth services will continue to be provided through September 30, 2020. Harvard Pilgrim will reassess these policies as circumstances warrant.

Hawaii Medical Service Association

Hawaii Medical Service Association will pay for any medically necessary care related to COVID-19 from a participating provider at no cost to members. HMSA will cover medically necessary COVID-19 testing and treatment from a participating doctor, urgent care facility, or emergency room. If a member is admitted to the hospital, HMSA will also cover the hospital stay.

HMSA will also cover medically necessary diagnostic tests for COVID-19 according to CDC guidelines with no copayment for members.

Health Alliance Plan (HAP)

Health Alliance Plan (HAP) will waive cost-sharing for COVID-19 testing. This applies to Medicare Advantage, Medicaid, fully insured, and individual plan members. Self-insured plans have the opportunity to opt-in.

Health Alliance Plan will waive member cost-sharing for testing and treatment of COVID-19, according to state and federal guidelines, which includes deductibles, copays and co-insurance associated with treatment for the virus. This cost-sharing waiver is currently in effect for services rendered through June 30, 2020.

Health Alliance Plan is also waiving cost-sharing for individual, fully-insured group and Medicare members using telehealth services through June 30, even if the service is not related to COVID-19.

Health Alliance Plan has extended its cost-sharing waiver for telehealth services through the end of the year. All cost-sharing is waived for HAP's individual, fully-insured employer group, Medicare, Medicaid and MI Health Link members using telehealth services through December 31, 2020, even if the service is not related to COVID-19. Self-insured employer group customers control their own health benefits, and HAP is working with its self-insured customers to determine how they will cover telehealth services.

For its individual members and small employer group customers, HAP will decrease monthly premiums by 5% through the end of the year. A small group is defined as an employer with fewer than 50 employees. These decreases will be reflected in monthly premium bills beginning July 1 and will be in effect through December 2020.

For its Medicare Advantage members, HAP will waive copays for all in-person primary care visits and behavioral health visits through the end of the year. In addition, HAP will waive all member cost-sharing for telehealth visits for its Medicare Advantage members through the end of the year. This means that HAP Medicare Advantage members will not be charged any copays, deductibles or co-insurance for telehealth visits made through December 31, 2020, even if it is unrelated to COVID-19.

Health Alliance Plan has been conducting personalized outreach to its most vulnerable members, many of whom are Medicare Advantage members. HAP has worked with its technology partners to identify those members most at risk for experiencing negative effects of loneliness and isolation, including food insecurity and behavioral health issues. During April and May, HAP conducted more than 8,500 phone calls to its members to determine if they are in need of food or other services. For those in need of mental health support, HAP has provided access to behavioral health resources. For Medicare members who lack access to nutritious meals, HAP has expanded its partnership with Mom's Meals to have two weeks' worth of frozen, ready-to-heat balanced meals delivered to their home.

Health Care Service Corp. (HCSC)

Health Care Service Corp. (HCSC) will waive co-pays and deductibles for COVID-19 testing and will not require prior authorization for those tests. This applies to all members they insure; the company is working with self-insured plans on their decisions.

HCSC is waiving member cost-sharing, including deductibles, copayments, and coinsurance related to treatment for COVID-19. The waiver applies to costs associated with COVID-19 treatment at in-network facilities and treatment for out-of-network emergencies.

HCSC will also offer a special enrollment period for its insured group customers. Employees of fully insured group customers who did not opt in for coverage during the regular enrollment period will have an opportunity to get coverage for their health care needs. The special open enrollment period begins April 1 and will end April 30, 2020.

Health Care Service Corp. will launch the Employed Clinician Volunteer Program for more than 3,000 doctors, pharmacists, nurses, behavioral health specialists and other clinicians with varied specialty backgrounds.

Through this program, HCSC will pay eligible and approved HCSC employees, who are medical clinicians, to volunteer for patient care in their field for up to 80 hours of paid time during their regular scheduled work hours.

Healthfirst, Inc.

Healthfirst, Inc. is waiving co-pays for all diagnostic testing and evaluations related to coronavirus. This means that if a primary care physician or in-network provider orders a coronavirus test, the person's Healthfirst health plan will cover the cost for the test and the in-network provider visit related to the coronavirus evaluation. Members will not be subject to any cost sharing for the test or the in-network provider visit.

Health Net

Health Net, a subsidiary of Centene, will cover coronavirus-related testing, screening and treatment for all members.

Health Net will provide $5.9 million in immediate assistance to support Medi-Cal providers impacted by the outbreak of the novel coronavirus (COVID-19). Health Net's investment will enable the expansion of telehealth capacity and capability at California safety net clinics, Federally Qualified Health Centers (FQHC), and independent provider practices serving the state's most vulnerable patient population and facing increased challenges amid the COVID-19 pandemic.

HealthPartners

HealthPartners is providing coverage with no cost share for the administration of the COVID-19 laboratory test (regardless of where the test is performed). It is also providing coverage with no cost share related to an in-network office visit or urgent care visit associated with the test.

HealthPartners will waive fully insured members' cost-share for the treatment of COVID-19 – including copays, coinsurance and deductibles–when getting care from an in-network* provider, effective March 1 through May 31, 2020.

HealthPartners Institute and researchers at the University of Minnesota have teamed up with developers to create a mobile app that provides users with data about the health of their neighborhood, helping them avoid potential COVID-19 hotspots.

The SafeDistance app crowdsources data down to the level of people's census block groups. These census block groups usually contain around 1,500 people and most accurately reflect neighborhoods.

HealthPartners is offering an innovative solution to provide consultation and direct support for businesses as they work to reopen, safely return workers and welcome back customers during the COVID-19 pandemic.

The new "Back to Business" COVID-19 employer preparedness solution is based on medical expertise and the latest scientific evidence and offers personalized support to businesses, including:

- COVID-19 preparedness planning. An employer assessment with personalized recommendations and best practices that support COVID-19 preparedness plan requirements
- Medical consultation on business preparedness. Medical expertise on how to safely resume business operations
- Absence policies consultation. Recommendations and best practices for employer absence policies regarding Family and Medical Leave Act expansion and Emergency Paid Sick Leave legislation related to COVID-19
- Employee communications consultation. Support for communicating employer preparedness plans to employees and customers
- Employee screening. Recommendations and implementation of COVID-19 screening best practices such as temperature, questionnaire or attestation screening as appropriate
- Employee testing. Recommendations and implementation of COVID-19 testing best practices for both symptomatic and asymptomatic employees
- Follow-up care support. Support for employees who screen at-risk of COVID-19 or test positive, connecting them to available resources
- Absence management. Case management for various leave types to keep employers compliant with regulations, minimize risk and reduce costs associated to employee leaves

HealthPartners is waiving Medicare member cost-sharing for all in-network primary care and behavioral health visits, effective July 1-Dec. 31, 2020. This will provide members with financial relief and encourage members to seek important and necessary care during the COVID-19 crisis.

Cost-sharing will be waived for in-person, phone and video primary care and behavioral health visits, including visits for substance abuse when services provided are in-network. This applies to all HealthPartners Medicare Advantage, Cost and group retiree plans in Minnesota, North Dakota, South Dakota, Iowa, Illinois and Wisconsin.

HealthPartners is also waiving the cost for fully insured members for the treatment of COVID-19 when getting care from an in-network provider, effective March 1 through September 30, 2020. This includes copays, coinsurance and deductibles.

Health Plan of San Joaquin

There is no cost to Health Plan of San Joaquin members for receiving medically-needed screening, testing, and treatment for COVID-19.

Highmark

Highmark will cover coronavirus testing, when recommended by a medical professional, for members of its fully insured group customers, as well as members of its Medicare Advantage and ACA plans. Self-insured health plan sponsors will be able to opt-out of the program.

Highmark has also waived member cost sharing for all covered telehealth services for 90 days and expanded access to telehealth vendor platforms for Medicare Advantage and Medicaid members.

Highmark will assist local primary care physicians by advancing payments made through the True Performance reimbursement program. The reimbursement payments would have been made in June, but will begin going out the week of April 6 as many physician practices are being affected financially by stay-at-home orders and other COVID-19 related issues.

More than 1,700 primary care practices or associated entities in Pennsylvania, West Virginia and Delaware will receive the advanced payments based on achievement in the True Performance program.

More than $30 million in advanced payments will be made during this extremely challenging time.

Highmark is waiving deductibles, co-insurance, and copays for members who require in-network, inpatient hospital care for COVID-19. The waiver will continue through May 31 as Highmark continues to monitor and evaluate the rapidly changing nature of this crisis.

Highmark has also introduced an additional 30-day grace period on late premium payments allowing members the ability to maintain their coverage and avoid cancellation for a more extended period of time.

Highmark has also announced that its commercial, Affordable Care Act and Medicare Advantage members in Pennsylvania and Delaware now have access to a comprehensive, technology-enabled opioid use disorder (OUD) program. The program, which was first rolled out to Highmark’s West Virginia members in January of 2020, will help preserve treatment access and promote recovery during the COVID-19 pandemic and beyond.

Highmark has collaborated with the CDC Foundation and Microsoft to develop and launch the COVID-19 Symptom Checker Healthbot. Anyone can use the Healthbot to check their symptoms, which will then provide guidance on seeking appropriate medical care when necessary during the COVID-19 pandemic.

Highmark is joining forces with four small and diverse Pittsburgh-based businesses to design, manufacture and donate over 1 million cloth face coverings throughout the summer months. The face coverings will be distributed to at-risk and vulnerable Highmark members, community organizations in need, health care professionals, and employer groups across Pennsylvania, Delaware and West Virginia.

Highmark Health

Highmark Health has expanded coverage for telehealth to all members, including self-funded customers who had previously opted out of telehealth coverage.

Highmark Health is also covering COVID-19 testing, both in-network and out-of-network, up to charges for out-of-network providers.

Highmark Health is ensuring access to teleaddiction services for members in PA, WV and DE who are in addiction treatment and need immediate help, but may not be able to access their regular provider during this time. These services are covered for both in- and out-of-network without cost sharing for members for 90 days.

Home State Health

Home State Health is collaborating with Quest Diagnostics to increase access to real-time reverse transcription polymerase chain reaction (rRT-PCR) COVID-19 testing in critical areas of need in St. Louis. Through this collaboration, Home State will facilitate the distribution of up to 1,000 Quest COVID-19 test kits each week to Affinia Healthcare and People's Health Centers, which are both Federally Qualified Health Centers.

Horizon Blue Cross Blue Shield of New Jersey

Horizon Blue Cross Blue Shield of New Jersey will waive prior authorizations for diagnosis of COVID-19, cover the full cost of diagnostic testing for COVID-19, waive early medication refill limits for 30-day prescription medications, and provide access to telehealth services at no cost.

Horizon Blue Cross Blue Shield of New Jersey is extending its previously announced waiver of all member cost-sharing obligations to include all covered benefits associated with treatment for COVID-19. The policy, retroactive to March 1, 2020 and in place through at least June 30, 2020, means that members will pay no deductible, co-pay, or coinsurance for inpatient and outpatient care when their claim indicates treatment was related to COVID-19.

Horizon Blue Cross Blue Shield of New Jersey is also is spending $2.35 million to donate 500,000 N95 respirator masks and 81,000 face shields to Governor Murphy's coordinated response effort.

Horizon Blue Cross Blue Shield of New Jersey has donated $2 million to The New Jersey Pandemic Relief Fund, the response and support organization established by Tammy Murphy, New Jersey's First Lady.

With the donation, Horizon has contributed $4.35 million for protective equipment for health care workers, food, and social services in response to the COVID-19 outbreak.

Horizon has also expanded paid-time-off for volunteer service to provide those employees answering New Jersey Governor Phil Murphy's Healthcare Professionals Call to Serve with 40 hours of compensated volunteer time. 72 doctors, nurses, pharmacists, and clinicians from Horizon have volunteered and are awaiting deployment.

Horizon Blue Cross Blue Shield of New Jersey has partnered with AbleTo to offer its members free access to AbleTo's individual teletherapy services. This partnership builds on Horizon BCBSNJ's larger initiative to provide in-network telemedicine services to members with zero out-of-pocket costs until at least June 30, 2020.

Horizon Blue Cross Blue Shield of New Jersey has launched Horizon Neighbors in Health, a comprehensive program to address social determinants of health. The state's largest health insurer is investing $25 million and partnering with some of New Jersey's most respected health organizations over the next three years on a model that employs local Community Health Workers to connect members with a wide-array of services that make good health more possible.

Addressing social determinants of health has become even more critical in light of the COVID-19 pandemic. Individuals whose access to services and care was challenging in the best of circumstances, now face even greater challenges.

Humana

Humana will waive out-of-pocket costs associated with COVID-19 testing. This applies to Medicare Advantage, Medicaid, and commercial employer-sponsored plans. Self-insured plan sponsors will be able to opt-out. The company is also waiving telemedicine costs for all urgent care for the next 90 days, and is allowing early refills on regular prescription medications.

Humana is waiving member cost share for all telehealth services delivered by participating/in-network providers, including telehealth services delivered through MDLive to Medicare Advantage members and to commercial members in Puerto Rico, as well as all telehealth services delivered through Doctor on Demand to commercial members.

Humana is waiving consumer costs for treatment related to COVID-19-covered services. Costs related to treatment for COVID-19, including inpatient hospital admissions, will be waived for enrollees of Medicare Advantage plans, fully insured commercial members, Medicare Supplement, and Medicaid.

The waiver applies to all medical costs related to COVID-19 treatment, as well any FDA-approved medications or vaccines.

There is no current end date for the waiver.

Humana is providing financial and administrative relief for the health care provider community facing unprecedented strain during the coronavirus pandemic.

Humana is also expanding its policy of suspending prior authorization and referral requirements, instead requesting notification within 24 hours of inpatient (acute and post-acute) and outpatient care.

The Humana Foundation will deploy $50 million in immediate short-term and long-term relief and partner with national and community service organizations to help those disproportionately impacted by the COVID-19 health crisis. The commitment will be split between organizations that support essential workers, food security, behavioral health and community-based organizations.

The Humana Foundation will distribute $34 million of the $50 million commitment to the immediate short-term response efforts of service organizations on the frontlines of the COVID-19 health crisis.

The remaining $16 million will go toward long-tern recovery and rebuilding support for service organizations that are fighting COVID-19.

Humana is eliminating out-of-pocket costs for office visits so that Medicare Advantage members can reconnect with their healthcare providers. To reduce barriers, Humana is waiving in-network primary care costs, not only for COVID-19 costs, but all primary care visits for the rest of 2020. In addition, the company is waiving member costs for outpatient, non-facility based behavioral health visits through the end of year.

Humana is also extending telehealth cost share waivers for all telehealth visits—PCP and specialty, including behavioral health, for in-network providers through 2020.

The Humana Foundation has awarded $2.2 million to nonprofit organizations in Louisville as part of its ongoing Community Partners Program. The initiative began in 2018 and has since awarded more than $6 million to local nonprofits addressing social determinants of health and creating greater health equity in Humana's corporate hometown.

The most vulnerable are disproportionately experiencing the economic and health implications of COVID-19. These challenges are compounding issues many were dealing with before the pandemic, including hunger and financial instability.

As of June 1, Humana will pay an additional $7 per Humana member dental claim – for all fully insured Humana dental members. At the end of each month, Humana will send a stipend to its dental provider partners, based on the total number of claims for Humana members that month. In addition to this financial support, Humana is also offering 24/7 access to its EAP and Work-Life Services to providers in its dental networks. These actions are a part of the company's wide-ranging proactive approach to supporting a better health care experience for its members, especially during this unprecedented health crisis.

Humana announces at-home and drive-through COVID-19 testing: Humana is proud to be the first insurer to offer LabCorp® at-home COVID-19 test kits and drive-thru COVID-19 testing at hundreds of Walmart Neighborhood Market pharmacies across the country. Testing is available for all eligible medical plan members, including Medicare Supplement.

If testing is recommended, members can opt to have a testing kit mailed to their homes within one business day. If members prefer a drive-thru test, Humana has teamed up with Walmart, Quest Diagnostics, and PWNHealth to offer drive-thru testing at Walmart Neighborhood Market pharmacies. The pharmacy staff will give members a test kit and help complete the process correctly.

Humana is continuing to waive all member costs related to covered COVID-19 testing and treatment.

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Independence Blue Cross

Independence Blue Cross will cover and waive cost-sharing (such as co-pays and coinsurance) for the COVID-19 test when performed at a hospital or an approved laboratory. This includes members enrolled in fully insured plans, employer-sponsored plans, Medicare Advantage and the individual and family plans available through the Affordable Care Act. Self-funded plans will be able to opt-out of this program. Independence has lifted prescription refill restrictions, such as the “refill too soon” limit, for members in states that have declared a state of emergency because of the virus, and is encouraging the use of telemedicine. Independence Blue Cross is also supporting the new PHL COVID-19 Fund, which will provide grants to Greater Philadelphia nonprofit organizations that serve vulnerable populations.

Independence Blue Cross is waiving member cost-sharing for in-network, inpatient, acute care treatment for COVID-19. This means members will pay no co-pay, co-insurance or deductible in this scenario.

Independence is also waiving cost-sharing for emergency department visits when members are admitted to the hospital under these same conditions. These changes are effective March 30, 2020 and will extend through May 31, 2020.

Independence is also temporarily suspending prior authorizations for acute inpatient admissions from an emergency department at all in-network facilities for members with a COVID-19 diagnosis through April 30. In addition, prior authorization requirements are temporarily suspended for transfers from acute in-network inpatient facilities to post-acute in-network facilities (long-term acute care hospitals, rehabilitation or skilled nursing facilities) for any diagnoses. Notification from facilities is still required.

Independence is waiving cost sharing payments for all primary care telemedicine visits through June 4.

Independence is also expanding coverage for telemedicine services to reimburse visits with specialists and ancillary service providers and expanding existing behavioral health telemedicine coverage to ensure that members with autism spectrum disorder receive Applied Behavior Analysis support.

Independence Blue Cross is offering a comprehensive COVID-19 preparedness tool developed by Quil to some Independence members at no cost.

Quil, the digital health joint venture of Independence Health Group and Comcast, is updating content in the tool daily based on new information and best practices. The tool includes resources for ways to support healthy living at home and help individuals adjust to new work/life balance realities.

Independence Blue Cross is offering members access to an emotional wellness app, Stop, Breathe & Think, at no cost until June 14, 2020. The app provides effective ways to alleviate feelings of anxiety, reduce stress, and find peace of mind.

Independence Blue Cross is expanding its temporary suspension of prior authorization for acute in-network inpatient admissions from the emergency department to include all diagnoses (including COVID-19) and for in-network transfers and transportation between facilities. The change, which is for fully insured members, takes effect immediately and will remain in effect until June 4, 2020.

Independence Blue Cross has developed a new initiative called “Calls of Kindness.” The initiative involves Independence employee volunteers making proactive check-in calls to Medicare members. The purpose of the calls is to give comfort and support to those who need it during the COVID-19 crisis. So far volunteers have made “Calls of Kindness” to more than 2,000 Medicare members.

Independence Blue Cross and Philadelphia-based United By Blue, a sustainable outdoor apparel and accessories brand, today announced the launch of a new program that offers four weekly grocery deliveries at no cost to Independence Medicare Advantage members. Each delivery contains fresh, local, and organic groceries, homemade soups, and household supplies.

The program is targeting 7,700 Medicare Advantage members who are enrolled in Independence’s Keystone 65 Individual HMO plans and have chronic obstructive pulmonary disease (COPD) and at least one of the following diagnosis: hemoglobin A1c level greater than 9, asthma, hypertension, congestive heart failure, end-stage renal disease, or ischemic heart disease.

Independence Blue Cross recently launched a comprehensive COVID-19 Provider Hub website. The site provides information on clinical and business initiatives taken by Independence to support doctors, hospitals, health systems, and other health care professionals during the pandemic.

Independent Health

Independent Health is expanding its partnership with Brook, a Seattle-based technology company, to offer the Western New York community free access to the Brook Personal Health Companion App for the duration of the COVID-19 health emergency.

Independent Health has waived copayments and cost-sharing for COVID-19 medical testing, diagnosis and treatment for its fully insured employer groups, Medicare Advantage, Medicaid and individual plan members.

In addition, Independent Health is covering in-network telehealth/telemedicine services, whether or not COVID-19 related, to encourage social distancing and help reduce the risk of spreading the coronavirus. There will be $0 copay or cost-sharing for these services as well.

Independent Health implemented a global payment reimbursement model to help primary care practices during the pandemic. By compensating practices through an all-encompassing global payment, Independent Health helped keep cash flow similar to a "typical" month prior to the pandemic. This way, practices were not solely dependent on office or telehealth visits for reimbursement to stay afloat.

For its members who do not have a primary care physician, Independent Health partnered with several primary care practices to connect these members with a doctor right away.

Independent Health is also allowing members who are considered to be at higher risk as defined by CDC guidelines to obtain an early refill of their medication if needed.

Indiana University Health

Indiana University Health provides free screening for COVID-19 via its virtual visits app where Indiana residents of any age are able to review symptoms with a health care provider. The team will recommend and facilitate appropriate pathways for care and will provide direct access and communication with local hospitals as medically appropriate.

Indiana University Health is expanding testing for the SARS-CoV-2 virus, which causes COVID-19, to any health care worker or first responder in Indiana who may have been exposed to the virus. This includes health care workers serving at non-IU Health facilities.

Indiana University Health is accelerating payments for purchased products and services. The initiative aims to boost cash flow for the many Indiana-based businesses that supply needed goods and services to health care providers and other Central Indiana companies during the global COVID-19 crisis.

IU Health is expediting the processing of over $5 million a week in billings into the accounts of its in-state vendors. The dozens of Indiana vendors who will see expedited payments from IU Health include many small businesses and women- and minority-owned enterprises.

Inland Empire Health Plan

Inland Empire Health Plan's (IEHP) response to COVID-19 includes collaborative efforts with counties, county hospitals, public health, local medical associations, providers, and partners to coordinate efforts to serve the plan's members, providers and community.

To ensure members continuity to access routine and COVID-19 related care, IEHP has partnered with county public health, county health systems, and one of the nation's largest Federally Qualified Health Centers, SAC Health System, to administer tests to members locally. The health plan has also expanded telehealth services to include both new and established patients for an array of services.

To support health care workers and providers in care delivery, IEHP has increased rates for Skilled Nursing Facilities so they may provide care for COVID-19 patients (when clinically appropriate) to lower the number of patients transferred to hospital emergency rooms. In addition, IEHP has also organized the procurement and distribution of personal protective equipment for hospitals and providers.

To address food and resource insecurity for the greater community, IEHP has provided sponsorships, donations of goods and volunteers to local food banks. To ensure the continuity of services from additional community-based-organizations, technology sponsorships have also been awarded to transition their critical services to digital platforms.

Inland Empire Health Plan has joined with local organizations to create several innovative initiatives, including: COVID-19 testing and lifted pharmacy restrictions for members; personal protective equipment and adjusted financial support for health workers; and resource support to the greater community.

IEHP has secured and distributed much-needed PPE to local hospitals and providers. They have also increased financial support for skilled nursing facilities to provide care for COVID-19 patients, when clinically appropriate. Dedicated IEHP webpages for COVID-19 information for providers, members, and community were developed and are updated daily with testing information, changes in county restrictions, and safety information.

Inland Empire Health Plan's provider payment initiative compares the average claim payments in 2019 to what a physician specialist received during the COVID-19 crisis in 2020. The difference, up to 90%, is paid to the physician so they can keep their practice and employees intact. All provider claims are also being processed in under 30 days to make sure critical cash flow is available to physicians, hospitals, clinics, and other providers.

Inland Empire has also provided $100,000 grants to Federal Qualified Health Centers who have begun testing for COVID-19 in their clinics.

Inland Empire is also providing 17 skilled nursing facilities in the area with increased rates to provide care to COVID-19 patients to lower the number of patients transferred to hospital emergency rooms.

Uninsured Inland Empire residents now have access to medical advice 24/7 through the Inland Empire COVID-19 Medline, due to a collaboration between Inland Empire Health Plan, 211 Riverside and San Bernardino County, Riverside and San Bernardino County Public Health, and Carenet Health.

This free resource is accessible to uninsured residents in Riverside and San Bernardino counties who call 211's social service line with COVID-19 related health questions. In addition to community resources, 211 can route callers to a health professional, staffed by Carenet Health.

Inland Empire Health Plan has sourced and donated more than 221,000 units of personal protective equipment supplies to local government agencies, medical societies, associations and hospitals in Riverside and San Bernardino counties during the COVID-19 pandemic.

Inland Empire Health Plan is amending its contracts to include a capitation feature that will pay a facility the hospital's expected net patient revenue for IEHP Medi-Cal members or their monthly claims' average for calendar year 2019, whichever is greater. IEHP is expecting to provide more than $90 million in support to providers during their pandemic response efforts.

Inland Empire Health Plan has provided more than 2.4 million units of personal protective equipment (PPE) to Inland Empire government agencies, medical societies, associations, and hospitals during the COVID-19 pandemic.

To date, the plan has provided over 1.9 million disposable masks, 145,000 N95/KN95 respiratory masks, 80,000 surgical gowns, 130,000 isolation gowns, 43,000 boxes of gloves, 150,000 containers of sanitizing wipes and 48,000 wipe refills.

Inter Valley Health Plan

Inter Valley Health Plan is treating COVID-19 diagnostic tests as covered benefits, and is waiving all cost sharing for members for screening and testing of COVID-19. It has also provided more flexibility for Part D refill restrictions to allow members to receive their needed medications.

InnovaCare Health

InnovaCare Health is fully compensating primary care physicians for April and May. Through its subsidiary, MSO of Puerto Rico, InnovaCare will also compensate specialists, dentists, hospitals and hospitalists to ease the financial stress from reduced patient volumes. Hospitals are receiving payments based upon average monthly billings while hospitalists are receiving full payment based on their contractual agreements.

InnovaCare expects to disburse more than $100 million in advanced payments to providers by the end of May.

InnovaCare has also implemented expedited claims processing, ensuring claims are processed within five days or sooner, allowing providers to be reimbursed as quickly as possible for the care they're providing.

At the onset of this pandemic, InnovaCare's plans were first in their markets to announce they would cover patients' healthcare usage related to COVID-19, ultimately waiving copays and deductibles during this time.

Through subsidiary Orlando Family Physicians, InnovaCare has expanded its telehealth offerings to

help patients access the care they need and maintain important relationships with their physicians.

The expanded capabilities have allowed OFP to handle an increased number of visits during the COVID-19 pandemic and also to be one of Central Florida's only provider groups to continue accepting new patients.

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Kaiser Permanente

Kaiser Permanente is contributing $1 million to 10 leading public health organizations and collaborating with CDC Foundation to strengthen the United States' public health infrastructure and response systems to stop the spread of COVID-19. Kaiser Permanente has more information about how its medical centers continue to prepare to contain and treat the disease. Kaiser Permanente is not requiring members to pay any costs related to COVID-19 screening or testing when referred by a Kaiser Permanente doctor.

Kaiser Permanente will waive all member out-of-pocket costs for inpatient and outpatient services related to the treatment of COVID-19.

Kaiser Permanente's elimination of member out-of-pocket costs will apply to all fully insured benefit plans, in all lines of business, in all markets, unless prohibited or modified by law or regulation. It will apply for all dates of service from April 1 through May 31, 2020, unless superseded by government action or extended by Kaiser Permanente.

Kaiser Permanente and Dignity Health will partner with California and Los Angeles County to open the Los Angeles Surge Hospital, a temporary facility in Los Angeles that will expand access to additional beds and expand ICU capacity for patients who contract COVID-19. The facility will be located on the campus of the former St. Vincent Medical Center in central Los Angeles.

The Los Angeles Surge Hospital is expected to open April 13.

Futuro Health, a California-based nonprofit established by Kaiser Permanente and the Service Employees International Union-United Healthcare Workers West (SEIU-UHW) to address the nation's allied health worker shortage, has expanded its education offerings to prepare front-line health care workers for an expected surge in COVID-19 cases, committing $1 million to launch a new pandemic-readiness program.

Kaiser Permanente members can now download Calm Premium on their smartphone, computer, or

tablet through their kp.org account.

Kaiser Permanente members will have unlimited access to Calm content, including an ever-growing library of guided meditations, sleep stories for deeper and better sleep, and video lessons on mindful movement and gentle stretching.

The availability of the Calm app is part of Kaiser Permanente's continued commitment to provide its members with new ways to support emotional wellness anytime and anywhere, particularly during times of increased stress and anxiety.

Kaiser Permanente has released a playbook, “Planning for the Next Normal at Work,” to guide employers and businesses through health considerations they will need to address as they safeguard workplaces during the COVID-19 pandemic and prepare to bring employees back to traditional work environments.

Examples of recommended safety modifications to the workplace include:

- Reconfiguring office space to allow at least 2 arms' length of space between workstations and providing hand sanitizer in multiple locations.
- Limiting meetings and gatherings to 10 people or fewer.
- Creating processes for potential employee diagnoses, including evaluating leave-of-absence policies.
- Reinforcing a psychologically healthy workplace where employees feel safe, respected, and empowered.

Kaiser Permanente will extend its waiver for most member out-of-pocket costs for inpatient and outpatient services related to the treatment of COVID-19 through December 31, 2020. This waiver, put into effect on April 1 and originally set to expire on May 31, is intended to alleviate the cost burden and stress of paying for care, allowing members to focus on recovery.

Kaiser Permanente's elimination of member out-of-pocket costs applies to all fully insured benefit plans, in all markets, unless prohibited or modified by law or regulation. It will apply for all dates of service from April 1 through December 31, 2020, unless superseded by government action or extended by Kaiser Permanente.

Kaiser Permanente is joining with nonprofit Civica Rx in its mission of assuring that health providers nationally have access to stable and affordable supplies of essential generic medications throughout the COVID-19 crisis and beyond.

Kaiser Permanente joins Civica as a governing member with a seat on the board of directors and as an integrated health system with 12.4 million members will provide an important voice in designing Civica's future strategy. The addition of Kaiser Permanente comes at a time when Civica is already

delivering 20 essential generic medications, 10 of which are currently being used to treat COVID-19 patients. Civica is also working to significantly boost generic drug production within the United States.

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L.A. Care

L.A. Care is waiving all costs associated with screening, testing and medically necessary treatment for COVID-19.

L.A. Care is moving to accelerate claims payments and provide other financial support to many providers in its provider network to help address the financial pressure caused by the COVID-19 pandemic.

L.A. Care will be accelerating more than $7 million in grant payments to 138 clinics and community-based organizations. The health plan is also committing more than $6 million in targeted grant support for its most vulnerable members and communities, including some who are experiencing homelessness.

L.A. Care is providing up to $35 million in accelerated claims payments to hospitals, and more than $21 million in advanced incentive payments for individual primary care physicians and FQHC clinics.

L.A. Care has committed grant funding of up to $550,000 to Project Angel Food. Project Angel Food provides medically tailored meals and nutritional counselling to 2,000 low-income individuals in Los Angeles County affected by life threatening illnesses each week. L.A. Care is helping Project Angel Food reduce their waiting list.

Food insecurity has long been a major deterrent to good health outcomes for low-income individuals, and the COVID-19 pandemic has exacerbated the problem. The 151 people on the Project Angel Food waiting list were part of a rush that applied for help in the wake of the COVID-19 outbreak. For a year, these clients will receive medically tailored meals based upon their personal health conditions.

L.A. Care has awarded nearly $1.5 million to 10 grantees through the Robert E. Tranquada, MD Safety Net Initiative XI. Health care centers and community clinics across Los Angeles County will receive between $100,000 and $150,000 to conduct projects that will primarily help communities of color, which have been harder hit by COVID-19.

The various projects involve combatting diabetes, hypertension, periodontal disease, and more, while tailoring their clinical services to meet COVID-19 demands. Total funding for the Tranquada Initiative is $1,425,000. In some cases, the funding will support hiring of nurses and support personnel who are members of the community they will serve. Other funding covers equipment, software, and renovations that will help the centers meets their goals.

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Magellan Health

Magellan Health is providing free access to one of its digital cognitive behavioral therapy, RESTORE®, for members who are experiencing sleep difficulty and insomnia related to the COVID-19 pandemic.

Magellan Health has expanded telehealth services to help support clients during the COVID-19 pandemic. Magellan will permit all credentialed and contracted behavioral health providers to conduct telehealth video sessions for all routine services and certain psychological testing, applied behavior analysis (ABA), intensive outpatient programs (IOP) and partial hospitalization program (PHP) services.

Magellan Health has opened a free national 24-hour crisis line for all first responders and healthcare workers who are serving on the front lines battling the coronavirus pandemic. These critical workers who call the hotline will speak directly to a certified licensed mental health clinician. The hotline is being operated by Magellan Healthcare, the behavioral and specialty healthcare segment of the company.

Magellan Health has launched a free crisis texting service for anyone who needs help during the COVID-19 crisis. Individuals can connect with a certified, licensed mental health clinician who will provide confidential mental health services. This service supports Magellan's crisis telephone hotline, offering another way to access mental health services.

Magellan's confidential mental health crisis text line is offered free-of-charge to the community to assist individuals as they try to cope with feelings of fear, sadness, anger and hopelessness. Individuals may also seek information and guidance to other available resources, such as community-based support.

Magnolia Health

Magnolia Health has partnered with the Mississippi Department of Child Protective Services to provide healthcare workers with the items they need. Magnolia Health, a MississippiCAN Medicaid health plan, has provided 500 masks to Child Protective Services workers.

Magnolia Health is providing additional mental health resources to Mississippi residents impacted by the COVID-19 pandemic. Through a series of local partnerships, Magnolia will enable providers to better support communities that are experiencing elevated levels of stress and mental strain caused by an increase in grief, loss, economic pressure, unemployment, and social isolation.

As part of this effort Magnolia, in partnership with its parent company Centene Corporation, is investing to support the following programs:

-

Provider Training and Support – Training for clinicians and support for front-line providers dealing with the COVID-19 crisis and the increase in mental health-related challenges in their practices.

- Expanding Access to Mental Health First Aid– An investment to help the National Council for Behavioral Health transition part of their training program to a virtual program, which will make MHFA training more accessible for people in Mississippi and nationwide.

Allwell from Magnolia Health has waived pre-authorizations, co-pays, and other costs related to COVID-19 testing, screening and medically necessary treatment. Allwell from Magnolia has also waived prescription refill limits, and members are able to refill prescriptions prior to their refill date during the crisis.

Effective July 1, 2020, expanded benefits will include:

- **$0 Member Liability Extension:** Allwell from Magnolia is waiving in-network member costs for all primary care visits for the rest of 2020. Allwell from Magnolia is also waiving member costs for outpatient, non-facility-based behavioral health visits and extending telehealth cost share waivers for all telehealth visits—primary care, specialty, and behavioral health—for in-network providers for the remainder of 2020. This does not include inpatient hospital, behavioral health facility, or urgent care visits. Medicare members with state benefits will continue to receive support through coordination with their states.
- **Extended Meal Benefits** –Members eligible for meal benefits due to a chronic condition or recent discharge may receive an additional 14 meals delivered to their home at no cost.
- **Increased Annual Wellness Visit Incentives** – Members may be eligible for an increased incentive for completing their annual wellness visits, a benefit offered at no cost to the member.
- **Additional Over-The-Counter (OTC) Benefits** – Plans with an OTC benefit may now receive additional allowance dollars in monthly or quarterly increments, adding up to as much as $150 for the remainder of 2020, depending on plan.
- **Access to WellCare's Community Connections Help Line** – The Community Connections Help Line – a toll-free line provided by partners at WellCare and available to anyone in need – is staffed by peer coaches and support specialists who can refer individuals and caregivers in need to a database of more than half a million social services in local communities across the country. By calling the line at 1-866-775-2192, members can also receive help coordinating of the expanded meal program benefits, OTC allowances, and annual wellness visit incentives via the line.

Beginning July 1, 2020, providers should also waive the member liability for the eligible primary and behavioral health care claims at the point of service, and forego the collection of the member cost share.

Martin's Point Health Care

Martin's Point Health Care has received the first Maine shipment of newly developed rapid COVID-19 tests. The new test offers results in minutes, rather than the days required by current tests.

Medica Health Plan

Medica Health Plan will waive co-pays, co-insurance and deductibles related to COVID-19 testing for all fully insured group, individual and Medicare members. Self-insured employers will have an opportunity to also waive fees related to the testing of COVID-19. To help limit the spread of COVID-19, Medica provides coverage for virtual care or telehealth services.

Medica has donated $1 million to Minnesota non-profits to address the health needs of the most vulnerable people in the state during the COVID-19 pandemic. Medica's funding is targeted to support key focus areas including child and family support, clinics and shelters, food security, mental health / telehealth services and general disaster relief.

Medica Health Plan is waiving copays, co-insurance, and deductibles for COVID-19 in-patient hospital care. The waiver will extend through May 31. Prior authorization will not be required for admissions to long-term care facilities, acute in-patient rehabilitation, or skilled nursing and home health care facilities. This change will extend through May 31.

Medica Health Plan is donating $200,000 to nine Nebraska non-profit organizations and community health centers that play important roles in addressing the needs of the most vulnerable people in communities statewide, especially during the coronavirus pandemic. Funding is being made available through the Medica Foundation.

The organizations include the United Way of the Midlands, the Nebraska Farm Bureau, and the Charles Drew Health Center.

Medica Health Plan is distributing more than 200,000 disposable protective masks to members who are at the greatest risk for experiencing complications related to COVID-19. Medica is also donating an additional 150,000 masks and other personal protection equipment to community organizations and its skilled nursing partners.

Medica Health Plan has waived in-person, in-network primary, specialty and behavioral care office visit copays for all Medica Advantage members for appointments completed between June 1, 2020 through September 30, 2020. Medica will continue to suspend prior authorization for admission to a post-acute care setting, also through September 30, 2020.

Medical Mutual of Ohio

Medical Mutual is waiving member cost sharing associated with COVID-19 testing and treatment.

This applies to services provided by both in-network and out-of-network providers.

For testing, this covers the cost of the test, as well as the cost of the provider visit, which could include a telehealth (telemedicine), urgent care or emergency room visit, to determine whether the COVID-19 testing is required, and the visit to administer the test. This is effective through the end of the national public health emergency declared by the U.S. Department of Health and Human Services.

Medical Mutual has extended the period during which cost sharing for all treatment related to COVID-19 will be waived to now go through July 24, 2020. Treatment includes hospitalizations and ground ambulance transfers for individuals with a positive COVID-19 diagnosis. In addition, Medical Mutual will permanently cover FDA-approved medications and vaccines when they become available.

MeridianHealth

MeridianHealth, a subsidiary of Centene, has identified four organizations serving as either Federally Qualified Health Centers and/or Community Mental Health Centers to receive $500,000 in total funding to continue their work during the COVID-19 crisis, including providing shelter or secure housing for those who have been exposed to COVID-19 and must be quarantined or those who have tested positive, but do not need hospitalization. In addition to this funding, Meridian has recently provided 100,000 protective masks to the Westside Homeless COVID-19 Response Workgroup.

MeridianHealth has donated more than 130,000 units of PPE to help protect Michigan’s first responders and essential workers on the front lines of the coronavirus (COVID-19) pandemic.

MeridianHealth is partnering with Aunt Martha’s Health and Wellness to offer COVID-19 PCR tests and antibody testing at no cost in the Chicago Heights and Kankakee communities.

HealthPartners

The HealthPartners Dental Plan will provide monetary relief to network providers as they face the cost of acquiring PPE to care for patients.

Beginning June 17th the HealthPartners Dental Plan will reimburse network providers the amount of $10 per visit through the use of the CDT code “D1999 – unspecified preventive procedure, by report” to document and report the use and cost of additional PPE.

Dentists can use this code once per patient visit/claim/day to attempt to offset the heightened cost of PPE.

MetroPlus Health Plan

MetroPlus Health Plan and Healthx have launched improved online engagement platforms for the health plan’s 545,000 members and more than 23,000 participating providers. The COVID-19 crisis has created an urgent need for increased remote engagement. The websites include strategic enhancements to the MetroPlus Health Plan’s previous websites, including secure messaging and

self-service tools like “gaps in care” alerts for members and clinical decision support powered by InterQual. The partnership between MetroPlus Health Plan and Healthx is designed to improve engagement and collaboration between members, providers, and MetroPlusHealth.

MetroPlus Health Plan has also started a new food and safety member care package initiative that will soon reach 10,000 of its members determined to be especially in need. The care packages, containing non-perishable foods and items like hand sanitizer and face masks, are particularly needed now as, due to the COVID-19 pandemic, there is an urgent need for lower income New Yorkers to safely access food and personal protective equipment.

MHS Health Wisconsin

MHS Health Wisconsin, a subsidiary of Centene, has donated $45,000 to food banks in Milwaukee, Eastern Wisconsin and Western Wisconsin.

Additionally, a partnership with Feeding America, Centene and MHS Health will coordinate a donation of 1 million meals a month for the next 12 months to feed those in Wisconsin and across the country.

MHS Wisconsin is also coordinating with Centene to purchase 500 gift cards for use on essential items. MHS Wisconsin will deliver the cards to FQHCs and a local pharmacy for distribution to individuals in need. The gift cards will have a value of $35 and can be used to purchase essential health care and educational items, including diapers, over-the-counter medicines, cleaning supplies, and books.

MHS Health has made several additional donations, including:

- $5,000 to Discovery World to support the museum’s online free, hands-on educational opportunities.
- $500 to Healthy Eats for Hospital Heroes. This organization prepares and delivers healthy meals to health care providers who are treating coronavirus patients at Froedtert Hospital in Milwaukee.
- 100 canvas bags filled with children’s supplies donated to Milwaukee Health Services Community Health Center (FQHC) for patients at their COVID-19 testing tents.
- In partnership with Log Cabin Sewing Company, MHS Health will mail 300 masks to high-risk members.

Minnesota Council of Health Plans

The Minnesota Council of Health Plans announced that Minnesota’s nonprofit health plans are enhancing support for enrollees impacted by the COVID-19 pandemic by extending cost-sharing waivers for in-patient treatment.

To the extent permitted by law, health plans are extending waivers for cost sharing for in-network COVID-19 hospitalization on fully insured, individual and group health plans until Sept. 30, 2020.

- Plans that have committed to this extension include:
    - Blue Cross and Blue Shield/Blue Plus of Minnesota
    - HealthPartners
    - Hennepin Health
    - Medica
    - PreferredOne
    - UCare

Moda Health

Alaska Moda is waiving cost sharing payments for all commercial medical members for respiratory diagnostic testing needs, including respiratory syncytial virus, influenza, and COVID-19 lab tests. This includes office visits, urgent care visits, telehealth visits, or emergency room visits when the purpose or outcome of the visit is to be tested for respiratory illness. The waiver applies to in-network and out-of-network providers, facilities, and laboratories. Oregon Moda is waiving cost sharing payments for commercial health members for COVID-19 testing needs, including:

- a telehealth visit to be evaluated for COVID-19 testing;
- a provider office visit, urgent care center visit, or emergency room visit to be tested for COVID-19;
- COVID-19 lab test for all testing facilities; and
- other testing received during a COVID-19 testing visit, when administered to determine if there is a need for COVID-19 testing.

Oregon Moda is waiving all cost sharing payments for Medicare Advantage members, including:

- a telehealth visit to be evaluated for COVID-19 testing;
- a provider office visit, urgent care center visit, or emergency room visit to be tested for COVID-19;
- COVID-19 lab tests for all testing facilities;

- and other testing received during a COVID-19 testing visit, when administered to determine if there is a need for COVID-19 testing.

Moda Health is waiving cost sharing for Oregon and Alaska Individual and Family plans and fully-insured employer groups plans for in-network medical treatment of COVID-19, both inpatient and outpatient, and FDA-approved medications administered inpatient for the treatment of COVID-19, until May 31.

Molina Healthcare

Molina Healthcare will waive all member costs associated with testing for COVID-19. Any related visit to a primary care doctor, urgent care or emergency care does not require prior authorization.

Molina Healthcare has launched a Coronavirus Chatbot, an enhanced digital tool for members seeking information about COVID-19 risk factors and their own personal risk profile. This new self-appraisal feature is available for members looking for current insight, risk factors, live help, and appropriate action to take if symptoms are present.

Molina Healthcare of New Mexico is donating a relief package that includes medical supplies for families, Indian Health Services, and 638 facilities across the Navajo Nation that are experiencing hardships as a result of the coronavirus pandemic.

The relief package includes 5,000 rapid test kits, 240 N95 masks, 200 first aid kits, cleaning supplies, and $25,000 for food supplies.

Molina Healthcare is waiving all COVID-19-related out-of-pocket expenses for its Medicare, Medicaid, and Marketplace members nationwide, following up on its previous announcement last month about waiving all member costs associated with testing for the coronavirus, which causes COVID-19.

Molina Healthcare of Ohio is committing $150,000 for the purchase of personal protective equipment, COVID-19 test kits, as well as other needed essentials to help protect providers, health care professionals, and those in need during the coronavirus pandemic.

Molina Healthcare has accelerated $150 million in payments to providers. Additionally, Molina has extended all previously approved prior authorizations until September 1, 2020. Molina has also enabled providers to be paid the same amount for servicing members via telehealth as they would have for in-person service, and has expedited credentialing to ensure providers are able to see members for any health care reason.

Molina has also provided personal protective equipment in many markets and continues efforts to seek and provide PPE where it is most needed.

Molina Healthcare of Ohio has partnered with the Make-A-Day Foundation and former Ohio State University Football Coach Urban Meyer to provide 20,000 nutritious meals to Ohioans experiencing homelessness or financial distress during the COVID-19 pandemic.

Molina Healthcare of Mississippi is committing nearly $50,000 for the purchase of personal protective equipment to help protect health care professionals and those in need during the coronavirus pandemic. Molina is aiding its provider partners most impacted by low and in some cases, depleted, PPE supply by donating more than 17,000 3-ply masks, 4,000 N95 masks, and 7,000 nitrile medical gloves. This contribution will support small clinics, federally qualified health centers, rural health clinics, and larger health systems.

Molina Healthcare of New York is donating over $38,000 to community-based organizations that are providing support and essentials during the COVID-19 crisis.

Molina Healthcare of Utah is donating $15,500 to relief efforts in the wake of COVID-19. Molina will provide funds to food banks and other community-based organizations across the state that are working to provide for the communities most in need.

Molina Healthcare of Illinois has donated $40,500 to an array of community-based organizations across the state. The grants and supply donations will help the nonprofits provide hygiene essentials, food, financial support, and other resources to help vulnerable communities during the COVID-19 pandemic.

Molina Healthcare of Texas has contributed $20,000 to the North Texas Food Bank to help replenish necessary food supplies for area residents experiencing high levels of unemployment or reduced income due to the current pandemic.

Molina Healthcare of Ohio has committed over $1.5 million to support innovative programs across Ohio. The Molina Community Innovation Fund will provide grants and sponsorships to various partners launching innovative programs designed to increase access to care, provide unique approaches to reinforce health and wellness, and support integrated care services. The funding also supports organizations helping to fill community needs around social determinants of health, which can have a lasting effect on the health outcomes of women, children, and vulnerable seniors. Through Molina's efforts with partner organizations, Ohioans will be provided with additional access to resources that support their physical and behavioral health, especially amid the COVID crisis.

Molina Healthcare of Washington has committed over $1 million in donations and relief efforts to local communities and organizations in the state as part of its comprehensive COVID-19 Community Response Plan. This initiative focuses on reducing disparities in access to care through the following: the provision of personal protective equipment (PPE) donations; telehealth support to various health care providers; and reducing food insecurity through charitable contributions to food banks and meals delivered directly to members' homes.

To increase access to telehealth services, Molina is providing more than 20 behavioral health provider organizations with technological support and resources, such as computers and cell phones. Molina is also offering cell phones and data plans to its Medicaid members who do not otherwise have the capabilities to contact their provider via virtual visits. This effort focuses primarily on smaller behavioral health organizations in rural and remote areas of the state.

MVP Health Care

MVP Health Care is making COVID-19 screening and testing free for all MVP members. Patients are not responsible for any co-payments, other cost-share, or fees associated with:

- an emergency room visit or visit to an in-network health care provider for the purpose of getting tested for COVID-19;
- drive-thru specimen collection sites; and
- telemedicine services, like MVP's myERnow virtual emergency room and myVisitNow online doctor visits.

MVP Health Care and Media Logic have launched a new website, trytelemedicinefirst.com, that serves as a directory of available telemedicine services, and can be searched by health insurance company name or by zip code – the latter of which will provide information on hospitals and providers that offer telemedicine services.

MVP Health Care, CDPHP, and Quick Response have partnered to provide the cities of Albany, Schenectady, and Troy with essential sanitation equipment to protect local first responders from COVID-19. Each city will receive two Defense Soap Cordless Electrostatic Hand or Backpack Sprayers for use by the police and fire departments. Each sprayer provides up to 23,000 square feet of disinfectant in a single tank.

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Neighborhood Health Plan of Rhode Island

Neighborhood Health Plan of Rhode Island will not require pre-authorization for COVID-19 testing and they will cover the cost if a doctor believes a patient needs testing and the patient meets testing guidelines from the CDC. There will be no cost sharing for those patients.

Neighborhood Health Plan of Rhode Island is waiving requirements for health care providers to seek prior authorizations for all behavioral health and all inpatient medical services regardless of whether they are COVID-19 related or not.

Neighborhood is also waiving prior authorizations and all members' out-of-pocket fees for treatment related to COVID-19, including copays, deductibles and co-insurance.

Northeast Delta Dental

Northeast Delta Dental will provide relief totaling $18.8 million in returned and reduced premiums to individual and group customers by: extending rate holds for fully insured individual and group customers renewing July through December, 2020; crediting all fully insured individual and group customers with a one-month dental premium in July based on June's billed amount; and crediting all self-insured group customers for the July administrative fee. It will help the producers and consultants who market its dental insurance by providing relief payments totaling $700,000 for the premium/administrative credit period based on commissions paid for the previous month.

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'Ohana Health Plan

'Ohana Health Plan has donated 26,000 units of personal protection equipment to the Hawaii Hospital Education and Research Foundation to help protect providers across Hawaii during the novel coronavirus (COVID-19) pandemic.

Oscar

Oscar will waive cost-sharing for the treatment of COVID-19 for its Individual and Small Group members through July 31, 2020. If you're treated at an out-of-network facility, we'll also waive the cost through July 31, 2020, as long as you've gotten prior-authorization.

Oscar is waiving cost-sharing for diagnostic testing for COVID-19, including the cost of the test and administration of the test, at both in-network and out-of-network facilities when recommended by a health care provider.

Oscar is offering telemedicine services at no cost to most members through its Doctor on Call service.

Oscar has also launched the first testing center locator for COVID-19 in the United States. It is free and accessible to the general public, and it is being updated daily to reflect both in-network and out-of-network facilities in the 29 markets that Oscar operates in. The tool builds on its at-home risk assessment survey.

Oscar and Uno Health are partnering to help Oscar Medicare Advantage members unlock financial assistance, providing critical relief during the COVID-19 pandemic. Uno has helped Oscar Medicare Advantage members achieve **an average financial assistance of more than $5,000 per member.**

30-50% of Medicare members are eligible for financial assistance through government programs, but have not enrolled in them – often because they don't know they exist or how to navigate complex signup processes.

Oscar and Uno are helping more Medicare Advantage members tap into this government support.

Oscar will waive cost-sharing for the treatment of COVID-19 for its Individual and Small Group members through July 31, 2020. If you're treated at an out-of-network facility, Oscar also will waive the cost through July 31, 2020, as long as the patient has received prior-authorization.

Optima Health

Optima Health is extending coverage for treatment of COVID-19 to June 30.

Effective now through June 30, Optima Health is providing the following benefits at no cost to members (i.e. no member co-pays or cost-share) for in-network providers and labs for its fully insured Commercial, Medicare Advantage, and Medicaid plans, as well as participating self-funded groups:

- All telehealth visits, including telephone only, with any in-network care provider
- Any necessary in-network or emergent out-of-network treatment of COVID-19

In accordance with the CARES Act, out-of-pocket member costs will be covered for medical care and testing provided to our members who see a health care provider, in-person or via-telehealth technology, when they suspect they are suffering from COVID-19 through the duration of the pandemic.

In order to help remove barriers to care and provide safe options for its members, Optima Health is covering the following through July 31, 2020:

- All telehealth visits, including telephone only, with any in-network care provider
- Any necessary in-network or emergent out-of-network treatment of COVID-19

Pre-authorization requirements for out-of-network services will be waived as appropriate for Medicaid members. For all other members, if they choose an out-of-network provider, the existing out-of-network benefits and costs will remain in place.

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PacificSource

PacificSource is waiving out-of-pocket costs for COVID-19 testing and diagnosis-related office visits, urgent care visits, telemedicine visits, ER visits, testing and radiology if billed with one of the COVID DX codes. PacificSource providers are instructed to not collect copay/coinsurance or deductibles for visiting and testing.

PacificSource is also increasing access to prescription medications by waiving early medication refill

limits on 30-day prescription maintenance medications, consistent with a member's benefit plan.

PacificSource is waiving all out-of-pocket costs for coronavirus (COVID-19) testing, diagnosis and treatment for its fully insured commercial, Medicare Advantage, and health savings accounts members. This waiver will apply to those members who have received or will receive care between Jan. 31 through June 30, 2020, regardless of place of care. The organization's self-funded businesses will have the option to adopt these provisions.

Passport Health Plan

Passport Health Plan will not charge any copays for COVID-19 screening and testing. This includes: Any related hospital emergency visit, urgent care visit, provider office visit, lab testing, telehealth, and immunizations (shots). Passport also will not require any prior authorizations.

Passport Health Plan is providing Medicaid members with virtual recovery support services for substance use disorders during the COVID-19 pandemic.

Peach State Health Plan

Peach State Health Plan is collaborating with Quest Diagnostics to increase access to real-time reverse transcription polymerase chain reaction (rRT-PCR) COVID-19 testing in critical areas of need Georgia. Through this collaboration, Peach State Health Plan will facilitate the distribution of approximately 1,000 Quest COVID-19 test kits each week to Federally Qualified Health Centers, including The Family Health Centers of Georgia, and Curtis V. Cooper Primary Health Care. The FQHCs will conduct testing as part of a broader initiative to test persons who are symptomatic and asymptomatic in underserved communities.

Physicians Health Plan of Northern Indiana

Physicians Health Plan of Northern Indiana is covering the cost of the COVID-19 screening test for members at no out-of-pocket expense. PHP will waive co-pays, co-insurance, deductibles, and prior authorization, when the test is medically necessary, for members of its fully insured health plans.

PHP will cover the COVID-19 test and the visit where the test takes place at 100%, with no deductible, copay, or coinsurance. If a patient is diagnosed with COVID-19, PHP benefit plans coverage applies to treatment.

This applies to all play types, including self-funded plans. Employers may not opt-out.

PreferredOne

PreferredOne will cover medically necessary COVID-19 laboratory testing without cost sharing for fully insured employer group and individual plan members. The tests will be available without prior authorization. PreferredOne is working with self-insured clients on their approaches.

PreferredOne is waiving cost-sharing for in-network COVID-19 hospitalization for fully-insured employer and individual plan members effective March 1st through May 31st, 2020.

PreferredOne is extending cost-sharing waivers for in-network COVID-19 hospitalization for fully-insured employer and individual plan members through September 30, 2020. Previously, the waivers were set to last through May 31, 2020.

Premera Blue Cross

Premera Blue Cross has expanded telehealth services to its members in response to the unprecedented demand for virtual care ignited by the COVID-19 pandemic. The company has signed agreements with 98point6 and Doctor On Demand to deliver text- and video-based virtual care to nearly all 2.3 million Premera and LifeWise Health Plan of Washington members for at least 90 days.

Premera Blue Cross is waiving consumer cost shares and deductibles for treatment related to COVID-19 services for all fully insured, Medicare and individual market customers through Oct. 1, 2020.

Premera Blue Cross is providing up to $100 million in financial support in the form of advance payments of claims to medical, dental and behavioral health providers facing significant financial pressures due to the COVID-19 pandemic.

Thousands of primary care providers, specialists, behavioral health providers and dentists in Washington state and Alaska could be eligible for the program. These funds will be recouped by Premera as a percentage of claims over the course of nine months beginning Jan. 1, 2021.

Premera Blue Cross has expanded its zero cost share options for virtual mental health care and substance use disorder treatment in response to the unprecedented demand for virtual care during the COVID-19 pandemic.

Premera has signed provider agreements with Doctor On Demand, Boulder Care and Workit Health to deliver video-based mental health care and substance use disorder treatment to nearly all 2.3 million Premera Blue Cross, Premera Blue Cross and Blue Shield of Alaska, and LifeWise Health Plan of Washington customers through at least June 30.

Premera Blue Cross announced that more than 200,000 of its commercial and individual customers across Washington and Alaska will receive up to $65 million in premium relief funds and premium rebates over the coming months.

Premera is committing up to $25 million to provide premium relief for small and large group commercial customers, many of whom have been particularly hard hit by the economic crisis in the wake of the COVID-19 pandemic. These employers can expect to see premium relief applied to their August billing cycle.

In addition, Premera is working to accelerate nearly $40 million in rebates required under the Affordable Care Act to Washington and Alaska customers who purchased their insurance in the individual market due to a requirement under the Affordable Care Act.

Premera Blue Cross is launching its first-ever virtual primary care plan. Called Premera NOW, the new product leverages digital solutions to help customers access care easily and affordably without leaving the comfort of their home. Washington-state employers can purchase the product now for availability October 1, 2020.

Designed with 98point6, the Premera NOW health plan will offer access to a 98point6 virtual provider at any time across the country at a $0 copay.

Priority Health

Priority Health is expanding its existing $0 copay telehealth to include all lines of business through April 30. All of the company's nearly 1 million members across commercial, individual, Medicaid and Medicare plans will now have virtual access to medical professionals for non-emergency care, at no additional cost.

Priority Health has added an Employer Decision Guide that outlines options for helping employees maintain health coverage, along with a new COVID-19 screening bot that helps the user determine their risk level and offers resources based on their individual result.

Priority Health has also expanded access to home medication deliveries. Members can take advantage of free home delivery options offered by national retailers Meijer, Walgreens and CVS, as well as their own local pharmacies that offer this service.

Priority Health is waiving all copays, deductibles and coinsurance for the treatment of COVID-19 through June 30. This means that all of the company's nearly one million members across Commercial, Individual, Medicaid and Medicare plans can get the testing and treatment they need for COVID-19 with no out-of-pocket health insurance costs. Covered treatment may be inpatient or outpatient from an in-network provider. Self-funded employer groups are also included unless they choose to opt-out.

Priority Health has created an affordable new option to help those who have lost their employer-based health benefits due to COVID-19. By combining a short-term plan, to bridge any coverage gap, with a special enrollment in an individual ACA plan, consumers can safely move from their employer-sponsored coverage to a new plan without the risk of going uninsured during the ongoing outbreak.

Priority Health is also offering a deductible credit to all new individual members transitioning from an employer group plan.

Priority Health has partnered with digital health specialist Livongo to offer free access to its members to myStrength, a mental wellness tool with activities to manage stress and bolster mental health.

Priority Health will provide financial support to members and employers facing challenges amid the ongoing COVID-19 crisis. Due to lowered utilization of health services, as well as efforts to keep administrative costs low, the company plans to offer premium credits and waive cost sharing for its most heavily impacted populations. Priority Health plans to return any revenue above the company's low, ten percent administrative rate back to employers and members.

Priority Health and Papa are enlisting college students to provide essential services and companionship to the most vulnerable during the COVID-19 crisis.

Papa connects college students to Medicare members with specific chronic conditions who need assistance with transportation, house chores, technology lessons, companionship, and other senior services. As COVID-19 has isolated seniors in a way the nation has never experienced before, Papa Pals provide a variety of services to help members including:

- Helping sign up for and use technology services including telehealth.
- Virtual hangouts to socialize.
- Pick-up and delivery of pharmacy refills and food.
- Identifying and preventing COVID-19 email and phone scams.
- Transporting members to necessary medical appointments.
- Cleaning and sterilizing frequently touched surfaces inducing mailboxes and doorknobs.

Prominence Health Plan

Prominence Health Plan is providing members telehealth services through Teladoc with zero-dollar copays.

Providence Health Plan

Providence Health Plan is waiving all cost sharing for testing services related to COVID-19, such as copays, coinsurance, and deductibles.

Providence Health Plan is waiving cost sharing for COVID-19 treatment for service dates beginning April 1 through May 31, 2020. This applies to in-network inpatient, outpatient, facility and professional visits. This change is applicable for all members on an individual and family plan, small group fully insured plan and large group fully insured plan.

Providence Health Plan is proactively taking action to ensure continuity of coverage – so members can continue to receive care and medications during this time of uncertainty.

- If an employer group has furloughed or laid off employees, Providence will continue to cover those employees contingent on payment of premium by the employer. This means that normal

minimum hour requirements will be waived. COBRA may be an option for some of those employees, but this "premium continuation" approach may provide additional stability in the event employers are willing to participate in hopes that they may be able to resume business in the near term.

- People who purchase individual plans through the federal marketplace and who receive an advance premium tax credit will continue to receive a 90-day grace period, established by federal law that we will continue to follow without adjustment.
- Providence will grant a 30-day extension for the following people that are unable to pay some or all of their premium:
  - People who purchase individual plans through the federal marketplace and who *do not* receive an advance premium tax credit
  - People who purchase individual plans direct (not through the federal marketplace)
  - Fully-insured employer group plans (small and large)

Providence Health Plans is waiving cost sharing for commercial insured members for COVID-19 treatments for in-network inpatient, outpatient, facility, and professional visits.

Providence is taking the initiative to help ensure healthcare workers have the necessary personal protective equipment (PPE), and to provide vulnerable populations with soap and disinfectant to help

Providence expanded its health plan premium payment grace period for commercial groups so members can continue to receive care and medications during this time of uncertainty. Providence is also allowing commercial groups to maintain coverage for their furloughed employees at the group premium rate.

Providence has waived all cost sharing for testing services related to COVID-19, such as copays, coinsurance, and deductibles.

Providence significantly expanded telehealth provider policies to reduce barriers to care and to encourage the use of telehealth services by members and provider partners. Providence has also added virtual capacity so that more providers can be seen quickly.

Providence's clinical pharmacists are monitoring the supply chain to anticipate and address any potential drug shortages, and are promoting 90-day supply of maintenance medications, early refills when appropriate, and mail delivery to support staying at home as well as extending prior authorization approval dates up to 90 days to enhance access to medication when appropriate.

Providence quickly developed and implemented a coronavirus assessment tool to help communities assess their symptoms in real time.

Providence's labs began testing for coronavirus early on, becoming the first hospital system in the

state to offer in-house lab analysis and increasing the community's testing capacity.

Providence Health Plans has extended the waiver for all member cost sharing for COVID-19 treatment until June 30. This applies to in-network inpatient, outpatient, facility and professional visits. This change is applicable for all members on an individual and family plan, small group fully insured plan and large group fully insured plan.

Providence Health Plan has extended the waiver for all cost sharing payments for COVID-19 treatment through Aug. 31, 2020.

Piedmont Community Health Plan

Piedmont Community Health Plan will waive out-of-pocket costs for COVID-19 testing, and is not requiring prior authorization for diagnostic services related to these tests. It is also waiving out-of-pocket costs for telehealth services, and is permitting online mental health counseling for all members at in-network providers. For members, CVS Caremark is waiving early refill limits on 30-day prescription medications, and CVS Pharmacy is waiving charges for home delivery where it's available. This applies to its commercial fully insured and exchange plan members.

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QualChoice Health Insurance

QualChoice Health Insurance will cover COVID-19 testing without any copay, cost sharing, or pre-authorization.

There is also no cost sharing for telehealth services, and no prior authorization is required through June 30.

QualChoice Health Insurance in partnership with its parent company Centene Corporation, will be purchasing Walmart gift cards for distribution to Arkansans in need to use on essential items. QualChoice will deliver the cards to local providers and other community resources for distribution to individuals in need. The Walmart gift cards will have a value of $35 and can be used to purchase essential healthcare and educational items, including diapers, over-the-counter medicines, cleaning supplies and books.

QualChoice is also providing additional resources to communities across Arkansas. Through partnerships with local organizations such as the Arkansas Food Bank, Healthy Connections, Hoover Treatment Center, Lucie's Place and others, QualChoice is working to provide food and essential resources to those who need it most.

Quartz Health Solutions

Quartz has waived out-of-pocket costs for testing related to COVID-19. Office visits and services associated with testing for COVID-19 will be covered with no out-of-pocket costs.

Quartz is offering telehealth, video visits, virtual visits, and e-visits with Quartz providers with no out-of-pocket costs. These benefit enhancements are being offered through July 31, 2020 and apply to Quartz's Commercial lines of business and members enrolled in a HDHP or HSA plan. Note: Self-insured plan sponsors may opt-in to these enhancements at their discretion.

Quartz has waived cost-sharing for inpatient hospitalizations at all in-network facilities for treatment related to COVID-19. This benefit enhancement is being offered through July 31, 2020 and applies to Quartz's Commercial lines of business. These services are also covered for both in and out-of-network providers for Quartz Medicare Advantage members as directed by CMS through the Public Health emergency.

Quartz is allowing earlier access to prescription drugs. For non-maintenance prescriptions, members can refill prescriptions 22 days before they should be needed based on the date of their last claim. For maintenance prescriptions eligible for a 90-day supply, members can refill prescriptions 30 days before they should be needed based on the date of their last claim. These benefit enhancements are being offered until further notice and apply to Quartz's Commercial lines of business. Quartz's Medicare Advantage members also have access to early refills, without limits, through the duration of the public health emergency.

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Regence BlueShield of Idaho

Regence BlueShield of Idaho will cover the cost of coronavirus testing without any out-of-pocket costs for fully insured members. Regence is working with federal officials to ensure coordination of benefits for Medicare members and those with health savings accounts (HSA). Regence is also easing access through virtual care, as well as access to regularly prescribed medications.

Regence BlueShield of Idaho will cover treatment for coronavirus (COVID-19) without any out-of-pocket costs for fully insured members through June 30, 2020.

Regence is offering health plan members free access to COVID-19 and mental wellness resources powered by myStrength, a digital behavioral health app, through the end of the year.

MyStrength from Livongo for Behavioral Health provides interactive, activity-based modules designed to manage heightened stress and feelings of social isolation stemming from the current COVID-19 crisis. Through year-end, Regence's fully-insured and self-funded members will have complementary access to myStrength's COVID-19 and Mental Wellness resources, which include stress-management strategies, tips for parenting during challenging times, ideas to manage feelings of social isolation, and other emotional support tools.

Regence BlueShield of Idaho's telehealth claims are up 4900 percent during the COVID-19 crisis. In January, Regence saw an average of 1,000 telehealth visits a week. In May, that average was more than 50,000 visits a week. Primary and specialty care are making up half of all telehealth utilization for Regence members, up from about 20% in January.

Members across Regence's four-state region who received behavioral health care before the COVID-19 crisis successfully switched to virtual care options to ensure their continued care from the earliest days of physical distancing. This included 87% of members in Washington, 85% in Oregon, 85% in Idaho, and 82% in Utah, averaging to 85% across the four states.

Regence has also extended coverage for coronavirus (COVID-19) treatment without any out-of-pocket costs for fully insured members through December 31, 2020.

In addition, Regence will continue paying providers for virtual care services at the same rate as in-person visits through September 2020 to help ease member access and support providers experiencing financial challenges. Diagnostic testing also remains covered at no cost to members.

Regence BlueCross BlueShield of Oregon

Regence BlueCross BlueShield of Oregon is covering COVID-19 testing at no cost, easing access to virtual care, easing access to regular prescription drugs, and proactively reaching out to high-risk members.

Regence BlueCross BlueShield of Oregon will cover treatment for coronavirus (COVID-19) without any out-of-pocket costs for fully insured members through June 30, 2020.

Regence is offering health plan members free access to COVID-19 and mental wellness resources powered by myStrength, a digital behavioral health app, through the end of the year.

MyStrength from Livongo for Behavioral Health provides interactive, activity-based modules designed to manage heightened stress and feelings of social isolation stemming from the current COVID-19 crisis. Through year-end, Regence's fully-insured and self-funded members will have complementary access to myStrength's COVID-19 and Mental Wellness resources, which include stress-management strategies, tips for parenting during challenging times, ideas to manage feelings of social isolation, and other emotional support tools.

Regence BlueCross BlueShield of Oregon's telehealth claims are up 4900 percent during the COVID-19 crisis. In January, Regence saw an average of 1,000 telehealth visits a week. In May, that average was more than 50,000 visits a week. Primary and specialty care are making up half of all telehealth utilization for Regence members, up from about 20% in January.

Members across Regence's four-state region who received behavioral health care before the COVID-19 crisis successfully switched to virtual care options to ensure their continued care from the earliest days of physical distancing. This included 87% of members in Washington, 85% in Oregon, 85% in Idaho, and 82% in Utah, averaging to 85% across the four states.

Regence has also extended coverage for coronavirus (COVID-19) treatment without any out-of-pocket costs for fully insured members through December 31, 2020.

In addition, Regence will continue paying providers for virtual care services at the same rate as in-person visits through September 2020 to help ease member access and support providers experiencing financial challenges. Diagnostic testing also remains covered at no cost to members.

Regence BlueCross BlueShield of Utah

Regence BlueCross BlueShield of Utah will cover the cost of coronavirus testing without any out-of-pocket costs for fully insured members. Regence is working with federal officials to ensure coordination of benefits for Medicare members and those with health savings accounts (HSA). Regence is also easing access through virtual care, as well as access to regularly prescribed medications.

Regence BlueCross BlueShield of Utah will cover treatment for coronavirus (COVID-19) without any out-of-pocket costs for fully insured members through June 30, 2020.

Regence is offering health plan members free access to COVID-19 and mental wellness resources powered by myStrength, a digital behavioral health app, through the end of the year.

MyStrength from Livongo for Behavioral Health provides interactive, activity-based modules designed to manage heightened stress and feelings of social isolation stemming from the current COVID-19 crisis. Through year-end, Regence's fully-insured and self-funded members will have complementary access to myStrength's COVID-19 and Mental Wellness resources, which include stress-management strategies, tips for parenting during challenging times, ideas to manage feelings of social isolation, and other emotional support tools.

Regence BlueCross BlueShield of Utah's telehealth claims are up 4900 percent during the COVID-19 crisis. In January, Regence saw an average of 1,000 telehealth visits a week. In May, that average was more than 50,000 visits a week. Primary and specialty care are making up half of all telehealth utilization for Regence members, up from about 20% in January.

Members across Regence's four-state region who received behavioral health care before the COVID-19 crisis successfully switched to virtual care options to ensure their continued care from the earliest days of physical distancing. This included 87% of members in Washington, 85% in Oregon, 85% in Idaho, and 82% in Utah, averaging to 85% across the four states.

Regence has also extended coverage for coronavirus (COVID-19) treatment without any out-of-pocket costs for fully insured members through December 31, 2020.

In addition, Regence will continue paying providers for virtual care services at the same rate as in-person visits through September 2020 to help ease member access and support providers experiencing financial challenges. Diagnostic testing also remains covered at no cost to members.

Regence BlueShield of Washington

Regence BlueShield of Washington is covering COVID-19 testing at no cost, easing access to virtual care, easing access to regular prescription drugs, and proactively reaching out to high-risk members.

Regence BlueShield of Washington will cover treatment for coronavirus (COVID-19) without any out-of-pocket costs for fully insured members through June 30, 2020.

Regence is offering health plan members free access to COVID-19 and mental wellness resources powered by myStrength, a digital behavioral health app, through the end of the year.

MyStrength from Livongo for Behavioral Health provides interactive, activity-based modules designed to manage heightened stress and feelings of social isolation stemming from the current COVID-19 crisis. Through year-end, Regence's fully-insured and self-funded members will have complementary access to myStrength's COVID-19 and Mental Wellness resources, which include stress-management strategies, tips for parenting during challenging times, ideas to manage feelings of social isolation, and other emotional support tools.

Regence BlueShield of Washington's telehealth claims are up 4900 percent during the COVID-19 crisis. In January, Regence saw an average of 1,000 telehealth visits a week. In May, that average was more than 50,000 visits a week. Primary and specialty care are making up half of all telehealth utilization for Regence members, up from about 20% in January.

Members across Regence's four-state region who received behavioral health care before the COVID-19 crisis successfully switched to virtual care options to ensure their continued care from the earliest days of physical distancing. This included 87% of members in Washington, 85% in Oregon, 85% in Idaho, and 82% in Utah, averaging to 85% across the four states.

Regence has also extended coverage for coronavirus (COVID-19) treatment without any out-of-pocket costs for fully insured members through December 31, 2020.

In addition, Regence will continue paying providers for virtual care services at the same rate as in-person visits through September 2020 to help ease member access and support providers experiencing financial challenges. Diagnostic testing also remains covered at no cost to members.

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Sanford Health Plan

Sanford Health Plan will cover 100% of the cost of specimen collection and testing for COVID-19. Testing is covered when indicated as medically necessary by a qualified practitioner. Sanford will also cover office visits and ER visits at 100% when related to COVID-19 testing. Sanford Health Plan is also extending prior authorizations an extra 90 days for all existing maintenance prescriptions with prior authorizations that will expire in 90 days or fewer.

Sanford Health Plan has deployed a test for COVID-19 that can deliver results within 90 minutes. These rapid tests will be used for the highest priority patients, including those who are hospitalized, health care workers and elderly adults living in long-term care facilities, and are available in Sioux Falls, South Dakota, and Fargo, North Dakota.

SCAN Health Plan

SCAN Health Plan has provided $200,000 in emergency funding for nonprofits to help them respond to demand for their services due to the COVID-19 pandemic. SCAN has also adapted many of their community services from in-person to telephonic, including clinical programs for seniors and caregivers and many volunteer efforts.

SCAN Health Plan is supporting California Governor Gavin Newsom's "Stay Home. Save Lives. Check In." campaign, which is aimed at combatting social isolation and food insecurity among those 65 and older.

SCAN has launched an employee "all hands" effort, proactively calling members to make sure they have what they need to stay healthy at home, focusing first on those who are:

- High-risk, such as those on oxygen or who are homebound
- Socially isolated, because they live alone or don't have a support system

SCAN is also providing emergency funding for nonprofits serving seniors, including, to date, an additional $330,000 to 14 organizations—most of which are delivering meals and other necessary supplies.

SCAN Health Plan is committing $5.1 million to address a variety of needs for vulnerable seniors and others at risk due to the effects of the COVID-19 pandemic.

The emergency funding will address:

- Delivery of additional services to seniors in need of nutritious meals and other essential supplies;
- Additional financial support to non-profit, senior-focused organizations and provider groups in addition to the nearly $350,000 in COVID-19-related funding SCAN has already provided to such groups; and
- Assistance for SCAN employees most impacted by current circumstances.

Sendero Health Plans

Sendero Health Plans has waived all costs to its members for treatment of COVID-19 with in-network providers. Sendero has also waived copayments for in-network doctor visits and lab costs to screen for the disease.

Sentara Healthcare

Sentara Healthcare has started providing drive-thru screening and testing at three locations for those who are concerned they may have coronavirus (COVID-19).

Sentara Healthcare is partnering with local health departments, Urban League and NAACP chapters, community organizations and faith groups to provide free coronavirus testing in minority communities Sentara serves across Virginia and in northeast North Carolina. These may include African-American and Hispanic neighborhoods, LGBTQ persons, homeless persons and others without ready access to testing.

Sharp Health Plan

Sharp Health Plan will waive the cost-share for all medically necessary screening and testing for COVID-19. This includes hospital (including emergency department), urgent care, provider office visits, and telehealth appointments for the purpose of screening and/or testing for coronavirus.

Sharp Health Plan has also waived out-of-pocket costs for all COVID-19 treatment received Apr. 1 through May 31, 2020 for members diagnosed with COVID-19.

Sharp Health Plan has extended its waiver for out-of-pocket costs for all COVID-19 diagnostic treatment through September 30, 2020.

SummaCare

SummaCare is waiving any co-pays and deductibles related to provider-ordered testing of COVID-19 for Medicare Advantage, Individual and Commercial members regardless of where the test is ordered and performed. Self-insured plans will determine how their coverage will apply.

Superior HealthPlan

Superior Healthplan is contributing a total of $100,000 to 9 organizations that support the disability community affected by the COVID-19 crisis. This includes funding to 6 organizations that will establish a Hygiene Closet to improve the health and well-being of the individuals they serve. These closets will be stocked with a variety of items, including personal protective equipment, toiletries, laundry baskets and detergents, and other items that can support people who have disabilities.

Superior HealthPlan is providing additional mental health resources to Texas residents impacted by the COVID-19 crisis. Through a series of partnerships, Superior will enable providers to better support communities that are experiencing elevated levels of stress caused by an increase in grief, loss, economic pressure, unemployment or social isolation.

As part of this effort, Superior is taking the following steps:

- Collaborating, in partnership with its parent company Centene Corporation, the Allegheny Health Network, and the CARES Institute at Rowan University to fund virtual Trauma-Focused Cognitive Behavioral Therapy training cohorts. This is an evidence-based treatment for providers for the impact of traumatic experience on child and adolescent mental health.
- Donating to the National Council for Behavioral Health's COVID-19 Relief Fund, specifically for the provision of Mental Health First Aid, ensuring a long-term impact beyond the current pandemic. MHFA teaches people to identify, understand and respond to someone who might be experiencing a mental health crisis, such as suicidal thinking or misusing substances. Superior's support will provide greater access to MHFA virtual trainings, helping more individuals support someone experiencing mental health and substance use challenges at this critical time.

Superior HealthPlan will cover the cost of medically necessary COVID-19 tests, screenings, associated physician's visit(s) and/or treatment for most members when medically necessary diagnostic testing, medical screening services and/or treatment is ordered and/or referred by a licensed health care provider. If applicable, your plan's copayment, coinsurance and/or deductible cost-sharing will be waived for medically necessary COVID-19 diagnostic testing, medical screening services and/or treatment.

Superior will not require prior authorization, prior certification, prior notification and/or step therapy protocols for medically necessary COVID-19 diagnostic testing, medical screening services, and/or treatment when medically necessary services are ordered and/or referred by a licensed health care provider.

Any medically necessary treatment related to COVID-19 would be considered a covered benefit.

Superior HealthPlan will cover the cost of medically necessary COVID-19 tests, screenings, associated physician's visit(s) and/or treatment for most members. If applicable, copayment, coinsurance and/or deductible cost-sharing will be waived for medically necessary COVID-19 diagnostic testing, medical screening services and/or treatment.

Superior will not require prior authorization, prior certification, prior notification and/or step therapy protocols for medically necessary COVID-19 diagnostic testing, medical screening services, and/or treatment when medically necessary services are ordered and/or referred by a licensed health care provider. Any medically necessary treatment related to COVID-19 would be considered a covered benefit.

Sutter Health Plan

Sutter Health Plus will waive the cost share for covered services related to screening and testing for COVID-19.

Sutter Health Plus will waive the cost-share for covered services related to COVID-19 treatment from February through the end of September 2020. This includes, but is not limited to, PCP office visits, urgent care visits, emergency department visits, inpatient hospital stays, telehealth visits, and lab tests. Members are responsible for the appropriate cost-shares for outpatient prescription drugs.

Sutter Health Plus will waive the cost-share for telehealth visits for covered services from April through the end of December 2020.

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TakeCare

TakeCare is providing coverage for the COVID-19 test and associated visit under the preventive care benefit, at no cost to members, when using in-network providers provided these tests and visits are not covered by the Public Health System. TakeCare is also allowing for early medication refills for an additional 30 days for members who meet criteria.

The Blue Cross and Blue Shield Federal Employee Program

The Blue Cross and Blue Shield Federal Employee Program will waive any copays or deductibles for medically necessary diagnostic tests or treatment if a member is diagnosed with COVID-19. It will waive prior authorization requirements for tests and treatment. It will eliminate cost sharing for prescriptions for up to a 14-day supply, and waive copays for telehealth services related to COVID-19.

The Health Plan

The Health Plan will cover the cost of copays, co-insurance and deductibles for COVID-19 testing for Commercial, Medicare and Medicaid members when recommended by a medical professional.

The Health Plan is also waiving cost sharing where applicable for telemedicine visits for the next 90 days.

Trillium Health Plan

Trillium Health Plan will cover the cost of COVID-19 tests and the associated physician's visit when medically necessary diagnostic testing or medical screening services are ordered and/or referred by a licensed health care provider. If applicable, your plan's copayment, coinsurance and/or deductible cost-sharing will be waived for medically necessary COVID-19 diagnostic testing and/or medical screening services.

Tufts Health Plan Foundation

Tufts Health Plan Foundation is donating $1 million to efforts driven by community and nonprofit organizations supporting older people affected by the coronavirus outbreak in Massachusetts, Rhode Island, New Hampshire and Connecticut.

Tufts Health Plan is waiving treatment costs for its members suffering from the coronavirus, including copays, deductibles and coinsurance. This coverage applies at in-network providers, urgent care centers, emergency rooms and other facilities, and at out-of-network providers in the event a member cannot easily find an in-network provider to provide timely services.

Tufts has also eliminated out-of-pocket costs for telehealth visits and removed prior authorization requirements for providers as it relates to treatment and care of coronavirus.

Tufts Health Plan Foundation is providing funding to 18 additional nonprofit organizations as part of the $1 million it has committed to support community efforts on behalf of older people affected by the coronavirus. This second wave of funding, totaling $345,000, focuses on housing and equity efforts in Massachusetts, Rhode Island, New Hampshire and Connecticut.

The organizations include housing providers, those working with people experiencing homelessness and immigrant communities, and several serving as hubs for collaborative regional responses.

Tufts Health Plan Foundation has made grants to five diverse community organizations to help them address the COVID-19 crisis. The organization range from helping the homeless to supporting veterans and LGBTQ+ youths. Each organization will receive $10,000.

Tufts Health Plan has launched an Employee Relief Fund to support employees who have been affected by the coronavirus pandemic and are experiencing financial hardship, including the loss of a job by someone in their household. Eligible employees can apply for $1,000 grants to cover essential living expenses, such as rent or mortgage, utilities and certain medical costs.

Tufts Health Plan Foundation announced $170,000 in grants to 10 nonprofit organizations, part of the $1 million it committed to support community efforts addressing coronavirus in Massachusetts, Rhode Island, New Hampshire and Connecticut. In total, 49 organizations on the front lines of the pandemic have received funding.

This funding goes to organizations working to improve access to food and respond to inequities in housing and services. It bolsters collaborative regional responses, particularly in communities reporting the highest rates of COVID-19 infection.

Tufts Health Plan Foundation board has approved an additional $900,000 to support recovery and rebuilding efforts addressing the effects of the coronavirus pandemic in Massachusetts, Rhode Island, New Hampshire and Connecticut. The Foundation's commitment to COVID-19 response now reaches nearly $2 million.

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UCare

UCare will waive all copays, coinsurance or deductibles for doctor-ordered COVID-19 testing in all of its plans. UCare is also covering copays, coinsurance or deductibles for medically necessary clinic and urgent care services received at the visit when a COVID-19 test is administered at an in-network clinic, and at out-of-network clinics if in-network alternatives are not available.

UCare is covering coinsurance, copays, and deductibles for members who receive in-network hospital services to treat COVID-19 through May 31, 2020. UCare will continue to track the situation and determine whether to extend this coverage beyond May 31.

The UCare Foundation is providing $500,000 in short-and long-term assistance to benefit Minnesotans impacted by COVID-19. The funds support needs related to social isolation, telehealth, food insecurity and personal protective equipment. The UCare Foundation is a community-directed initiative focused on supporting innovative services, education, community outreach, and research that improve health.

UCare is reducing member premium payments by 20% in July and August of 2020.

UCare is also:

- Removing copays for Medicare primary care and mental health clinic services – including telehealth – during the COVID-19 public health emergency
- Continuing to waive copays, coinsurance and deductibles for COVID-19 tests and associated clinic, urgent care and emergency room visits
- Continuing to waive copays, coinsurance, deductibles for COVID-19 inpatient hospitalizations through September 2020
- Supplying health care providers, group homes, nursing homes, assisted living facilities, social service organizations and vulnerable members with telehealth home kits, masks, healthy snack boxes and iPads
- Offering $25,000 grants to small provider groups and community clinics to build infrastructure during COVID-19

UniCare Health Plan of West Virginia

UniCare Health Plan of West Virginia and its Foundation announced $134,000 in grants to community-based organizations to support health care workers and first responders, access to food and shelter for the homeless, and other vital community needs and resources.

The grants are being provided to several community-based organizations in West Virginia, and are part of UniCare Health Plan of West Virginia and its Foundation's commitment to the whole health of individuals and families.

These efforts are part of UniCare's coordinated response to COVID-19 for members, local community organizations, health care workers, and frontline responders. UniCare Health Plan has also provided ongoing member support for those that may have an increased need during this crisis, including those high-risk members impacted by immunosuppression, chronic conditions, or social isolation. These virtual check-ins assess if members need assistance addressing areas such as medical attention, telehealth access, medications, food insecurity, or isolation.

UnitedHealthcare

UnitedHealthcare is waiving costs for COVID-19 testing provided at approved locations in accordance with the CDC guidelines, as well as waiving copays, coinsurance and deductibles for visits associated with COVID-19 testing, whether the care is received in a physician's office, an urgent care center or an emergency department. This coverage applies to Medicare Advantage and Medicaid members as well as commercial members. United is also expanding provider telehealth access and waiving member cost sharing for COVID-19 testing-related visits.

UnitedHealthcare is also opening a special enrollment period for some of its existing commercial customers beginning March 23 through April 6 due to the COVID-19 pandemic. UnitedHealthcare is also suspending prior authorization requirements to a post-acute care setting through May 31, and suspending them when a member transfers to a new provider through May 31.

UnitedHealthcare is waiving member cost sharing for the treatment of COVID-19 through May 31, 2020 for its fully insured commercial, Medicare Advantage, and Medicaid plans.

Starting March 31, 2020 until June 18, 2020, UnitedHealth will also waive cost sharing for in-network, non-COVID-19 telehealth visits for its Medicare Advantage, Medicaid, and fully insured individual and group market health plans.

UnitedHealth Group, through UnitedHealthcare and Optum, is taking steps immediately to accelerate nearly $2 billion in payments and other financial support to health care providers in the U.S. to help address the short-term financial pressure caused by the COVID-19 emergency.

UnitedHealth Group's move to accelerate claim payments to medical and behavioral care providers applies to UnitedHealthcare's fully insured commercial, Medicare Advantage and Medicaid businesses. Other financial support currently includes the provision for up to $125 million in small business loans to clinical operators with whom OptumHealth is partnered.

UnitedHealth Group has been asked to assist the U.S. Department of Health and Human Services in distributing, as directed by the Department, an initial $30 billion in emergency funding to health care providers seeking assistance under the CARES Act.

UnitedHealthcare Group is donating $5 million to support a federally sponsored program seeking to accelerate and expand the availability of investigational convalescent plasma treatments for COVID-19 patients nationwide. The initiative, led by Mayo Clinic, coordinates efforts to collect blood plasma from donors who have recovered from COVID-19 and distribute the plasma to hospitalized patients with severe or life-threatening COVID-19 infections.

UnitedHealthcare is providing $1.5 billion in additional support for its customers. Actions taken to deliver the support include:

- Applying credits to premium billings received by June for people served by UnitedHealthcare commercial fully insured benefits. The credits will range from 5% to 20%.
- All specialist and primary care physician cost sharing will be waived at least through the end of September for people served by UnitedHealthcare under Medicare Advantage plans.
- Providing both new and renewal premium price stability and support for people served by UnitedHealthcare AARP Medicare Supplement policies.
- Accelerating funds to state partners and critical care providers to serve more people and expanding its Housing+Health and homeless support programs, providing shelf stable food and baby formula for people served by UnitedHealthcare Medicaid plans.

UnitedHealth Group and Microsoft Corp. have joined forces to launch ProtectWell™, an innovative return-to-workplace protocol that enables employers to bring employees back to work in a safer environment. ProtectWell™ helps employees determine they are safe to go to work, co-workers know their colleagues have been screened, and employers feel confident that their workplace is ready to do business. ProtectWell™ incorporates Centers for Disease Control and Prevention (CDC) guidelines and the latest clinical research to limit the spread of COVID-19 by screening employees for symptoms and establishing guidelines to support the health and safety of the workforce and workplace.

ProtectWell™ combines UnitedHealth Group's clinical and data analytics capabilities with Microsoft's technology leadership to help in the next phases of COVID-19 recovery efforts.

UPMC and UPMC Health Plan

UPMC and UPMC Health Plan will waive any applicable deductibles, copayments, or other cost-sharing for COVID-19 testing when ordered by a member's treating medical provider. This no-cost coverage of COVID-19 testing as a preventive service will apply for members in all of UPMC's commercial UPMC Advantage group and individual products, UPMC for Life Medicare Advantage plans, and UPMC for You Medical Assistance plans. Self-insured or administrative services only (ASO) employer groups will be permitted to opt-out of preventive coverage at their discretion.

UPMC Health Plan is waiving all member cost sharing payments for all in-network virtual health care visits with UPMC telehealth providers. The waiver lasts until June 15, 2020.

UPMC is also waiving early refill limits on medications filled at retail and specialty pharmacies until June 15, 2020.

UPMC is also working with a bank to help small businesses find available loans from state or federal programs.

UPMC is waiving all deductibles, co-insurance and co-pays for all in-network, inpatient COVID-19 treatment for its members enrolled in fully-insured group, ACA and Medicare Advantage plans, as well as in self-insured employer group plans that opt in to this coverage. This policy change is effective immediately and will stay in effect through June 15, 2020.

UPMC Health Plan is extending $0 cost-sharing for all covered telehealth services through September 30, 2020.

With UPMC Health Plan's commitment to remove financial barriers that could discourage members from seeking telehealth services, including through UPMC AnywhereCare, members will not face deductibles, copayments, or cost-sharing of any kind for in-network virtual visits with a health care provider, including primary care physicians, specialists, and both physical and occupational therapy. This extension until September 30, 2020, applies to individuals enrolled in UPMC Health Plan's fully-insured commercial group coverage, individual ACA Marketplace plans, and UPMC *for Life* Medicare Advantage plans, as well as self-insured employer group plans that opt into this coverage.

Upper Peninsula Health Plan

Upper Peninsula Health Plan is waiving all costs associated with any diagnostic laboratory tests for COVID-19, when used in accordance with Centers for Disease Control and Prevention (CDC) testing recommendations.

Upper Peninsula is also waiving prior authorizations for diagnostic tests and for covered services related to COVID-19 that are medically necessary and in accordance with CDC guidelines.

Copays for telehealth services are also being waived for the next 90 days.

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Valley Health Plan

Valley Health Plan will waive out-of-pocket costs for screening and testing for COVID-19. It is also waiving other hospital, urgent care, and primary care physician fees for members showing symptoms of COVID-19. The company is waiving prescription refill limits and encouraging the use of telehealth.

Viva Health

Viva Health will cover FDA-approved lab testing from a participating/in-network reference lab (Labcorp or Quest), as well as the Alabama Department of Public Health. No deductible, copayment, or coinsurance will apply to the lab test, and prior authorization is not required. Members can have telehealth visits from any location with any in-network physician, nurse practitioner, or physician assistant who offers this service. Members will not have a copayment for telehealth visits with their local provider for the next 30 days.

If a member requires hospitalization for the treatment of COVID-19, inpatient hospital treatment will

be covered at 100% on all Viva Health fully insured plans through September 30.

Viva Health announced that if a member requires hospitalization for the treatment of COVID-19, inpatient hospital treatment will be covered at 100% on all Viva Health fully insured plans through September 30, 2020.

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WEA Trust

WEA Trust will waive cost sharing, including co-pays, coinsurance and deductibles, for the COVID-19 test. In addition, it will not require pre-authorization for medical services related to the testing for COVID-19.

WellCare

WellCare, which was acquired by Centene on Jan. 23, is covering Medicaid, Medicare and Marketplace members' coronavirus testing, screening and treatment.

WellCare of Georgia will award grants up to $1,500 to local community partners through its Community Connections Resource Grant process to help support those affected by the novel coronavirus (COVID-19). The goal of the grant process is to identify local, community-based organizations that are creating innovative solutions to address social service barriers affecting vulnerable populations due to the COVID-19 pandemic.

WellCare of South Carolina will award grants up to $1,500 to local community partners through its Community Connections Resource Grant (CCRG) process to help support those affected by the novel coronavirus (COVID-19). The goal of the grant process is to identify local, community-based organizations that are creating innovative solutions to address social service barriers affecting vulnerable populations due to the COVID-19 pandemic.

To qualify, an organization must address the following social service areas:

- Food access
- Financial assistance
- Transportation
- Medication assistance
- Homelessness/housing

WellCare of North Carolina, a subsidiary of Centene Corporation, is partnering with community-based organizations and other programs across the state to provide access to food and other essential supplies.

WellCare of North Carolina has donated $40,000 directly to local food pantries and community partners across the state. The donation will help increase access to food support initiatives that serve vulnerable populations in high-need areas due to the COVID-19 pandemic.

WellCare also purchased nearly $35,000 worth of Walmart gift cards to support vulnerable populations in the community who are in need of food, supplies and support during the COVID-19 pandemic. Each gift card holds a value of $35 and can be used to purchase essential items like diapers, over-the-counter medicines, and cleaning supplies.

Wellmark Blue Cross and Blue Shield

Wellmark Blue Cross and Blue Shield is offering virtual health care visits for all appropriate medical and behavioral health visits at no cost to members until June 16. Those who do not currently have a provider can use an in-network provider through Doctor on Demand. Telephonic visits are also permitted when audio/visual capabilities are not accessible. Wellmark is covering diagnostic testing for COVID-19 at no cost-share to members. It permits early refills of prescription medications. Wellmark's BeWell 24/7 service is available to members to help them connect on various health concerns.

Wellmark Blue Cross and Blue Shield will waive members' cost-share related to the treatment of COVID-19 (copay, coinsurance and deductible) when seeking care from an in-network provider, effective Feb. 4 through at least June 16, 2020.

Wellmark Blue Cross and Blue Shield will extend its previously announced COVID-19 benefits through Aug. 31, 2020. The benefits include member cost-share waivers for COVID-19 testing and treatment, virtual visits, and support for business customers. The extension also includes payment parity for providers of virtual health care visits. Without the extension, Wellmark's COVID-19 coverage benefits would have expired on June 16, 2020.

Wellmark Blue Cross and Blue Shield is extending the same reimbursement fee to Iowa providers for virtual visits as is paid for in-person visits until Feb.1, 2021. This applies to all appropriate medical and behavioral health virtual visits with any Wellmark in-network provider in Iowa.

Western Health Advantage

Western Health Advantage will waive all cost-sharing for medically necessary screening and testing for COVID-19, including hospital/emergency room, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19.

West Virginia Association of Health Plans

The West Virginia Association of Health Plans announced that managed care organizations that manage West Virginia's Medicaid program will temporarily remove all prior authorization/service authorization requirements for all covered medical services for out-of-network and in-network providers.

An additional measure will extend the time period for patients to remain in residential substance abuse disorder treatment facilities.

WPS Health Insurance

WPS will waive any cost-sharing for laboratory tests related to COVID-19. WPS will waive prior authorization requirements, and cover with no out-of-pocket costs to the customer, COVID-19 diagnostic laboratory testing and health care costs associated with provider visits for testing (e.g., office visits, urgent care visits, hospital visits, emergency room visits, etc.) for all fully insured policyholders and for self-funded plan policyholders where the group has instructed us to provide this coverage. This coverage applies for both in-network and out-of-network providers.

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X

N/A

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Y

N/A

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Z

N/A

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A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

America's Health Insurance Plans (AHIP) will continue to monitor the spread of COVID-19 closely. We are working with our members to continue delivering affordable access to high-quality health care that Americans deserve.

For more information, please visit our Fact Sheet.

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Help Center

Vermont Health Connect

News and Events

Important Messages

- Please call Vermont Health Connect between the hours of 8AM-4:30PM Monday-Friday.

- Due to the COVID-19 emergency, Vermont Health Connect has opened a **Special Enrollment Period until August 14, 2020**. During this time, any uninsured Vermonter can sign up for a Qualified Health Plan through Vermont Health Connect. Qualified families can also get financial help paying for coverage.. Please call us at 1-855-899-9600 to learn more.
- Need to report a life change? Find out how. (http://info.healthconnect.vermont.gov/Report_Change)

Vermont Health Connect Updates

February 2020 Updates

- Individual and Small Group Enrollment Data (/sites/hcexchange/files/2020%20Individual%20and%20Small%20Group%20Enrollment%20Data.pdf)

June 2019 Updates

- 2019 Health Coverage Map (/sites/hcexchange/files/Health_Coverage_Map-2019Mar%20v2.pdf)

May 2019 Updates

- Individual and Small Group Enrollment Report (/sites/hcexchange/files/March%202019%20Individual%20and%20Small%20Group%20Enrollment%20Report%20v2.pdf)

March 2019 Updates

- 2019 Health Coverage Map (/sites/hcexchange/files/Health_Coverage%20Map-2019%20Jan%20REVISED%20v3.pdf)

February 2019 Updates

- Vermont's 2019 Individual Enrollment in Five Graphs (/sites/hcexchange/files/2019%20Individual%20Enrollment%20Recap.pdf)
- Operational Key Performance Indicators (KPI) February 2019 (/sites/hcexchange/files/DVHA-HAEEU-Feb2019-KPI.pdf)

January 2019 Updates

- Operational Key Performance Indicators (KPI) January 2019 (/sites/hcexchange/files/DVHA-HAEEU-Jan2019-KPI.pdf)

December 2018 Updates

- Open Letter on End of 2019 Open Enrollment (https://info.healthconnect.vermont.gov/news12-10-18)

November 2018 Updates

- Happy Thanksgiving, Happy Open Enrollment Halftime (https://info.healthconnect.vermont.gov/news11-22-18)
- 2nd Quarter 2018 Health Coverage Map (/sites/hcexchange/files/Health_Coverage_Map-2018Q2.pdf)
- Operational Key Performance Indicators (KPI) November 2018 (/sites/hcexchange/files/DVHA-HAEEU-November2018-KPI.pdf)
- Changes in Financial Help and Plan Options (https://info.healthconnect.vermont.gov/sites/hcexchange/files/FAQ%202019%20Changes.pdf) - Frequently Asked Questions (FAQ) about what's new in 2019, including Reflective Silver plans

October 2018 Updates

- 2019 Plan Comparison Tool is Live! (https://info.healthconnect.vermont.gov/news10-19-18)
- Operational Key Performance Indicators (KPI) October 2018 (/sites/hcexchange/files/DVHA-HAEEU-October2018-KPI.pdf)

September 2018 Updates

- 2019 Open Enrollment Countdown (https://info.healthconnect.vermont.gov/news9-27-18)

July 2018 Updates

- Operational Key Performance Indicators (KPI) July 2018 (/sites/hcexchange/files/DVHA-HAEEU-July2018-KPI.pdf)
- 1st Quarter 2018 Health Coverage Map (/sites/hcexchange/files/Health_Coverage_Map-2018Q1.pdf)

June 2018 Updates

- Heat Advisory June 29, 2018 (/sites/hcexchange/files/Heat%20advisory_0618.pdf)
- Operational Key Performance Indicators (KPI) June 2018 (/sites/hcexchange/files/DVHA-HAEEU-June2018-KPI.pdf)

April 2018 Updates

- Operational Key Performance Indicators (KPI) April (/sites/hcexchange/files/DVHA-HAEEU-March2018-KPI.pdf)2018 (/sites/hcexchange/files/DVHA-HAEEU-April2018-KPI.pdf)

March 2018 Updates

- Operational Key Performance Indicators (KPI) March (/sites/hcexchange/files/DVHA-HAEEU-March2018-KPI.pdf)2018 (/sites/hcexchange/files/DVHA-HAEEU-January2018-KPI.pdf)

January 2018 Updates

- Operational Key Performance Indicators (KPI) January 2018 (/sites/hcexchange/files/DVHA-HAEEU-January2018-KPI.pdf)

December 2017 Updates

- Operational Key Performance Indicators (KPI) December 2017 (/sites/hcexchange/files/DVHA-HAEEU-December-KPI.pdf)
- Dec. 11 - More than 20,000 sessions on 2018 Plan Comparison Tool (https://vt.checkbookhealth.org/hie/vt/2018).
- Dec. 11 - Customer Support Center is open extended hours (8am-8pm) for the last four days of Open Enrollment (12/12-12/15).
- Dec. 11 - 2018 Open Enrollment Q+A - the Sequel (https://www.facebook.com/VermontHealthConnect/videos/1615609431828521/) on Facebook Live

November 2017 Updates

- Nov. 30 - Customer Support Center to Open Next Two Saturdays (http://info.healthconnect.vermont.gov/news11-30-17)
- Nov. 30 - 2018 Open Enrollment Q+A (https://www.facebook.com/VermontHealthConnect/videos/1604278092961655/) on Facebook Live
- Nov. 29 - Operational Key Performance Indicators (KPI) November 2017 (/sites/hcexchange/files/DVHA-HAEEU-November-KPI.pdf)
- Nov. 2 - 11 Fast Facts about Open Enrollment (http://info.healthconnect.vermont.gov/news11-2-17)

October 2017 Updates

- 2018 Open Enrollment to run November 1, 2017 through December 15, 2017.
- Oct. 17 - 2018 Plan Comparison Tool (https://vt.checkbookhealth.org/hie/vt/2018) is now live - read announcement (http://info.healthconnect.vermont.gov/news10-17-17) or use tool (http://vt.checkbookhealth.org/hie/vt/2018)
- Vermonters who want to get a jump start on Open Enrollment can also download a "Getting Started" (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Educational_Materials/GettingStartedWithVHC_Onesheet_10.15.pdf) worksheet, learn about key health insurance terms with a "Health Insurance 101" (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Educational_Materials/HealthInsurance101_Onesheet.pdf) flyer, and find additional resources in the "Health Insurance Basics" (http://info.healthconnect.vermont.gov/information/individuals/basics) section of this site.
- Sign up for 2018 Plan Comparison webinars on November 9th. (http://info.healthconnect.vermont.gov/events/month/2017-11)
- Operational Key Performance Indicators (KPI) October 2017 (/sites/hcexchange/files/DVHA-HAEEU-October2017-KPI.pdf)

September 2017 Updates

- Operational Key Performance Indicators (KPI) September 2017 (/sites/hcexchange/files/DVHA-HAEEU-September-KPI.pdf)

August 2017 Updates

- Operational Key Performance Indicators (KPI) August 2017 (/sites/hcexchange/files/DVHA-HAEEU-August-KPI.pdf)

July 2017 Updates

- Operational Key Performance Indicators (KPI) July 2017 (/sites/hcexchange/files/DVHA-HAEEU-July-KPI.pdf)

June 2017 Updates

- New payment mailing address (http://info.healthconnect.vermont.gov/faq#Payment)! If your bank mails your checks for you, please inform them of the new address.
- Health Coverage Dashboard May 2017 (/sites/hcexchange/files/Coverage%20Dashboard-May2017.pdf)
- Operational Key Performance Indicators (KPI) June 2017 (/sites/hcexchange/files/DVHA-HAEEU%20June%20KPI-6-15.pdf)

May 2017 Updates

- Operational Key Performance Indicators (KPI) May 2017 (/sites/hcexchange/files/DVHA-HAEEU-May-KPI.pdf)

March 2017 Updates

- Health Coverage Dashboard February 2017 (/sites/hcexchange/files/Coverage%20Dashboard-February2017.pdf)

January 2017 Updates

- Health Coverage Dashboard December 2016 (/sites/hcexchange/files/Coverage%20Dashboard-December%202016.pdf)

December 2016 Updates

- Health Coverage Dashboard October 2016 (/sites/hcexchange/files/VHC%20October%202016%20Dashboard.pdf)

October 2016 Updates

- 2017 Plan Comparison Tool (https://vt.checkbookhealth.org/) is now available

September 2016 Updates

- 2017 Broker Compensation Schedule. (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Broker%20comp%20fee%20Letter9_2016.pdf)
- See where to find help filling out the 202-Med (http://info.healthconnect.vermont.gov/IF/faq#MABD)to apply for Medicaid for the Aged, Blind and Disabled

August 2016 Updates

Health Coverage Dashboard July (/sites/hcexchange/files/VHC%20July%202016%20Dashboard.pdf) 2016 (http://info.healthconnect.vermont.gov/sites/hcexchange/files/VHC%20May%202016%20Dashboard.pdf)

June 2016 Updates

Health Coverage Dashboard May 2016 (http://info.healthconnect.vermont.gov/sites/hcexchange/files/VHC%20May%202016%20Dashboard.pdf)

May 2016 Updates

- The 2017 Navigator Organization Grant Request for Application (http://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=16600) is now available!
  - Application will close on June 3, 2016
- Health Coverage Dashboard April 2016 (/sites/hcexchange/files/Health%20Coverage%20Dashboard%20April%202016.pdf)

January 2016 Updates

- Open Enrollment is November 1st - January 31st. Click here to learn more. (http://info.healthconnect.vermont.gov/learn_more)
- Health Coverage Dashboard December 2015 (/sites/hcexchange/files/Health%20Coverage%20Dashboard%20December%202015.pdf)
- January 30, 2016 - Navigator Open Enrollment Event at BROC - Community Action in SW Vermont (http://info.healthconnect.vermont.gov/node/1583)

December 2015 Updates

- New Plan Comparison Tool (https://vt.checkbookhealth.org/hie/vt/2016/index.cfm?data=eyJGT1JNIjp7fSwiVVJMIjp7IkNPVkVSQUdFIjoiSW5kaXZpZHVhbCJ9fQ%3D%3D)launched, helping Vermonters understand total costs
- November 2015 Dashboard (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health%20Coverage%20Dashboard%20November%202015.pdf)

November 2015 Updates

- October 2015 Dashboard (/sites/hcexchange/files/Health%20Coverage%20Dashboard%20October%202015.pdf)

October 2015 Updates

- 2016 Health Plans (http://info.healthconnect.vermont.gov/healthplans), including plan designs, rates, and additional information
- Use the 2016 Subsidy Estimator (http://info.healthconnect.vermont.gov/subsidy_estimator) to see if you qualify for financial help to lower the cost of health insurance.
- Dental Plans (http://info.healthconnect.vermont.gov/sites/hcexchange/files/2016Dental.pdf), including stand-alone plans and dental details that are embedded in health plans
- Fact sheet: "8 Things to Know about Full-Cost Individual Direct Enrollment." (http://info.healthconnect.vermont.gov/sites/hcexchange/files/8%20Things%20to%20Know%20about%20Full-Cost%20Individual%20Direct%20Enrollment.pdf)
- September 2015 Dashboard

September 2015 Updates

- August 2015 Dashboard (/sites/hcexchange/files/Health%20Coverage%20Dashboard%20August2015.pdf)(9/21/15)
- 2016 Broker Compensation Schedule (http://info.healthconnect.vermont.gov/information/community_partners/brokers) (9/18/15)
- 2015 Customer Experience Evaluation (http://info.healthconnect.vermont.gov/2015Evaluation) (9/17/15)

2015 and 2014 Updates

- End-of-May Systems Update FAQ (/sites/hcexchange/files/FAQ%20May%20systems%20update.pdf) (5/14/15)
- While Open Enrollment has ended, you may still be able to sign up. Learn about Special Enrollment Periods and Qualifying Events (/qualifyingevents) (2/16/15)
- Resources to help with Filing Taxes (taxes) (1/19/15)
- Public Notice: 2016 Qualified Health Plans on Vermont Health Connect (/sites/hcexchange/files/Public%20Notice%20for%202016%20QHPs%20December%202014.pdf) (12/16/14)
- New Dental Tier for 2015 (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Dental2015.pdf): Tier VI covers multiple children for the price of two children (11/15/14
- If you've had a "qualifying event" such as a marriage, new baby, or loss of health insurance, you don't need to wait until 2015 to get covered. Call 1-855-899-9600. (9/10/14)
- Info Sheet: Tips for Enrolling Online (/sites/hcexchange/files/Tips_for_Enrolling.pdf) (7/2/14)
- Report: Enrollment Update (/sites/hcexchange/files/Vermont%20Health%20Connect%20Enrollment%20Update_4.30.14.pdf) (5/2/14)
- Notice of Application: 2014-2015 Navigator Organization Grants (http://dvha.vermont.gov/administration/2013-requests-for-proposals) (4/1/14)
- Info Sheet: Moving from Catamount/VHAP to Medicaid (/sites/hcexchange/files/Catamount%20VHAP%20to%20Medicaid.pdf) (3/11/14)
- Tips: Using VermontHealthConnect.gov to Find a Health Plan (/sites/hcexchange/files/Tips_Using%20VHC%20gov_v%203.pdf) (1/21/14)

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- 2018 Open Enrollment to run November 1, 2017 through December 15, 2017.
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- Vermonters who want to get a jump start on Open Enrollment can also download a "Getting Started" (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Educational_Materials/GettingStartedWithVHC_Onesheet_10.15.pdf) worksheet, learn about key health insurance terms with a "Health Insurance 101" (http://info.healthconnect.vermont.gov/sites/hcexchange/files/Educational_Materials/HealthInsurance101_Onesheet.pdf) flyer, and find additional resources in the "Health Insurance Basics" (http://info.healthconnect.vermont.gov/information/individuals/basics) section of this site.
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