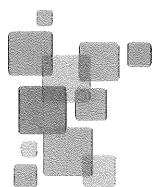


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**REPORT ON THE MNSURE
APPEALS PROCESS FOR
ELIGIBILITY DETERMINATIONS**

*February 1, 2014
Report to the Legislature*

Report on the MNsure Appeals Process for Eligibility Determinations

As Required By Laws of Minnesota 2013, Chapter 9, Section 16

Under subdivision 6 of Minnesota Statutes, section 62V.05

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MNsure's Accessibility & Equal Opportunity (AEO) office can provide this report in accessible formats for individuals with disabilities. The AEO office can be reached via 1-855-3MNSURE (1-855-366-7873) or AEO@MNsure.org.

Cost of Report Preparation

The total cost for MNsure to prepare this report is approximately \$320.00. These costs include staff time (10 managerial hours at \$32/hr) in compiling and analyzing data, and preparing the written report. Incidental costs include printing, copying, and other office supplies, and are not included in this estimate.

Estimated costs are provided in accordance with Minnesota Statutes, section 3.197, which requires that the cost of preparing a required report must be provided at the beginning of all reports to the legislature.

Executive Summary

The Patient Protection and Affordable Care Act (“ACA”) mandates an appeals process for certain Exchange eligibility determinations.¹ In 2013, the Minnesota Legislature authorized the MNSure board of directors to administer an appeal process for eligibility determinations. These eligibility determinations expressly exclude those for which an appeals process exists under Minnesota Statutes, section 256.045.²

In creating its appeal process, MNSure has entered into a service level agreement with the Minnesota Department of Human Services (DHS) and the Office of Administrative Hearings (OAH) to develop and implement its appeals process. Through its partnerships, MNSure developed business processes, administrative rules, and public education materials.

On October 1, 2013, MNSure opened for business as the new central marketplace where Minnesota individuals, families and small employers can get quality, affordable health insurance and access tax credits or assistance to help pay for coverage.

MNSure is in the early months of its first appeals cycle; yet, it has included early data metrics in this Report. MNSure looks forward to calendar year 2014 and refining its business operations for consumers; strengthening its partnerships with other State agencies and stakeholders; and cultivating its reputation with the Minnesota public.

¹ 42 U.S.C. § 18081(f).

² As relevant to MNSure, this includes eligibility determinations pertaining to Medical Assistance and MinnesotaCare. While these determinations may be operationally communicated through MNSure, they remain determinations of DHS, and the administration of respective appeals similarly remains under the authority of DHS.

Statutory Background

Federal

Under the ACA, the Secretary of the United States Department of Health and Human Services (“DHHS”) must establish procedures by which the Secretary administers an appeals process for certain Exchange eligibility determinations.³ Accordingly, the DHHS Secretary promulgated proposed procedures on January 22, 2013, which addressed Medicaid fair hearings, as well as Exchange appeals.⁴ On August 30, 2013, the Secretary promulgated final procedures for Exchange appeals.⁵

The appeals procedures separate three types of appeals for Exchanges: (1) individuals may appeal Exchange determinations regarding the subsidies and coverage for which they are eligible; (2) employers may appeal Exchange determinations that their employees are eligible for federal subsidies, which could trigger employer penalties; and (3) employers and employees may appeal eligibility determinations made by a SHOP Exchange.⁶ Under the federal regulations, only the first type of appeals requires a hearing; employer and SHOP appeals require only a desk review.⁷

The federal regulations allow state-based Exchanges, like Minnesota, to choose to administer appeal operations, so long as they are compliant with federal regulations and so long as an individual may appeal to DHHS once it has exhausted the state-based Exchange appeals process.⁸ For all types of appeals, an individual has 90 days from the date of the eligibility determination to file an appeal; and the appeal decision must be issued within 90 days of the date upon which the appeal was filed.⁹

³ 42 U.S.C. § 18081(f).

⁴ “Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing,” CMS-2334-P, 78 *Fed Reg* 4594. Accessible at: <https://federalregister.gov/a/2013-00659>.

⁵ “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule,” CMS-9957-F, 78 *Fed Reg* 54070; 45 C.F.R. §§ 155.500-155.555, 155.740. Accessible at: <https://www.federalregister.gov/articles/2013/08/30/2013-21338/patient-protection-and-affordable-care-act-program-integrity-exchange-shop-and-eligibility-appeals>

⁶ 45 C.F.R. §§ 155.500-155.555, 155.740.

⁷ 45 C.F.R. §§ 155.555 and 155.740.

⁸ 45 C.F.R. § 155.505(c)(1).

⁹ C.F.R. §§ 155.520(b)(1), 155.545(b)(1), 155.555(c)(1), 155.555(k), 155.740 (f)(1), 155.740(m).

In administering state based appeals operations, Exchanges have the option to use informal resolution processes to potentially resolve the need for a formal appeal.¹⁰ Individuals must have the opportunity to preserve their right to a hearing in case they disagree with the outcome of the informal process and they must not be required to submit duplicate information if their appeal proceeds to hearing.¹¹

The proposed rules address coordination of appeals across the Income Assistance Programs, which include Advance Payment of Premium Tax Credits ("APTC"), cost Sharing Reductions ("CSR"), and Medicaid.¹² The proposed rules for Medicaid fair hearings require that an appeal of APTC or CSR eligibility automatically trigger a hearing for a Medicaid denial.¹³ In these cases, the Medicaid hearing may be sequenced so as to occur within 45 days of the exchange decision, or the Medicaid appeal may occur simultaneously.¹⁴ Yet, the Medicaid agency cannot request duplicate information from the appellant.¹⁵

State

Under Minnesota Statutes, section 62V. 05, subdivision 6, the Mnsure board may conduct hearings, appoint hearing officers, and recommend final orders related to appeals of any MNSure determinations, except for those determinations where a state agency hearing is available under section 256.045. Under this statutory authority, the board was ordered to establish hearing processes which provide for a reasonable opportunity to be heard and timely resolution of the appeal and which are consistent with the requirements of federal law and guidance.¹⁶ Additionally, MNSure is empowered to establish service-level agreements with state agencies to conduct hearings for appeals.¹⁷

Program Description

Program summary

In consultation with stakeholders, OAH, and DHS, MNSure partnered with DHS to provide a simple, unified system for MNSure's eligibility appeals. DHS' long experience with appeals in the health care arena made it a great asset for MNSure to build on going

¹⁰ 45 C.F.R. § 155.535(a).

¹¹ *Id.*

¹² Minnesota's Medicaid program is called, "medical assistance."

¹³ 78 Fed. Reg. 4683 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 431.221(e)).

¹⁴ 78 Fed. Reg. 4684 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 431.224(f)(2)).

¹⁵ 45 C.F.R. § 155.345(g)(3).

¹⁶ Minn. Stat. § 62V.05, subd. 6(a).

¹⁷ Minn. Stat. § 62V.05, subd. 6(b).

into the future. Under this foundation, individuals seeking to appeal MNSure eligibility determinations are presented a single, MNSure-branded “front door,” which leads to the existing DHS appeals infrastructure. Additionally, because the DHS appeals unit already administers medical assistance appeals, such a structure allows one hearing for appellants who are appealing both Exchange and medical assistance eligibility issues, which is consistent with the cooperation necessitated by the federal regulations, less burdensome to the appellant, and produces cost savings to the State.

Program governance and oversight

MNSure is governed by a board of directors with seven members.¹⁸ Membership of the MNSure board consists of the following: three members appointed by the governor with the advice and consent of both the senate and the house of representatives, with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, and one member representing small employers; three members appointed by the governor with the advice and consent of both the senate and the house of representatives, who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets; and the commissioner of human services or a designee.¹⁹

The MNSure board has the authority to employ personnel and delegate administrative, operational, and other responsibilities to the director and other personnel as deemed appropriate by the board.²⁰ Currently, the MNSure executive director manages the MNSure general counsel. The MNSure general counsel supervises the MNSure appeals manager.

Additionally, the Minnesota Legislative Oversight Committee (“LOC”) provides oversight of all MNSure operations.²¹ Annually, MNSure must present to the LOC a report on the appeals process.²² Moreover, prior to January 1, 2015, the MNSure board must submit

¹⁸ Minn. Stat. § 62V.04, subd. 1.

¹⁹ Minn. Stat. § 62V.04, subd. 2(a).

²⁰ Minn. Stat. § 62V.05, subd. 1(b)(1).

²¹ Minn. Stat. § 62V.11, subd. 1(a). The LOC consists of five members of the senate, three members appointed by the majority leader of the senate, and two members appointed by the minority leader of the senate; and five members of the house of representatives, three members appointed by the speaker of the house, and two members appointed by the minority leader of the house of representatives. Minn. Stat. § 62V.11, subd. 2(a).

²² Minn. Stat. § 62V.11, subd. 1(c).

proposed rules to the committee at the same time the proposed rules are published in the State Register.²³

Service level agreements

MNSure may establish service-level agreements with state agencies to conduct hearings for appeals.²⁴ On May 23, 2013, MNSure, OAH, and DHS entered into an interagency agreement, under which OAH would provide consultation services necessary to quickly develop an innovative and robust appeals structure; and DHS would implement said appeals process and adjudicate MNSure's Exchange appeals. The interagency agreement was first amended on September 27, 2013, and expires on June 30, 2014.²⁵

Applicability of MNSure appeals process for eligibility determinations

The MNSure appeals process for eligibility determinations is only available for determinations made by MNSure. Accordingly, it does not apply to appeals for medical assistance or MinnesotaCare, for which determinations are made by DHS. Similarly, it does not apply to determinations regarding coverage benefits, which are made by health plans. Finally, where MNSure delegates to DHHS determinations of individual mandate exemptions, appeals of the same determinations are administered by DHHS, not MNSure.²⁶

Business process

MNSure accepts appeals online, by phone, by mail, and in-person. As appeals arrive at MNSure, they are promptly delivered to the DHS appeals unit. The DHS appeals unit then docket the appeal request and processes to the appellant, via United States postal mail, an acknowledgement of appeal. If the appellant requests an expedited appeal due to a medical emergency, the emergency is quickly assessed and the need for an expedited hearing is decided upon and communicated to the appellant without delay.

The DHS appeals unit then assigns the appeal to an examiner, or "judge," who schedules a hearing and mails to the appellant a scheduling notice, if a hearing is warranted. If no hearing is required (i.e., a documentary review of evidence is legally appropriate), the judge alerts the parties of their rights, including their right to submit additional documentation for review. Prior to the hearing, both parties may submit evidence. After the hearing, which is presumed to be a telephone hearing, except in certain circumstances, the examiner issues a recommended written decision.

²³ Minn. Stat. § 62V.11, subd. 3(a).

²⁴ Minn. Stat. § 62v.05, subd. 6(b).

²⁵ A copy of the service level agreements is included as an attachment.

²⁶ 45 CFR 155.505(c)(2)(iii).

The recommended written decision is subsequently reviewed by a Co-Chief Judge, or his or her authorized designee, who issues the final order on behalf of the MNsure board. The final order is mailed to all parties.

MNsire Appeal Process

① File your appeal



You disagree with a MNsure decision about your eligibility and choose to file an appeal. You may file online, by phone or mail. You must file within 90 days of the decision (30 days for Medical Assistance and MinnesotaCare or 90 days with good cause).

② Hearing scheduled



An appeals examiner will decide if your appeal should be heard. (If your appeal is dismissed, you may appeal the dismissal.)

You will receive scheduling notice if your appeal is scheduled for a hearing.

③ Prepare for hearing



Review MNsure Appeals Frequently Asked Questions and all information mailed to you. Follow the instructions mailed to you for submitting documents and evidence to the appeals examiner.

If you need an interpreter or other accommodation, contact the appeals examiner as soon as possible.

④ Attend hearing



Your hearing will be conducted by an appeals examiner by telephone or in person. You may use documents and witnesses to show why you should be granted your appeal.

⑤ Appeal decided



The appeals examiner makes a written decision and sends it to you.

If you feel the decision is wrong, you can ask for reconsideration or appeal the appropriate agency or court.

Administrative rules

On July 22, 2013, MNSure solicited public comment on its proposed rules governing MNSure appeals. Notice of the proposed rules was published in the Minnesota State Register and the proposed rules were published on the MNSure website. The public comment period was open through Monday, August 13, 2013. During the public comment period, MNSure received many valuable public comments. Subsequently, on August 30, 2013, the United States Department of Health and Human Services published final regulations governing Exchange appeals.

MNSure Appeals thoroughly considered the aforementioned public comments and final federal regulations. Based on its review, the MNSure Legal and Compliance Division recommended modifications to its proposed rules governing MNSure appeals. The MNSure board considered and approved the modifications on September 11, 2013. Notice of the final rules was posted in the Minnesota State Register on September 23, 2013. The rules and the modifications were also posted to the MNSure website; and subsequently, the rules were published as Minnesota Rules Parts 7700.0100 – 7700.0105.

Minnesota Rules Part 7700.0100 describes the applicability of the rules governing MNSure appeals. The rules governing MNSure appeals must be read in conjunction with the federal Affordable Care Act, Public Law 111-148; Code of Federal Regulations, title 45, part 155; and Minnesota Statutes, chapter 62V; and sections 256.045 and 256.0451.²⁷ Minnesota Rules Parts 7700.0100 to 7700.0105 do not proscribe appeals rights and processes for medical assistance and MinnesotaCare.²⁸ Additionally, nothing in these rules limits or supersedes the ability of the commissioners of commerce and health to conduct investigations or facilitate appeals as authorized by laws administered by the Departments of Commerce and Health.²⁹

Minnesota Rules Part 7700.0101 lists definitions for parts 7700.0100 – 7700.0105. Minnesota Rules Part 7700.0105 details at length the MNSure appeals process. It addresses, among others, justiciability, procedures for filing appeals, legal timeframes, access to and communications with the tribunal, dismissals, scheduling, commencement and conduct of hearings, decisions, and administrative and judicial review.

Public education materials

In its partnership with OAH and DHS, MNSure has created public education materials. Every eligibility determination mailed to a MNSure consumer informs the consumer of his or her appeal rights, and provides important information about those rights. Additionally, consumers can find information about appeals on the www.mnsure.org website under “Get Help.” In addition to general information about filing appeals and the appeals

²⁷ Minn. R. 7700.0100, subp. 1.

²⁸ Minn. R. 7700.0100, subp. 2.

²⁹ Minn. R. 7700.0100, subp. 3.

process, the www.mnsure.org website contains helpful Frequently Asked Questions ("FAQ") about appeals. These webpages are available at: <https://www.mnsure.org/help/appeals.jsp>; <https://www.mnsure.org/faq/appeals-faq.jsp>.

Subject to redaction and compliance with data privacy laws, appeal decisions are made available upon public request. MNSure is working with MN.IT Central to build a searchable online repository for a representative sample of decisions, redacted of personally identifiable information and compliant with data privacy laws. MNSure expects the repository to be available in the spring of 2014.

Summary of appeals representation

An appealing party may be represented by a representative or legal counsel at MNSure appeals hearings, but this is not a requirement.³⁰ "Representative" means a person who is empowered by the party to support, speak for, or act on behalf of the party.³¹ Representative includes legal counsel, relative, friend, or other spokesperson or authorized representative under Code of Federal Regulations, title 45, section 155.227.³²

A partnership may be represented by any of its members, an attorney, or other representative.³³ A corporation or association may be represented by an officer, an attorney, or other representative.³⁴

In a case involving an unrepresented appellant, the appeals examiner shall examine witnesses and receive exhibits for the purpose of identifying and developing in the appeal record relevant facts necessary for making an informed and fair decision.³⁵ An unrepresented appellant shall be provided an adequate opportunity to respond to testimony or other evidence presented by the agency at the appeal hearing.³⁶ The appeals examiner shall ensure that an unrepresented appellant has a full and reasonable opportunity at the appeal hearing to establish a record for appeal.³⁷

MNSure may be represented by an attorney who is an employee of MNSure.³⁸ In the course of representation, the MNSure representative may contact the appellant or his/her legal counsel, as appropriate, and attempt to resolve the appeal informally. If a

³⁰ Minn. Stat. § 62V.05(a); Minn. R. 7700.0105, subp. 11.

³¹ Minn. R. 7700.0101, subp. 16.

³² *Id.*

³³ Minn. R. 7700.0105, subp. 11.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ Minn. Stat. § 62V.05(c); Minn. R. 7700.0105, subp. 11.

resolution is achieved, the appellant may withdraw the appeal before the hearing and/or final order.

Metrics for October 1, 2013 – December 31, 2013

The following are select metrics for October 1, 2013 until December 31, 2013:

Total cases:	276
Total appeals received in October	37
Total appeals received in November	50
Total appeals received in December	189
Total closed cases:	92
Total expedited medical emergency cases requested:	3
Total expedited medical emergency cases granted:	1
Mean net elapsed time of open cases:	17.6
Median net elapsed time of open cases:	15
Net elapsed time past 90 days of filing date:	0
Mean net elapsed time of closed cases:	25.1
Median net elapsed time of closed cases:	24.5
Total cases closed on dismissal:	4
Total cases closed on appellant withdrawal:	83
Total cases on dismissal for appellant failure to appear:	4
Total cases closed due to duplicate docketing:	1
Total agency actions affirmed:	0
Total agency actions reversed:	0
Total cases remanded:	0

Goals for calendar year 2014

The MNsure appeals process was established in accordance with four cornerstone principles. Accordingly, the chief goal of the appeals process for calendar year 2014 is to continue abiding by the following principles:

1. Accessibility, for all appellants;
2. Integrity, building a reputation for soundness of moral character;
3. Solutions, consistently fostering resolutions and innovation, rather than status quo or stagnation; and
4. Communication, with the public, stakeholders, and agency partners.

In addition to the chief goal, there exist five more goals. First, MNsure intends to release to the public its online searchable decision repository. Second, MNsure intends to support DHS in procuring an electronic case management system. Third, MNsure aims

to have zero cases elapsing beyond 90 days of the appeal filing date, as administratively feasible. Fourth, MNsure hopes to establish notification procedures that include secure email. Fifth, and finally, MNsure intends to perform a comprehensive review of all public education materials, administrative rules, and business process at the close of the open enrollment period to incorporate public and stakeholder feedback, increase effectiveness, and implement lessons learned.

Conclusion

MNsure appreciates the opportunity to submit this report in an effort to provide the legislature with objective data necessary to inform its continuing policy discussions regarding MNsure appeals. As we strive for program integrity and innovation, if any further information would be helpful, please contact the MNsure General Counsel, Michael A. Turpin at (651) 539-1335, Michael.A.Turpin@state.mn.us.

Attachments

- Attachment: Announcement regarding MNsure Appeals
- Attachment: federal regulations
- Attachment: interagency agreement between DHS, OAH, and MNsure
- Attachment: Appeal request form
- Attachment: Administrative Rules



April 15, 2013

To: MNSure Interagency Steering Committee

From: Jessica M. Kennedy
Appeals Manager & Legal Counsel
MNSure

Subject: MNSure appeals

It is with great satisfaction that I announce that MNSure will be partnering with the Minnesota Department of Human Services ("DHS") to provide a simple, unified system for all MNSure eligibility appeals. DHS' long experience with appeals in the health care arena is a great asset that MNSure can build on going into the future.

MNSure and DHS will also work collaboratively with the Minnesota Office of Administrative Hearings ("OAH") in developing and implementing the MNSure appeals process to help us assure that consumers receive appropriate and timely review of their appeals. Individuals seeking to appeal MNSure eligibility determinations will be presented a single, MNSure-branded "front door," which will lead to the existing DHS appeals infrastructure. In partnering with these two experienced and well-respected administrative hearing tribunals and in utilizing the infrastructure of a single entity supported by two other entities, MNSure appeals will maximize innovation with tried-and-true expertise.

All three entities will collaborate in the design, development, and implementation of MNSure appeals operations. MNSure, DHS, and OAH are currently drafting an interagency agreement governing the responsibilities of each agency. I will be available to provide real-time updates and take your questions during the upcoming Interagency Steering Committee meeting on Tuesday, April 16, 2013. Should you have immediate questions or concerns, my contact information follows: Jessica.M.Kennedy@state.mn.us; (612) 279-8955 (video relay).



FEDERAL REGISTER

Vol. 78

Friday,

No. 169

August 30, 2013

Part VI

Department of Health and Human Services

45 CFR Parts 147, 153, 155, et al.

Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 153, 155, and 156

[CMS-9957-F]

RIN 0938-AR82

Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Specifically, this final rule outlines Exchange standards with respect to eligibility appeals, agents and brokers, privacy and security, issuer direct enrollment, and the handling of consumer cases. It also sets forth standards with respect to a State's operation of the Exchange and Small Business Health Options Program (SHOP). It generally is finalizing previously proposed policies without change.

DATES: These regulations are effective on September 30, 2013.

FOR FURTHER INFORMATION CONTACT: Leigha Basini at (301) 492-4380, or Noah Isserman at (301) 492-4401 for general information and matters relating to parts 155 and 156.

Seth Schneer at (301) 492-4405 for matters relating to the SHOP.

Jacob Ackerman at (301) 492-4179 for matters relating to part 147.

Jaya Ghildiyal at (301) 492-5149 for matters relating to part 153.

Christine Hammer at (301) 492-4431 for matters relating to part 155 subpart F.

Paul Tibbits at (301) 492-4229 for matters relating to part 156, subpart K.

SUPPLEMENTARY INFORMATION:

Electronic Access

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

Acronyms and Short Forms

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below: Affordable Care Act The Affordable Care Act (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 of 2010 (Pub. L. 111-152))

AV Actuarial Value

CFR Code of Federal Regulations

CHIP Children's Health Insurance Program

CMP Civil Money Penalty

CMS Centers for Medicare & Medicaid Services

DOI State Department of Insurance

DOL U.S. Department of Labor

EFT Electronic Funds Transfer

EHB Essential Health Benefits

FEHB Federal Employees Health Benefits

FFE Federally-facilitated Exchange

FFE API Federally-facilitated Exchange

Application Programming Interface

FF-SHOP Federally-Facilitated Small

Business Health Options Program

GAO United States Government

Accountability Office

GLBA Gramm Leach Bliley Act

HHS U.S. Department of Health and Human Services

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

191, as amended) and its implementing regulations

IRS Internal Revenue Service

LEP Limited English Proficiency

MAGI Modified Adjusted Gross Income

MLR Medical Loss Ratio

NAIC National Association of Insurance Commissioners

NPRM Notice of Proposed Rulemaking

OMB Office of Management and Budget

PCIP Pre-existing Condition Insurance Plan

PHI Protected Health Information

PHS Act Public Health Service Act

PII Personally Identifiable Information

PRA Paperwork Reduction Act

QHP Qualified Health Plan

SHOP Small Business Health Options Program

The Code Internal Revenue Code of 1986

TIN Taxpayer Identification Number

Executive Summary

Starting on January 1, 2014, qualified individuals and qualified employees will be able to be covered by private health insurance coverage through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges" (also called Health Insurance Marketplaces). This rule sets forth standards for eligibility appeals, verification of eligibility for minimum essential coverage, and treatment of incomplete applications. It also establishes additional consumer protections regarding privacy and security; clarifies the role of agents, brokers, and issuer application assisters in assisting consumers with obtaining Exchange coverage; provides for the handling consumer cases; and establishes non-discrimination standards for methods of premium payment. Finally, it sets forth provisions regarding a State's operation of the SHOP.

Although many of the provisions in this rule will become effective by October 1, 2013, we do not believe that affected parties will have difficulty complying with the provisions by their effective dates, because the standards are based on existing standards currently in effect in the private health insurance market, were previously addressed in the Exchange Blueprint process, discussed in agency-issued sub-regulatory guidance, or discussed in the preambles to the Exchange Establishment Rule,¹ Premium Stabilization Rule,² or the HHS Notice of Benefit and Payment Parameters for 2014.³ In addition to comments on the substance of the provisions we are now finalizing, we sought input on ways to implement the proposed policies to minimize burden.

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¹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310 (March 27, 2012).

² Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 FR 17220 (March 23, 2012).

³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 FR 15410 and 15541 (Mar. 11, 2013).

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I. Background

A. Legislative Overview

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

Subtitles A and C of Title I of the Affordable Care Act reorganized, amended, and added to the provisions of Title XXVII of the Public Health Service Act (PHS Act) relating to health insurance issuers in the group and individual markets and to group health plans that are non-Federal governmental plans. As relevant here, section 2701 of the PHS Act (fair health insurance premiums) provides that the premium rate charged by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market may vary with respect to a particular plan or coverage only based on family size, rating area, age (within a ratio of 3:1 for adults), and tobacco use (within a ratio of 1.5:1).

Starting on October 1, 2013 for coverage starting as soon as January 1, 2014, qualified individuals and qualified employers will be able to enroll in qualified health plans (QHPs)—private health insurance that has been certified as meeting certain standards—through competitive marketplaces called Exchanges or Health Insurance Marketplaces. The Departments of Health and Human Services, Labor, and the Treasury have been working in close coordination to release guidance related to QHPs and

Exchanges in several phases. The word “Exchanges” refers to both State Exchanges, also called State-based Exchanges, and Federally-facilitated Exchanges (FFE). In this final rule, we use the terms “State Exchange” or “FFE” when we are referring to a particular type of Exchange. When we refer to “FFEs,” we are also referring to State Partnership Exchanges, which are a form of FFE.

In the proposed rule, we encouraged State flexibility. Sections 1311(b) and 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange. Section 1311(b)(1) gives each State the opportunity to establish an Exchange that both facilitates the purchase of QHPs and provides for the establishment of a Small Business Health Options Program (SHOP) that will help qualified employers enroll their qualified employees in QHPs. Section 1311(b)(2) contemplates the separate operation of the individual market Exchange and the SHOP under different governance and administrative structures, permitting the individual market Exchange and SHOP to be merged if States have adequate resources to assist both populations (individual and small employers).

Section 1321(a) of the Affordable Care Act provides general authority for the Secretary of Health and Human Services (referred to throughout this rule as the Secretary) to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of Title I of the Affordable Care Act.

Section 1321(c)(1) requires the Secretary to establish and operate an FFE within States that either: do not elect to establish an Exchange or, as determined by the Secretary, will not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the Exchange standards using civil money penalties (CMPs) on the same basis as detailed in section 2723(b) of the PHS Act.⁴ Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Title XXVII, Part A of the PHS Act when a State fails to substantially enforce these provisions, as determined by the Secretary.

⁴ Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act. This was clearly a typographical error, and we have interpreted section 1321(c) of the Affordable Care Act to incorporate section 2723(b) of the PHS Act.

Section 1311(d)(4)(A) of the Affordable Care Act directs that each Exchange must implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by the Secretary.

Section 1312(c) of the Affordable Care Act directs a health insurance issuer to consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer to be members of a single risk pool for each of its individual and small group markets. Section 1312(c) of the Affordable Care Act also gives States the option to merge the individual and small group markets within the State into a single risk pool.

Section 1312(e) of the Affordable Care Act directs the Secretary to establish procedures under which a State may permit agents and brokers to enroll qualified individuals and qualified employers in QHPs through an Exchange, and to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions.

Section 1313 of the Affordable Care Act, combined with section 1321 of the Affordable Care Act, provides the Secretary with the authority to oversee the financial integrity, compliance with HHS standards, and efficient and non-discriminatory administration of State Exchange activities. Section 1313(a)(6)(A) of the Affordable Care Act specifies that payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729, et seq.) if those payments include any Federal funds.

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 shared responsibility payment under section 5000A of the Code.

Section 1411(g) of the Affordable Care Act specifies that information provided by an applicant or received from a Federal agency may be used only for the purpose of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including for the purpose of verifying the eligibility of an individual to enroll through an Exchange, to claim a premium tax credit or cost-sharing reduction, or for verifying the amount of the tax credit or reduction.

Section 1411(h) of the Affordable Care Act sets forth civil penalties that any person may be subject to if he or she fails to provide correct information or

knowingly and willfully provides false or fraudulent information under section 1411(b), or improperly uses or discloses information provided by an applicant or another Federal agency under section 1411(b), (c), (d), or (e).

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 Secretary under section 1321(a)(1) of the Affordable Care Act.

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on a number of policies related to the operation of Exchanges, including the SHOP, and premium stabilization programs. HHS has held a number of listening sessions with consumers, providers, employers, health plans, and State representatives to gather public input. HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC); regular contact with States through the Exchange establishment grant process and the Exchange Blueprint approval process; and meetings with tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all of the public input as we developed the policies in the proposed rule and this final rule.

II. Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments

A proposed rule, titled “Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards” (78 FR 37032), was published in the **Federal Register** on June 19, 2013 with a comment period ending on July 19, 2013. In total, we received 99 public comments on the proposed rule from various stakeholders, including States, health insurance issuers, consumer groups, agents and brokers, provider groups, Members of Congress, Tribal organizations, and other stakeholders.

Of the comments received, about 22 were substantially identical submissions related to non-discrimination standards, Web-brokers, incomplete applications, and payment method non-discrimination standards for the unbanked. We received a few comments that were outside the scope of the proposed rule. In this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing. We are not finalizing all the provisions from this proposed rule. This final rule includes those provisions that need to be effective for the beginning of open enrollment on October 1, 2013. We will finalize the other provisions at a later date.

Another proposed rule, entitled “Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing, and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing” (78 FR 4594), was published in the **Federal Register** on January 22, 2013 with a comment period ending on February 13, 2013. We received a total of 741 comments from various stakeholders including individuals, State Medicaid agencies, advocacy groups, and Tribal organizations. In this final rule, we are only addressing from that proposed rule the provisions related to appeals in Part 155 Subpart F and § 155.740. Other provisions from the January 22, 2013 proposed rule were finalized in a final rule, titled “CMS–2234–F: Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment” (78 FR 42160) published in the **Federal Register** on July 15, 2013.

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

1. Fair Health Insurance Premiums (§ 147.102)

We proposed two clarifications in § 147.102, which implements section 2701 of PHS Act regarding fair health insurance premiums. In paragraph (a), we proposed to add a reference to the single risk pool standard codified in § 156.80 to clarify the connection between section 1312(c) of the Affordable Care Act and section 2701 of the PHS Act with respect to the development of rates and premiums for

health insurance coverage in the individual and small group markets.

In paragraph (a)(1)(ii), we proposed to clarify that for rating purposes under section 2701 of the PHS Act, the geographic rating area is determined in the small group market using the principal business address of the group policyholder, and in the individual market using the address of the primary policyholder, regardless of the location of other individuals covered under the plan or coverage. These proposed standards would apply both inside and outside of the Exchanges and are consistent with previously released guidance describing our intended approach.⁵ We solicited comments on this proposal.

Comment: While some commenters supported our proposal that issuers in the small group market apply rates based on the employer’s principal business address, other commenters noted that issuers in some States have already developed administrative systems and rates for 2014 based on guidance from State regulators to use each employee’s place of residence. These commenters requested that States have flexibility to use either employer or employee address when rating for geography.

Response: We believe it is important that all issuers offering coverage within a State, both through the Exchanges and outside of the Exchanges, use a consistent geographic rating methodology to promote the accuracy of the risk adjustment program established under section 1343 of the Affordable Care Act. Further, we believe that rating based on the employer’s principal business address is consistent with current prevailing industry practice and will simplify administration of the geographic rating factor. We recognize, however, that issuers in some cases may have relied in good faith on guidance or instructions from States to rate based on employee address for 2014. Thus, while we are finalizing our proposed policy that geographic rating be based on the employer’s principal business address generally for plan years beginning on or after January 1, 2014, we are also providing in this final rule that where issuers can demonstrate that they have relied in good faith on different guidance from a State insurance regulator prior to the issuance of this final rule, the amendments to § 147.102(a)(1)(ii) will not apply until the first plan year beginning on or after

⁵ Questions and Answers Related to Health Insurance Market Reforms (April 26, 2013). Available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html.

January 1, 2015 with respect to coverage in the small group market. We believe this approach promotes consistency in rating, while affording issuers in certain circumstances a reasonable period of time to transition to the geographic rating methodology in this final rule. We note that this flexibility will not apply to plans offered through the Federally-facilitated Small Business Health Options Program (FF-SHOP), which will apply rates based on the employer's principal business addressing beginning in 2014.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 147.102 of the proposed rule with the addition of a transition period for issuers in certain circumstances.

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

1. Subpart F—Health Insurance Issuer Standards Related to the Risk Corridors Program

a. Definitions (§ 153.500)

In the proposed rule, we sought comment on our proposed amendment to § 155.20 that for a plan offered outside the Exchange to be considered the same plan as one that is certified as a QHP and offered through the Exchange, the benefits package, provider network, service areas, and cost-sharing structure of the two offerings would have to be identical. As discussed below in Part C(1)(a) of this final rule, we are finalizing this policy as proposed. In the proposed rule, we also proposed that this standard be used to determine which off-Exchange plans would be subject to the risk corridors program. As discussed below in Part C(1)(a) of this final rule, many commenters suggested that, in addition to the plans described in our proposal, plans that differ from a QHP offered through the Exchange only as a result of Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside an Exchange, should be afforded the protection of risk corridors.

For example, several commenters suggested that a plan offered outside the Exchange that differs from a QHP offered through an Exchange solely based on inclusion of the required pediatric dental EHB should be included in the risk corridors program. Because health insurance issuers may sell a QHP without the pediatric dental

EHB through an Exchange if a stand-alone dental plan that covers the pediatric dental EHB is offered on that Exchange, commenters argued that plans that differ solely due to coverage of the pediatric dental EHB differ only because of a Federal requirement, and that this requirement should not prevent the plans from receiving risk corridors protections when offered outside the Exchange. Another commenter suggested that the network requirements for multi-state plan (MSP) issuers set by the Office of Personnel Management (OPM) could conflict with comparable State requirements, similarly potentially disqualifying plans offered outside the Exchanges that are comparable to MSP options from participating in the risk corridors program.

We agree with these commenters that the risk corridors program should also cover plans offered outside the Exchanges that differ from a QHP only as a result of Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the Exchange; therefore, we are not finalizing this risk corridors policy as proposed. Rather, we are reiterating our policy, previously finalized in the preamble to the Premium Stabilization Rule (77 FR 17237), where we stated that health plans that are substantially the same as a QHP will be subject to the risk corridors program and signaled an intent to clarify this standard in future rulemaking. Here, we clarify that a plan offered by an issuer outside the Exchange that differs from a QHP offered by the issuer through the Exchange only as a result of Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the Exchange, is “substantially the same” as the QHP and will, therefore, participate in the risk corridors program. To effectuate this change, we are amending the definition of “qualified health plan” at § 153.20 and moving it to § 153.500 to apply solely for purposes of the risk corridors program. Here, we are also clarifying that, when reading the regulations at 45 CFR part 153, subpart F regarding risk corridors, any reference to a “qualified health plan” or “QHP” includes plans that are the “same” as a QHP, as specified below in Part C(1)(a) of this rule, and plans that are “substantially the same” as a QHP, as specified above. We note that changes in service area, and changes in benefits, cost-sharing structure, premium, or provider network

that are not tied directly and exclusively to the Federal or State requirements or prohibitions on the coverage of benefits that apply differentially to a plan depending on whether it is offered through the Exchange, disqualify the plan offered outside the Exchange from participation in the risk corridors program. Additionally, we recognize that OPM may issue additional standards for MSP issuers in the future (for example, standards related to provider networks) that could create situations analogous to the ones we discuss above. We will consider whether a plan that differs from a QHP (as defined at § 155.20) based on these standards would be considered to be “substantially the same” as a QHP for purposes of participating in the risk corridors program, and may address this topic in future rulemaking.

We intend to issue guidance on the operational aspects of this standard, including how HHS and issuers will identify plan submissions (including those submitted for the 2014 benefit year) that are “substantially the same” as a QHP offered through an Exchange for the purposes of determining whether the plan will participate in the risk corridors program. We note that this amendment is limited to the risk corridors program, and does not expand the definition of a QHP for other purposes, including for purposes of parts 155 and 156.

Summary of Regulatory Changes

We are adding a definition of “qualified health plan” at § 153.500 to specify which plans will be subject to the risk corridors program. We are deleting the definition of “qualified health plan” at § 153.20.

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

1. Subpart A—General Provisions

a. Definitions (§ 155.20)

We proposed to amend 45 CFR 155.20 to reflect new flexibility permitting a State to elect to establish and operate just a SHOP, and not both a SHOP and an individual market Exchange, by modifying the definition of “Exchange.”

Exchange

We proposed to amend the term “Exchange” to mean a governmental agency or non-profit entity that meets the applicable standards of Part 155 and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, under the proposed definition this term would include an Exchange serving the

individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

Although we received no direct comment on this proposed change, we received several general comments to the proposed amendments to § 155.100 in support of permitting a State to elect to establish just a SHOP while HHS operates the individual market Exchange. These comments are addressed in conjunction with the comments to §§ 155.100.

Issuer Application Assister

We proposed to define a new term, “issuer customer service representative” to mean an employee, contractor, or agent of a QHP issuer that provides assistance to applicants and enrollees, but is not licensed as an agent, broker, or producer under State law. However, for the same reasons specified in the preamble to § 155.415 below, we will use the term “issuer application assisters” in place of “issuer customer service representatives” to more clearly articulate the role of such individuals. Moreover, as also specified in the preamble to § 155.415 below, we are finalizing a modified definition in this section to reflect in more detail the role of issuer application assisters as defined in § 155.415.

Qualified Health Plan

In the proposed rule, we proposed to specify that, for a plan offered outside an Exchange to be considered the same plan as one that is certified as a QHP and offered through the Exchange, the benefits package, provider network, service areas, and cost-sharing structure of the two offerings would have to be identical. We noted that nothing in that proposal would relieve an issuer of a plan that has been certified as a QHP by an Exchange from the requirement to charge the same premium for the QHP sold to consumers outside of an Exchange pursuant to sections 1301(a)(C)(iii) of the Affordable Care Act and 45 CFR 156.255(b) and 45 CFR 147.104. We also proposed to clarify that a plan sold to consumers outside of an Exchange would only be subject to the risk corridors program if it is the same plan as a QHP *actually offered* by that issuer on the Exchange. We requested comment on all aspects of this approach.

In this final rule, we are finalizing the proposed policy regarding when a plan is the same plan as a QHP for purposes of the same premium requirement.

However, as discussed above in Part B(1)(a) of this final rule, in response to many of the comments we received on this policy with regard to the risk corridors program, we are not finalizing our proposed policy that would have required a plan sold to consumers outside of an Exchange to be the same plan as a QHP offered through an Exchange for purposes of participating in the risk corridors program. We further discuss this policy with respect to the risk corridors program above in Part B(1)(a) of this final rule.

Comment: A number of commenters stated that requiring a plan offered outside of an Exchange to be identical to a QHP offered through an Exchange with respect to the characteristics described above in order to be considered the same plan was too restrictive. As discussed above in Part B(1)(a) of this final rule, commenters were particularly concerned about the effect of such a standard on plans that differ from Exchange QHPs solely as a result of Federal and State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the Exchange.

Response: Although we understand the commenters' concern that Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the Exchange could deprive plans offered outside the Exchange of the protections of risk corridors, we do not believe that this policy concern should result in our considering plans that are “substantially the same” as a QHP to be the “same plan” as the QHP.

In the Premium Stabilization rule (77 FR 17220), we stated that a plan offered outside of an Exchange that is “substantially the same” as a QHP would qualify for the risk corridors program, and stated that we might clarify that standard in future guidance. In response to comment, in Part B(1)(a) of this final rule we are clarifying which plans are “substantially the same” as a QHP, and will therefore be subject to the risk corridors program.

We believe that, for plans that are substantially the same as a QHP, any variations in benefits and cost-sharing structure that are directly tied to Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the Exchange could affect QHP premium rating. Therefore, we are clarifying that a plan offered by a QHP issuer outside an Exchange would be the same as a QHP offered by that same

QHP issuer through the Exchange, only if they are identical with respect to benefits, provider network, service area, and cost-sharing structure, and that, in contrast to our statement in the Exchange Establishment rule, only plans that are the same as a QHP offered through an Exchange must have the same premium as the QHP offered through the Exchange, pursuant to 45 CFR 156.255(b). We also note that this definition of what constitutes the same QHP defines identical plan offerings based only on the criteria set forth above. Accordingly, plan offerings that differ only in other respects (for example, plans' appeals processes or plan name) would not be considered different plans for purposes of the requirement that the same premiums be charged both through and outside the Exchange.

Comment: A few commenters expressed concern that issuers would have already submitted their QHPs to Exchanges for approval for 2014 without the benefit of knowing how to align plans offered outside the Exchanges with QHPs offered through the Exchanges. They asserted that issuers were relying on a “substantially the same” standard when they filed their rates and designed their plan offerings for the 2014 benefit year, and that implementation of the proposed definition in the 2014 benefit year could have a destabilizing effect on the market. Although some commenters recommended that HHS adopt a “substantially the same” standard for QHPs offered outside the Exchanges for the duration of the temporary risk corridors program, others believed that a one-year transition period would provide issuers sufficient time to develop 2015 benefit year offerings that would be eligible for risk corridors. Most commenters did not attempt to clarify how they would decide which plans were “substantially the same” as a QHP; however, one commenter suggested that any plan offered outside the Exchange that could qualify as a QHP be considered “substantially the same” as a QHP.

Response: In Part B(1)(a) of this final rule, we are revising the risk corridors regulations at Part 153 to set forth standards for plans offered outside of an Exchange that are “substantially the same” as a QHP and that will be subject to the risk corridors program. We believe that the regulation text we codify in this rule reflects the standard set forth in the Premium Stabilization Rule, provides flexibility for plans that were relying on an undefined “substantially the same” standard prior to the 2014 rate filing deadline, and also

helps to ensure the integrity of the risk corridors program so that it is clear, prior to the end of 2014 when data for the risk corridors calculation become available, which off-Exchange plans are subject to risk corridors, and which off-Exchange plans are not. We note that we intend to issue guidance on the operational aspects of this standard, including how HHS and issuers will identify plans submissions (including those submitted for the 2014 benefit year) that are "substantially the same" as a QHP offered through an Exchange for the purposes of determining whether the plan will participate in the risk corridors program.

Comment: In the proposed rule, we indicated our intention to clarify that, in order to be the same plan as a QHP, the off-Exchange plan must be offered by the same issuer that offers a QHP inside of an Exchange. Two commenters stated that requiring plans offered through the Exchange and plans offered outside of the Exchange to be offered by the same issuer could present significant operational challenges for issuers that organize their corporate structures so that Exchange offerings are provided by one entity and offerings outside of an Exchange are provided by another. One of the commenters was also concerned that the requirement could restrict the range of products that would be available outside of an Exchange, and recommended that we revise our proposed policy to clarify that an off-Exchange QHP would be subject to the risk corridors program if it met the criteria in our proposed policy and was offered on an Exchange by the same "issuer group," as defined at 45 CFR 156.20, instead of the same issuer.

Response: While we recognize that the structure of some organizations may result in Exchange offerings and offerings outside of an Exchange that are offered by different issuers within the same issuer group, we believe that expanding this definition beyond the issuer level is inconsistent with how pricing is developed pursuant to the single risk pool provision at 45 CFR 156.80, which applies at the issuer level to all non-grandfathered plans in the individual and small group markets within a State. Expanding the risk corridors program to plans that are the same or substantially the same as QHPs offered outside the Exchange by a different issuer within an issuer group could result in a risk corridors calculation that must take into account total claims costs and total premiums for the entire risk pool for all the relevant issuers in the issuer group. We believe the risk corridors program properly considers claims and

premiums only for the risk pool applicable to the single issuer.

Comment: One commenter supported our proposal requiring a plan offered outside of an Exchange to have an identical provider network and service area as a QHP offered through an Exchange in order to be the same plan as the QHP offered through the Exchange. Another commenter opposed these requirements, arguing that the proposed standard should only include EHB, actuarial value (AV), and cost-sharing structure. The commenter believed that requiring identical networks and service areas was too restrictive because it would not allow for differences in network and service areas that result from licensure restrictions.

Response: As stated above, a plan is the same as a QHP only if it is identical with respect to benefits, provider network, service area, and cost-sharing structure to a QHP offered by the same issuer through the Exchange. We believe that certification of a plan's service area is an integral part of the QHP certification process, and so believe it is integral to what it means to be the same QHP. We also believe it important that Exchange enrollees enjoy access to the same service areas (and networks) as enrollees in the same plans when offered outside the Exchanges.

Summary of Regulatory Changes

We are finalizing the definition of "Exchange" as it was proposed. We are not codifying changes to the definition of "qualified health plan" in this section. For purposes of clarity, in finalizing this policy, we will use the term "issuer application assisters" in place of "issuer customer service representatives" to more clearly articulate the role of such individuals and we are finalizing a modified definition of "issuer application assisters" to reflect in more detail the role of issuer application assisters as defined in § 155.415.

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

a. Establishment of a State Exchange, Approval of a State Exchange, (§§ 155.100, 155.105, and 155.140)

Consistent with our proposed amendment to the definition of "Exchange" in § 155.20, we proposed to amend § 155.100 to permit a State to establish and operate only a State-based SHOP while the individual market Exchange is established and operated as an FFE. We proposed that pursuant to the proposed amendment, States would

not be permitted to establish and operate only the individual market Exchange.

We proposed in § 155.100(a)(3) that a State that has timely applied for certification of an Exchange for 2014, and that has received conditional approval for its application, would be able to modify its Exchange Blueprint pursuant to 45 CFR 155.105(e) to exclude the operation of the individual market Exchange functions for 2014. We explained in the preamble to the proposed rule that such States have been preparing to establish and operate both the individual market and SHOP Exchanges for 2014, and would be in a position to establish and operate just the SHOP in 2014. We sought comment on this approach.

We proposed to amend § 155.105 so that the Exchange approval criteria set forth therein would be consistent with the Exchange operational models proposed in §§ 155.20, 155.100, and 155.200, and to permit HHS to operate only a FFE that will make QHPs available to qualified individuals when a State has elected to operate only an Exchange providing for the establishment of a SHOP pursuant to proposed § 155.100(a)(2).

We also proposed an amendment to § 155.105(f) to clarify that the regulatory provisions that will apply in an FFE include the nondiscrimination requirements of § 155.120(c). Section 155.120(c), as written, applies to all Exchanges, and its previous omission from the list of provisions referenced in § 155.105(f) was inadvertent.

We also proposed to amend § 155.140 to clarify how a subsidiary or regional Exchange may operate in light of the proposed amendments to permit a State to establish and operate an Exchange only providing for the establishment of a SHOP.

Comment: We received several general comments in support of permitting a State to elect to establish and operate only a SHOP. Some commenters supported the additional flexibility provided for States to establish and operate only a SHOP in 2014 and recommended expanding the provision further to allow other States, such as States that timely submitted a complete Blueprint, to establish and operate only a SHOP in 2014. One commenter supported allowing any State that believes it would be ready to establish and operate only a SHOP to do so in 2014. Other commenters opposed allowing a State to establish and operate only a SHOP, noting potential adverse consequences to consumers due to a loss of efficiencies and coordination by having different entities administering

the individual market Exchange and the SHOP. One commenter supported the proposed policy of not allowing a State to establish and run only an individual market Exchange and the while the SHOP is established and operated as an FF-SHOP. This commenter noted that in this scenario, there would be less leverage for attracting issuer participation in the SHOP and the SHOP would suffer diminished operational efficiencies if it is not accompanying an individual market Exchange.

Response: We agree with the commenters who suggested that we should extend the opportunity to establish and operate only a SHOP in 2014 to more than just those States that have a conditionally approved Exchange Blueprint in place for 2014. As we explained in the preamble to the proposed rule, our intent in limiting the option in 2014 was to make sure that only those States that would be in a position to establish and operate just the SHOP in 2014 do so. We are convinced by the commenters who suggested that these States might include more than just those States with a conditionally approved Exchange Blueprint. Accordingly, we have modified the proposed language to extend the option of establishing and operating only a SHOP Exchange for 2014 to any State that provides reasonable assurances, through the Exchange Blueprint submission and/or amendment process, to CMS that it will be in a position to establish and operate just a SHOP in 2014.

Comment: A number of commenters expressed support for our clarification in § 155.105(f) that the regulatory provisions that apply in FFEs include the nondiscrimination requirements of § 155.120(c). Commenters recommended including in § 155.105(f) a reference to section 1557 of the Affordable Care Act, and one commenter asked CMS to identify prohibited practices under section 1557 of the Affordable Care Act. Commenters also requested further clarification on the application of these antidiscrimination protections to consumer assistance entities receiving funds associated with implementation and operation of the Federally-facilitated Exchanges.

Response: We are finalizing this clarification as proposed. We note that § 155.120(c)(1) already specifies that the State and the Exchange, which would include FFEs and State Partnership Exchanges through this amendment to 155.105(f), must comply with applicable nondiscrimination statutes. Section 1557 of the Affordable Care Act applies to all Exchanges as entities created

under Title I of the Affordable Care Act. Therefore, we do not think it is necessary to refer to any specific nondiscrimination statutes in this regulation text. Further clarification of prohibited practices under section 1557 of the Affordable Care Act is beyond the scope of this rulemaking. For a more detailed discussion of the application of § 155.120(c) to Exchange consumer assistance entities, please see the recent final rule, Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, 78 FR 42824, 42829–42830, 42844 (July 17, 2013).

Comment: One commenter sought clarification in proposed § 155.140 on the provision relating to the geographic area covered by subsidiary SHOPS in a State operating only a SHOP. The commenter wanted to ensure that if a State establishes subsidiary SHOPS that it must provide access to a SHOP in all geographic areas of the State.

Response: We clarify here that the proposed provision on subsidiary SHOPS in a State operating only a SHOP requires the combined geographic area of all subsidiary SHOPS established by the State to encompass all geographic areas of the State. In such circumstances, HHS would establish an individual market Exchange that covers all geographic areas of the State. Thus, the combined geographic areas of any subsidiary SHOPS would also be required to encompass all geographic areas of the State.

Summary of Regulatory Changes

We are finalizing these provisions as follows. We are finalizing § 155.100(a)(3) at 155.100(b) and redesignating § 155.100(b) as § 155.100(c) to ensure parallel structure in the regulatory text. We are modifying § 155.100(b) to expand the opportunity to operate only a SHOP in 2014 to States that provide reasonable assurances, through the Exchange Blueprint submission and/or amendment process, to CMS that they are prepared to establish and operate only a SHOP in 2014. We are also modifying § 155.105(b)(1) and (f) to include cross-references to the Exchange minimum functions concerning eligibility appeals and exemptions from the shared responsibility payment that are being finalized at the time of this rule.

3. Subpart C—General Functions of the Exchange

a. Functions of an Exchange (§ 155.200)

Consistent with the amendments described above to §§ 155.20, 155.100, 155.105, and 155.140, which permit a State to operate only an Exchange providing for the establishment of a SHOP, we proposed amending § 155.200 so that a State operating an Exchange which provides only for the establishment and operation of a SHOP need perform only the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein. Under such circumstances, the Exchange operated by HHS need not perform the minimum functions related to the establishment of a SHOP.

Although we received no direct comment on this proposal, we received several general comments and comments to § 155.100 in support of permitting a State to elect to establish just a SHOP.

Summary of Regulatory Changes

We are finalizing the provision, with a modification to include cross-references to the Exchange minimum functions concerning eligibility appeals and exemptions from the shared responsibility payment that are being finalized at the time of this rule.

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

We proposed amending § 155.220(c)(3)(i), which currently requires that a Web-broker meet all standards for disclosure and display of QHP information contained in § 155.205(b)(1) and § 155.205(c). We sought comment on whether we should instead remove § 155.220(c)(3)(ii).

We proposed adding a new paragraph (c)(3)(vii) that would require a disclaimer be used by Web-brokers on their Web sites.

We proposed to add a new § 155.220(c)(4) that would require any Web-broker who makes an Internet Web site available to other agents and brokers to enroll consumers in QHPs through the FFE to require as a condition of agreement or contract that the agent or broker accessing and using the Internet Web site complies with § 155.220(c) and (d). We also proposed that a Web-broker that makes an Internet Web site available for this purpose would be required to provide to HHS a list of agents and brokers who are under such arrangements, and that the Web-broker

be required to ensure that the agent or broker accessing or using the Internet Web site would be required to comply with the policies that the Web-broker would be required to develop under proposed § 155.220(d)(4).

We further proposed adding a new § 155.220(d)(4) requiring agents and brokers assisting or enrolling consumers in the individual market of an FFE to establish policies and procedures implementing the privacy and security standards pursuant to § 155.220(d)(3). We proposed such standards to include training employees, representatives, contractors, and agents with regard to those policies and procedures on a periodic basis, and to ensure such individuals comply with those policies and procedures. We sought comment on the appropriate frequency of retraining requirements.

We also proposed adding a new § 155.220(f), which would require agents and brokers who wish to terminate their agreement with an FFE to send to HHS a 30-day advance written notice of the intent to terminate, and invited comment on whether we should additionally require agents and brokers to also directly notify their clients of the termination.

We proposed adding a new § 155.220(g), which would set forth standards under which HHS may terminate an agent's or broker's agreement with an FFE for cause. In § 155.220(g)(1), we proposed that HHS may pursue termination with notice of an agent's or broker's agreement with an FFE executed pursuant to § 155.220(d) if, in HHS's determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe. In § 155.220(g)(2), we set forth the violations that could lead to a termination for cause. We explained that we were also considering implementing informal procedures to resolve certain compliance issues that would take place prior to HHS's termination of an agent's or broker's agreement for cause. Notwithstanding the fact that we were also contemplating an informal resolution procedure, we also proposed that upon identification of a sufficiently severe violation, HHS would formally notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance, as proposed in § 155.220(g)(3). The agent or broker would then have a period of 30 days from the date of the notice to correct the noncompliance to HHS's satisfaction, through good faith efforts. If after 30 days, the noncompliance is not appropriately addressed, we proposed

HHS may terminate the agreement for cause.

We proposed adding a new § 155.220(h) to provide an agent or broker whose agreement with the FFE was terminated for cause with a process to request reconsideration of the termination. We proposed that the agent or broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written notice from HHS, after which the HHS reconsideration entity would provide the agent or broker with a written notice of a final reconsideration decision within 30 calendar days of the date the request was received.

Comment: Many commenters offered feedback on the proposed amendment to § 155.220(c)(3)(i). Some commenters expressed support for the amendment while several other commenters opposed any changes to the requirement for Web-brokers to display QHP information. In expressing their opposition to the amendment of § 155.220(c)(3)(i), some commenters offered recommendations in the event we finalized the amendment. Some commenters suggested that a Web-broker prominently display a standardized disclaimer provided by HHS if the Web-broker is not able to display the required QHP information for a given plan, and that the Web-broker provide a Web link to the Exchange Web site.

Response: We did not accept the comments which suggested that we not finalize the proposed amendment to § 155.220(c)(3)(i) because there may be circumstances beyond the control of Web-brokers that will preclude them from displaying all of the information required under § 155.205. For instance, Web-brokers currently obtain plan data directly from issuers, and generally only obtain data from issuers if they have contractual arrangements and/or appointments to sell the issuer's plans. Thus Web-brokers may be restricted from displaying all plan data, including premium and rate information, if they do not have agreements or appointments with some issuers. Similarly, the Exchange may be precluded by trade secret and confidentiality considerations from providing all Web-brokers with certain data elements necessary to meet the § 155.205(b)(1) standards. As a result, we continue to believe that the amendment to § 155.220(c)(3)(i) is necessary. In such circumstances, it is important that Web-brokers ensure applicants are aware that not all QHP information may be available on their Web sites by

displaying required disclaimers under § 155.220(c)(3)(i) and (vii).

Comment: The proposed amendment to § 155.220(c)(3)(i) also added to the standards for Web-brokers' Web sites by requiring a link to the Exchange Web site. In addition, proposed § 155.220(c)(3)(vii) required a disclaimer that included acknowledgement that the Web-broker's Web site might not display all QHP data available on the Exchange Web site. A number of commenters proposed combining these two concepts, recommending that HHS provide a standardized disclaimer and a link to the Exchange Web site to the extent that not all QHP information required under § 155.205(b)(1) is displayed on a Web-broker's Web site. Conversely, other commenters suggested that this disclaimer should be separate from the disclaimer proposed in § 155.220(c)(3)(vii) informing the consumer that the Web-broker's Web site is not the Exchange Web site. Commenters suggested that a standardized disclaimer would provide a uniform and consistent way to notify the consumer regarding how to obtain the available QHP information in the event that such information is not available on the Web-broker's Web site.

Response: We found these comments regarding the need for a standardized disclaimer and Web-link to be persuasive so applicants are aware of the incompleteness of the information available on these Web sites. As a result, we have modified the amendment to § 155.220(c)(3)(i) by requiring Web-brokers to prominently display a standardized disclaimer and to provide a Web link to the Exchange Web site. We will make available a HHS-approved standardized disclaimer that Web-brokers can use to meet this requirement, stating that information required under § 155.205(b)(1) for the QHP is available on the Exchange Web site.

We considered, but did not accept, other recommendations provided by commenters if the amendment were to be retained, including consideration of an inline frame or "I-frame" approach to presenting QHP information, requiring that Web-brokers refer consumers to Navigators and certified application counselors if unable to display all QHP information, and to have HHS release all plan information for a particular QHP to Web-brokers if the issuer of the QHP requests that HHS do so. We recognize that each of these suggestions may help provide additional information to consumers about their QHP options, but may be difficult to implement prior to the start of open enrollment.

Comment: Many commenters offered recommendations about whether to remove § 155.220(c)(3)(ii), which requires Web-brokers to provide consumers with the ability to view all QHPs offered through the Exchange, as an alternative to amending § 155.220(c)(3)(i). Several commenters expressed support for retaining § 155.220(c)(3)(ii) as a key consumer protection, while other commenters recommended removing the requirement in lieu of amending § 155.220(c)(3)(i).

Response: We agree with commenters that the requirement for Web-brokers to provide consumers with the ability to view all QHPs offered through the Exchange is an important consumer protection, even if the Web-broker is not able to display all plan details for each QHP. We are retaining § 155.220(c)(3)(ii) without modification.

Comment: A number of commenters expressed support for proposed § 155.220(c)(3)(vii) so consumers would be informed that the Web-broker's Web site is not the Exchange Web site, and that the Web-broker has agreed to comply with applicable regulations as a condition of their agreements with HHS. Some commenters recommended that HHS provide a standardized disclaimer that could be used by all Web-brokers to meet this requirement, to ensure uniform and consistent communication to consumers across all Web-broker Web sites. Commenters recommended specific elements that should be included in the disclaimer. Other commenters suggested that Web-brokers be required to display the disclaimer in specific locations or on every page of the Web-broker's Web site. One commenter recommended that the disclaimer not reference the Web-broker's agreement with HHS, but rather the standards to which the Web-broker must comply. To provide for greater consumer protection, several commenters also suggested that HHS standardize the notification by providing a standardized disclaimer, which would provide for uniform and consistent communication to consumers across all Web-broker Web sites.

Response: The proposed § 155.220(c)(3)(vii) added to the standards for Web-broker's Web sites in FFEs by requiring prominent display of language notifying consumers that the agent's or broker's Web site is not the FFE Web site, that the agent or broker's Web site might not display all QHP data available on the FFE Web site, that the agent or broker has entered into an agreement with HHS pursuant to paragraph (d) of this section, and that the agent or broker agrees to conform to

the standards specified in paragraphs (c) and (d) of this section. While the proposed § 155.220(c)(3)(vii) specified the elements to be included in the notification, it would have permitted Web-brokers to independently develop their own notifications.

To provide for greater consumer protection, we agree with commenters that a standardized disclaimer should be used for the FFEs, and we have modified the final § 155.220(c)(3)(vii) to require Web-brokers to use a standardized disclaimer provided by HHS, which would distinguish the Web-broker's Web site from the FFE Web site. The standardized disclaimer would include the following notifications: (1) That the Web-broker's Internet Web site is not an FFE Web site, (2) that the Web-broker's Web site may not contain all QHP data available on the FFE Web site, (3) that the Web-broker is required to conform to the standards specified in paragraphs (c) and (d) of § 155.220, and (4) the Web-broker is subject to privacy and security standards established by HHS pursuant to § 155.260.

We also recognize that commenters provided other suggestions for topics to include in the disclaimer, including information about whether the Web-broker's Web site contains all information for QHPs in a given State, or information about how consumers can contact HHS if the Web-broker does not comply with the requirements for display of QHPs. Although we are not adopting these suggestions at this time, HHS may adjust the disclaimer in the future to meet the needs of the FFE and its consumers.

We believe that requiring the disclaimer to be posted on every Web page of a Web-broker's Web site may be repetitive and burdensome. However, we agree that the disclaimer should be prominently displayed, and that display on more than a single Web page may be warranted so that the consumer may be fully informed. We plan to address how the disclaimer should be displayed in future guidance.

Comment: Several commenters recommended that we clarify the process that Web-brokers must follow when a consumer (or a member of that consumer's family) using a Web-broker's Web site is determined or assessed to be eligible for Medicaid or CHIP.

Response: As indicated in CMS's guidance titled "Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces,"⁶ we expect

⁶ Role of Agents, Brokers, and Web-brokers in Health Insurance Marketplaces (May 1, 2013), available at: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf>.

agents and brokers, including Web-brokers, to work with all consumers, including individuals who are ultimately determined to be eligible for Medicaid or CHIP. In such cases, we expect that agents, brokers and Web-brokers will refer the individual to the appropriate State agency for enrollment in health coverage.

Comment: Some commenters recommended that we apply § 155.220(c)(3)(vii) to State Exchanges. Other commenters requested that we clarify that State Exchanges are not required to contract with Web-brokers, and that they may set more stringent standards than the FFE.

Response: While we did not accept the comment to apply § 155.220(c)(3)(vii) to State Exchanges, we note that State Exchanges have discretion to apply a similar or more stringent requirements.

Comment: We received substantial feedback on proposed § 155.220(c)(4). Many commenters expressed support for allowing arrangements under which agents and brokers would be able to enroll qualified individuals in an FFE through a Web-broker's Internet Web site, even if the agent or broker were not an employee or subcontractor of the Web-broker. Such commenters noted that requiring independent agents and brokers to subcontract with Web-brokers is not standard in the industry. Some commenters recommended that we clarify the types of arrangements that would be permitted between Web-brokers and other agents and brokers. Other commenters recommended prohibiting agents and brokers from accessing Web-brokers' Web sites altogether, unless they were an employee or subcontractor of the Web-broker. Such commenters believed that such arrangements bring additional complexity, noting that Web-brokers' Web sites may not display all required QHP information, and were concerned that these agents and brokers might not be subject to the same level of oversight as other agents and brokers in the FFE, since they are not party to HHS' agreement with the Web-broker.

Some commenters responded to our concerns regarding oversight of other agents and brokers that access the Web-broker's Web sites, objecting to the provision requiring Web-brokers to ensure that agents and brokers accessing their Web sites comply with § 155.220(c) and (d). These commenters noted that it could result in a Web-broker and all agents and brokers accessing its Web site to have their connection to the Federally-facilitated Exchange terminated based upon violations by a single agent or broker.

Other commenters provided specific recommendations for Web-broker requirements if agents and brokers are permitted to use Web-brokers' Web sites to enroll consumers in QHPs through the Exchange, including ensuring agents and brokers provide unique identifiers such as FFE User ID numbers or National Producer Numbers (NPNs), and other documentation to the Web-broker proving they are trained and registered to sell products on the Exchange, and have entered into agreements with CMS to abide by the terms of § 155.220. Commenters stated there should be a way for CMS to identify and notify Web-brokers providing access to other agents and brokers, if the other agent or broker commits a material breach of their agreements with HHS, so that the Web-broker may limit the agent's or broker's access as needed.

Response: While we recognize that agents and brokers may be able to reach and enroll significant number of consumers through Web-broker's Web sites, we are also concerned about ensuring that such agents and brokers comply with the standards in § 155.220(c) and (d). We note that agents or brokers who carry out the functions authorized under § 155.220(a)(2) and (3) are required to comply with the standards in § 155.220(c) and (d), regardless of whether they use a Web-broker's Web site, and that they ultimately remain responsible for their own compliance. Many agents and brokers currently use Web sites and other systems technology provided by Web-brokers to help significant numbers of consumers compare and purchase individual market coverage across multiple issuers. If Web-brokers are able to provide a way for other agents and brokers to leverage their Web sites and connection to HHS when the Exchanges begin operating, these agents and brokers would be able to reach additional individuals currently without coverage. As a result, we did not accept comments that agents and brokers be prohibited from entering into arrangements that would enable them to use a Web-broker's Web site to assist a consumer in enrolling in a QHP through the Exchange. While we recognize that some Web-brokers might be willing to be responsible for overseeing the actions of other agents and brokers who access their Web sites, we also did not want to limit the permissible arrangements to those in which the agent and broker can only use the Web-broker's Web site as a subcontractor so as to maximize opportunity for agent and broker participation.

We also recognize the concerns of Web-brokers that they, along with other

agents and brokers who access their Web sites, might be held accountable for the non-compliance of a single agent or broker. However, we also want to ensure that HHS can take action against the single non-compliant agent or broker if necessary, and that the Web-broker and HHS can terminate that agent's or broker's ability to transact eligibility and enrollment information through the Web-broker's Web site. We also want to ensure that HHS has a way to contain privacy and security incidents and breaches, should they be caused by agents and brokers accessing the Web-brokers' Web sites. As a result, we have modified the proposed § 155.220(c)(4) so that the Web-broker is no longer the entity that must ensure that agents and brokers accessing its Web site comply with the standards in § 155.220(c) and (d). We accept commenters' recommendations that the Web-broker must verify that any other agent or broker accessing its Web site is licensed by the applicable State(s), has completed training, has signed all required agreements with the FFE, and is registered with the FFE pursuant to § 155.220(d). The Web-broker must cooperate with HHS in taking compliance actions against a non-compliant agent or broker, including facilitating a shut-down of any connection to HHS systems while privacy and security incidents and breaches are investigated, ensuring compliance with applicable standards by all agents and brokers accessing its Web site, and performing necessary actions to assist HHS with overseeing the actions of agents and brokers using its Web site. In response to the comments, we believe that requiring the Web-broker to display its name and identifier on the Web site when it is made available to another agent or broker, will increase transparency regarding the relationships between the other agents and brokers and the Web-broker, and facilitate CMS and/or State enforcement actions against an agent or broker accessing its Web site, in the event of a breach or violation.

In response to all of these comments, we are modifying the final § 155.220(c)(4) to clarify the requirements that apply to a Web-broker that permits other agents or brokers to access its Web site pursuant to a contractual arrangement. In response to comments recommending clarification of the types of permissible arrangements between Web-brokers and other agents and brokers under this provision, we clarify that the provision applies to contractual or other arrangements in which an agent or broker accesses the

Web-broker's Web site to enroll consumers through the FFE. We have also added language to the final rule clarifying that in such arrangements, the agent or broker is the agent of record on the enrollment. As finalized, § 155.220(c)(4) would allow HHS to identify Web-broker's Web sites and take appropriate action if the agent or broker who uses the Web-broker's Web site violates the terms of the agent's or broker's agreement with HHS. Section 155.220(c)(4)(i) applies the following requirements on Web-brokers that allow other agents and brokers to access their Web sites: (1) The Web-broker must provide the FFE with a list of agents or brokers who enter into such an arrangement if requested by HHS; (2) the Web-broker must verify that the agent or broker using the Web site is licensed in the FFE's State, has completed training and registration, and has signed all applicable agreements with the Federally-facilitated Exchange; (3) the Web-broker must ensure that its name and any identifier required by HHS, such as the Web-broker's National Producer Number (NPN), appears on the Internet Web site and written materials containing QHP information that can be printed from the Web site, even if the agent or broker that is accessing the Internet Web site is able to customize the appearance of the Web site; (4) terminate the other agent or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of § 155.220 and any required agreement between HHS and the agent or broker is terminated; and (5) report to HHS and applicable State Department of Insurance any potential material breach of the standards in § 155.220(c) and (d) by the agent or broker accessing the Internet Web site, should the Web-broker become aware of any such potential breach.

This approach would ensure that agents and brokers that access Web-broker's Web sites must meet the same registration and training requirements and be subject to the same oversight requirements as other agents and brokers in the FFE. This approach would also ensure that agents and brokers whose agreements with HHS are terminated are no longer able to access HHS systems through a Web-broker's connection. In addition, this requirement would also help provide transparency and traceability back to the Web-broker making the Web site available, if HHS or a State department of insurance needed to take action with respect to an agent or broker using a Web-broker's Web site.

Section 155.220(c)(4)(ii) clarifies that HHS retains the right to temporarily

suspend the Web-broker's connection to HHS' systems in the event of a privacy and security incident or breach involving a Web-broker that makes its Web site available to third party agents and brokers under previously described arrangements. In the case of an incident or breach, HHS must follow its incident response plan to address privacy and security incidents and breaches. In adhering to its incident response plan, HHS may need to temporarily suspend a Web-broker's connection to HHS' systems to contain further damage from the incident or breach if the incident or breach is related to the Web-broker and its connection to HHS' systems. The temporary suspension would provide HHS with the ability to conduct an investigation and work with the Web-broker to remedy the breach or incident.

Comment: Several commenters recommended that Web-brokers not be permitted to use data collected for Exchange enrollment purposes for any other purpose.

Response: Data collected for Exchange application purposes may be used only in accordance with section 1411(g) of the Affordable Care Act. Consistent with section 1411(g), in the agreements that HHS will enter into with Web-brokers, HHS will permit Web-brokers to use personally identifiable information (PII) collected through the Exchange application and enrollment process only for certain functions related to the efficient operation of the Exchange, such as assisting with applications for QHP eligibility, supporting QHP selection and enrollment by assisting with plan selection and plan comparisons, and assisting with applications for the receipt of APTCs or CSRs, and selecting an APTC amount.

Comment: Several commenters expressed support for proposed § 155.220(d)(4), which proposed requiring agents and brokers participating in the FFE individual market to implement policies to train their workforce in privacy and security standards pursuant to § 155.220(d)(3). Some commenters further recommended that such training occur on an annual basis, at a minimum. One commenter also recommended that HHS clarify that agents and brokers could only use PII accessed from individuals during the QHP eligibility and enrollment process for FFE-related functions that agent or broker is authorized to carry out under the terms of its agreement with HHS, and several others stressed that agents and brokers should be required to destroy any PII obtained during the eligibility and enrollment process after the termination

of an agent or broker's relationship with an FFE.

Response: We believe it is critical to ensure that agents and brokers implement appropriate safeguards and procedures, including privacy and security training to protect the PII of individuals whom they assist with applications for Exchange coverage, advance payments of the premium tax credit, and cost sharing reductions, and with QHP enrollment through the FFE. We note that § 155.260(b) requires non-Exchange entities, including agents and brokers, to abide by the privacy and security policies adopted by the FFE as a condition of contract or agreement with the FFE. Because obligations regarding compliance with privacy and security standards will be imposed on agents and brokers through agreements executed pursuant to § 155.260(b), we are not finalizing § 155.220(d)(4), or additional privacy and security requirements for agents and brokers in this rule. Instead we clarify here that in the FFEs, agents and brokers will agree to comply with the Exchange's privacy and security standards as required by § 155.220(d)(3) through separate agreements that the FFE will execute with agents and brokers under § 155.260. Such agreements will specify the authorized functions for which agents and brokers may use PII, and will set forth the agent's or broker's duties to protect and maintain the privacy and security of PII for such functions, including developing privacy and security training programs for members of their workforces who access PII while carrying out such authorized functions. The agreements will also prohibit agents and brokers from using PII accessed through the Exchange application and enrollment process for any purpose other than the specific functions authorized by the agreements.

HHS seeks to minimize burdensome duplication of existing laws and any Exchange-specific requirements and standards for protecting PII pursuant to section 1411(g) and § 155.260. We recognize that agents and brokers are also required to adhere to other Federal laws safeguarding certain kinds of information, such as HIPAA and the Gramm-Leach-Bliley Act (GLBA), in addition to any applicable State laws, and may leverage existing compliance infrastructures as appropriate to implement Exchange privacy and security requirements to protect PII.

Comment: We received broad support from commenters for proposed § 155.220(f), which provided for a 30-day advance written notice of termination from agents and brokers to HHS. A few commenters stressed it

would be appropriate for all agents or brokers that receive a 30-day advanced notice of termination to be immediately suspended from assisting individuals to enroll in a QHP offered through the FFE and/or the ability to securely exchange information with HHS, at least temporarily. In response to our request for comments, commenters expressed support for a requirement that agents and brokers notify clients of such termination. Commenters recommended that agents and brokers should continue to assist existing clients with completion of QHP applications and/or enrollment until the agent's or broker's intended date of termination, and to inform clients that additional assistance is available through the FFE.

Response: We agree with commenters' recommendations to also require agents and brokers to notify consumers if the agent or broker plans to terminate its agreement with an FFE under § 155.220(f). Further, we agree that agents and brokers should continue assisting consumers throughout the pre-termination period, and should inform consumers that they can continue to obtain additional assistance through an FFE. We have modified the final rule to include provisions reflecting these comments.

Comment: Several commenters supported proposed § 155.220(g) and suggested that we specify that HHS may terminate an agent's or broker's agreement for violations of specific State laws, including patterns of steering or unfair and deceptive trade practices. Other commenters that expressed support for § 155.260(g) also recommended HHS immediately suspend an agent's or broker's agreement, if findings of noncompliance were sufficiently egregious, until the cure period is completed to HHS' satisfaction.

Response: We will look to State authorities to enforce their own State laws regulating agents and brokers. In response to the comments regarding immediate and temporary suspensions or terminations from the FFE, we believe the implementation of an informal resolution procedure prior to terminating an agent's or broker's agreement that was discussed in the preamble and contemplated under the cure period in § 155.220(g), addresses the range of potential responses and recognizes that nothing would preclude HHS from retaining the right to bypass these informal procedures. We also note that HHS retains the ability to terminate an agent's or broker's relationship with an FFE for cause, including based on termination of the separate agreement executed pursuant to § 155.260(b).

Comment: Several commenters also recommended HHS should be required to inform State departments of insurance (DOIs) of any administrative or disciplinary actions taken against licensed agents and brokers for violations of FFE rules under § 155.220. One commenter also suggested HHS should not take any action based on an FFE violation until the State takes action.

Response: As we emphasized in the preamble to the proposed rule, we expect that States will continue to oversee and regulate agents and brokers within their States, both inside and outside of the Exchange. This applies whether the Exchange is an FFE, including a State Partnership Exchange, or a State Exchange. To avoid duplication of oversight activities related to agents and brokers enrolling or assisting consumers through an FFE, HHS will focus its oversight activities primarily on ensuring that agents and brokers in an FFE meet the standards outlined in § 155.220, including the requirements set forth in the agreements entered into under § 155.260(b). Thus, we intend to defer to States in all areas where the State DOIs are the primary regulators of agent and broker conduct, which will entail open communication and collaboration with State DOIs.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.220(c)(3) of the proposed rule as follows: in paragraph (c)(3)(i), we amend the provision to require the prominent display of a standardized disclaimer provided by HHS stating that QHP information required under § 155.205(b)(1) is available on the Exchange Web site and providing Web link to the Exchange Web site, for use when not all QHP information required under § 155.205(b)(1) is displayed on the Web-broker's Web site. In paragraph (c)(3)(vii), we modify the provision to require the display of a standardized disclaimer provided by HHS, and provision of a Web link to the Exchange Web site. In paragraph (c)(4), we clarify that the provisions in this paragraph are applicable to a Web-broker when it permits other agents and brokers to use its Internet Web site to enroll individuals in an FFE through a contract or other arrangement, and the agent or broker accessing the Web site pursuant to the arrangement is listed as the agent of record on the enrollment. We also require that such a Web-broker must: (1) Provide HHS a listing of agents and brokers entering into such arrangements if requested by HHS; (2) ensure that the agent or broker is licensed in the State

in which the consumer is selecting the QHP; (3) verify that the agent or broker has completed training, registration and has signed all required agreements with the FFE; (4) ensure that its name and any identifier required by HHS prominently appears on the Internet Web site and on written materials containing QHP information that can be printed from the Web site, (5) terminate the agent's or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker, and (6) report to HHS and the applicable State DOI any potential material breach of the standards in § 155.220(c) and (d), or the agreement entered into pursuant to § 155.260(b), by the agent or broker accessing the Internet Web site. Furthermore, paragraph (c)(4)(ii) also permits HHS to temporarily suspend the Web-broker's ability to transact information with HHS in the event of a severe privacy and security incident or breach, for the period in which HHS conducts an investigation and the incident or breach is remedied.

Additionally, we are not finalizing § 155.220(d)(4) and are amending § 155.220(f) to require agents and brokers to also notify consumers that they plan to terminate their agreement with an FFE. We revised § 155.220(f) and (g) to refer to the agreements that the FFE will enter into with agents and brokers pursuant to § 155.260(b), and are making a technical correction to correct a typographical error in § 155.220(h)(3).

c. Electronic Information Exchange With Covered Entities (§ 155.270)

Section 155.270 of 45 CFR directs Exchanges that perform electronic transactions with a HIPAA-covered entity to use standards, implementation specifications, operating rules, and code sets adopted by the Secretary in 45 CFR parts 160 and 162. When 45 CFR 155.270 was finalized in its current form, HHS believed that the HIPAA standard transactions, adopted pursuant to 45 CFR Parts 160 and 162, were the most appropriate standards for transmitting information electronically between Exchanges and issuers. Since then, the Accredited Standards Committee X12,⁷ which governs the electronic transactions addressed in 45 CFR 160 and 162, has determined that the currently approved transaction used to communicate payment-related information, the HIPAA ASC X12

005010X218, will not provide the program-level payment information necessary for the risk adjustment, reinsurance, and risk corridors programs, and therefore does not meet the business requirements of the Affordable Care Act programs. As a result, HHS has worked with the Accredited Standards Committee X12 to develop and finalize the ASC X12 005010X306, referred to as the "HIX 820." The HIX 820 meets the same HIPAA technical requirements as the currently approved ASC X12 005010X218, but it is a new implementation of the transaction, so it has not yet been adopted by the Secretary pursuant to 45 CFR parts 160 and 162. We believe that the HIX 820 is another appropriate method for transmitting payment-related information between the Exchange and a covered entity. We note that the HIX 820 is the only method that provides the program-level payment information necessary for the risk adjustment, reinsurance, and risk corridors programs. HHS intends to use the HIX 820 for those reasons. To provide for flexibility should similar situations arise in the future, we proposed to amend § 155.270 to specify that to the extent that an Exchange performs electronic transactions with a HIPAA-covered entity, an Exchange must use standards, implementation specifications, operating rules, and code sets that are adopted by the Secretary pursuant to 45 CFR parts 160 and 162 or that are otherwise approved by HHS. We further proposed to approve the HIX 820 transaction for transmitting payment-related information between the Exchange and a HIPAA-covered entity. We note that the choice of transaction protocol does not implicate privacy or security concerns.

After considering the comments below, we are finalizing the amendment to this provision as proposed. We are also finalizing in the preamble approval of the HIX 820 transaction, and we are identifying the NACHA CCD with Addenda Record (CCD+) as the HIPAA standard for healthcare electronic funds transfer when a HIX 820 transaction is transmitted between an Exchange and a covered entity.

Comment: One commenter asked HHS to require all Exchanges to use the HIX 820 transaction as a condition of participation with the Federal data services hub because a uniform standard would streamline data processes for multi-State issuers.

Response: HHS will not require Exchanges to use the HIX 820 transaction. Many State Exchanges are deploying systems using the currently

⁷ The Accredited Standards Committee is chartered by the American National Standards Institute. See, <http://www.x12.org/>.

approved HIPAA ASC X12 005010X218 standard, and we do not wish to require States to rework existing implementations.

Comment: Several commenters asked that HHS commit to working through existing standards organizations and attempt to leverage existing standards, or those derived from existing standards, for approving electronic transactions. Those commenters asked HHS to engage the affected stakeholders or trading partners in a formalized advisory process to develop an appropriate proprietary transaction standard with the goal of minimizing trading partner system disruptions or burdens.

Response: In the future, we anticipate consulting with stakeholders and standards bodies prior to approving a new electronic transaction, as we did with the HIX 820 and as we do now with the NACHA CDD with Addenda Record (CCD+).

Comment: One commenter requested that Exchanges that have adopted their own transaction standards be permitted to use those standards given the limited time period to implement Federal standards.

Response: In adopting the HIX 820, we are providing Exchanges with the flexibility to use a transaction format developed with the Affordable Care Act provisions in mind. However, in the interests of standardization, we are not permitting States additional flexibility, in order to simplify issuers' implementation.

Comment: One commenter recommended that the Secretary clarify in the final rule that the healthcare EFT standard under HIPAA should be used as the electronic funds transfer when an HIX 820 transaction is transmitted between an Exchange and a HIPAA-covered entity. One commenter recommended that the Secretary "otherwise approve" the use of the Corporate Trade Exchange (CTX) Automated Clearing House (ACH) standard as an alternative healthcare electronic funds transfer standard for use when an Exchange and a covered entity need to transmit a HIX 820.

Response: We are clarifying that the NACHA CCD with Addenda Record (CCD+) is the healthcare electronic funds transfer standard when a HIX 820 transaction is transmitted between an Exchange and a covered entity. We are not approving use of the CTX ACH standard because the CCD+ is the healthcare electronic funds transfer standard adopted pursuant to 45 CFR 162.1602 (77 FR 1556) for the period on and after January 1, 2014.

Summary of Regulatory Changes

At 45 CFR 155.270, we are finalizing this provision related to the use of standards and protocols for electronic transactions as proposed.

d. Oversight and Monitoring of Privacy and Security Requirements (§ 155.280)

In § 155.280, consistent with section 1411(g) and (h) of the Affordable Care Act, we proposed that HHS will monitor any individual or entity who would be subject to the privacy and security requirements as established and implemented by an Exchange under § 155.260. We proposed in § 155.280(a) that HHS will oversee and monitor the FFEs and non-Exchange entities associated with FFEs for compliance with the privacy and security standards established and implemented by the FFEs pursuant to § 155.260 for compliance with those standards. We proposed that HHS will monitor State Exchanges for compliance with the privacy and security standards established and implemented by the State Exchanges pursuant to § 155.260. In addition, we proposed that State Exchanges will oversee and monitor non-Exchange entities associated with the State Exchange for compliance with the standards implemented by the State Exchange pursuant to § 155.260.

In § 155.280(b), we proposed the oversight activities that HHS may conduct in order to ensure adherence to the privacy and security requirements in § 155.260. These may include, but are not limited to, audits, investigations, inspections and any reasonable activities necessary for appropriate oversight of compliance with the Exchange privacy and security standards as permitted under sections 1313(a)(2) and (a)(3) of the Affordable Care Act.

In § 155.280(c)(1)(i) and (ii), we proposed definitions for the terms "incident" and "breach" as they apply to the privacy and security of PII in the Exchanges. In § 155.280(c)(2) we proposed that in the event of an incident or breach, the entity where the incident or breach occurs would be responsible for reporting and managing it according to the entity's documented incident handling or breach notification procedures.

In § 155.280(c)(3), we proposed that FFEs, non-Exchange entities associated with FFEs, and State Exchanges must report all privacy and security incidents and breaches to HHS within one hour of discovering the incident or breach. We also proposed that a non-Exchange entity associated with a State Exchange must report all privacy and security

incidents and breaches to the State Exchange with which they are associated.

Comment: We received comments expressing concern about the requirements of § 155.280 that would apply to entities that are already required to be HIPAA-compliant. Commenters noted that there are existing State-based insurance regulations as well as existing Federal laws that apply to the various types of the non-Exchange entities that will be associated with FFEs. These commenters were concerned that HHS was proposing to implement an additional regulatory regime with largely the same goals as HIPAA and other laws and regulations, which would be overly burdensome. Commenters suggested relying on compliance with existing HIPAA regulations and standards, or accountability under State-based insurance regulation, to provide adequate oversight and monitoring to ensure compliance.

Response: Section 155.260 was implemented to create a uniform set of privacy and security principles that would apply to Exchanges and non-Exchange entities. Section 155.280 permits Exchanges to conduct oversight to ensure compliance with the standards established pursuant to § 155.260. We believe that a single comprehensive framework is needed for oversight and monitoring of all Exchanges and non-Exchange entities for compliance with the standards established pursuant to § 155.260. Section 155.280 is necessary because not all entities that are subject to § 155.260 and § 155.280 are currently covered under another single set of oversight regulations, such as HIPAA or State insurance regulations.

HIPAA does not provide comprehensive safeguards because the privacy, security, and breach notification rules issued under HIPAA will not apply to all actors who are subject to §§ 155.260 and 155.280, or to all information that will be protected under those provisions. HIPAA requirements apply only to covered entities (defined under HIPAA as certain health care providers, health plans, health care clearinghouses, 45 CFR 160.103) and their business associates (defined under HIPAA generally as a person or entity who performs functions or activities on behalf of, or certain services for, a covered entity that involve the use or disclosure of protected health information (45 CFR 160.103). The HIPAA Omnibus Final Rule (78 FR 5566, January 25, 2013) added to the definition of "business associate", a

subcontractor that creates, receives, maintains or transmits protected health information on behalf of a business associate).

Similarly, State insurance regulations will not provide comprehensive safeguards because they do not apply to all entities subject to §§ 155.260 and 155.280. State insurance regulations will vary from State to State and will often apply to agents, brokers, QHP issuers, and issuers of health plans.

We recognize that Exchanges and non-Exchange entities may be subject to other regulations and oversight frameworks that are similar to the framework outlined in §§ 155.260 and 155.280. However, we believe that §§ 155.260 and 155.280 are necessary to safeguard the information that section 155.260 was implemented to protect. We intend to implement § 155.280 without significantly increasing the burden on already regulated entities.

Comment: Several commenters requested clarification on the definition of “non-Exchange entities.” One commenter was concerned that the definition for a non-Exchange entity was too broad. Another commenter requested that since QHP issuers are HIPAA covered entities and comply with HIPAA standards, they should not be included in the definition of non-Exchange entities under § 155.260(b).

Response: We intend to further clarify the scope of applicability of § 155.260(b) in future rulemaking.

Comment: Commenters raised points regarding the definitions for incident and breach established within proposed §§ 155.280(c)(1)(i) and 155.280(c)(1)(ii). The majority of comments noted that these definitions were different from what has been established for HIPAA, and raised concerns that this difference created the potential for conflicting standards. Additionally, there were comments regarding the breadth of the definitions and the types of events that would fall under each of the definitions, which generated a concern about administrative burden.

Response: The definitions for incident and breach that we proposed to codify in this regulation have been included in the computer matching, information exchange and other data sharing agreements, as authorized under sections 1413(c) and 1413(d) of the Affordable Care Act. CMS has executed these agreements with other Federal agencies (Internal Revenue Service, Social Security Administration, Department of Homeland Security, Department of Defense and Veterans Health Administration, Office of Personnel Management, and Peace Corps), administering entities and State

agencies (State Exchanges, Medicaid and CHIP agencies), and non-Exchange entities. In addition, the requirements regarding incident and breach management proposed in § 155.280(c)(2) are also included in the various data sharing agreements enumerated above. In these agreements, the definition for “breach” is taken from OMB’s Memorandum on Safeguarding Against and Responding to the Breach of Personally Identifiable Information, dated May 22, 2007 (OMB M–07–16), which provides guidance to Federal agencies for safeguarding against and responding to the breach of PII. The definition for “incident” is set forth by the Federal emergency response center, United States Computer Emergency Readiness Team (US–CERT), and is derived from the definition of incident in the National Institute of Standards and Technology Special Publication 800–61, Revision 2, dated August 2012. US–CERT is used as the source of the definition, because the Federal Information Security Management Act of 2002 (Pub. L. 107–347) requires Federal agencies to report incidents involving PII to US–CERT. We recognize that these definitions are based on Federal laws, regulations and guidance that typically do not extend to States. However, the information that State exchanges, State agencies, and non-Exchange entities will receive pursuant to their agreements with CMS is derived from Federal sources and requires safeguarding that complies with Federal standards. CMS acknowledges the volume of reports that is anticipated will be generated by these definitions and will continue to evaluate and analyze the definitions as the program evolves. Therefore, because uniform definitions for incident and breach and the requirements for incident or breach management have been included in all the data sharing agreements required under the Affordable Care Act, we are not finalizing the definitions for incident and breach nor the requirements for incident or breach management that we had proposed in § 155.280(c)(1)(i), § 155.280(c)(1)(ii), and § 155.280(c)(2).

Comment: We received many comments supporting the proposed regulation and requesting additional rulemaking to either increase transparency for the public at large, or further protect the PII of individuals applying for eligibility determinations and enrolling in insurance affordability programs as various individuals or entities (such as agents, brokers, Navigators, etc.) who provide assistance come into contact with the individual’s

information. To further increase transparency for the public, several commenters requested that CMS require the privacy and security practices established by either an FFE or State Exchange, which implement the requirements of § 155.260, be made publicly available. One commenter recommended that the final rule should state explicitly that there is an incident handling protocol for the FFEs. There was also a request that § 155.280 ensure that consumers are informed when a security breach occurs that may affect them and their PII. Additionally, one commenter requested that annual summary reports be made public regarding the results of the audit and investigatory activities defined under § 155.280(b).

Response: With respect to requiring Exchanges to make privacy and security standards publicly available, CMS intends to publish the FFE privacy and security standards and encourages State Exchanges to publish their standards in an effort to increase transparency. In response to the comment requesting that the FFEs have an incident handling protocol, we note that the FFEs, as part of a CMS-run program, will follow the CMS incident handling protocol. Non-Exchange entities subject to the FFE privacy and security standards will be required through agreement with CMS to implement incident handling and breach notification procedures that are consistent with CMS’ incident handling and breach notification procedures and will be required to memorialize them in the non-Exchange entity’s own written policies and procedures.

In response to the comment requesting that annual summary reports be made public, we anticipate future rulemaking related to oversight and monitoring of privacy and security as it relates to both Exchanges and non-Exchange entities, and will consider this comment at that time. Finally, in response to the comment requesting consumer notification when a security breach occurs, we note that the FFEs’ incident handling procedures will require CMS to determine whether a risk of harm exists and if individuals need to be notified. State Exchanges would be expected to follow the breach notification laws for the State in which they operate.

Comment: Many commenters were concerned that the requirement in proposed § 155.280(c)(3) that all privacy and security incidents and breaches be reported to HHS within one hour of discovering the breach or incident was not practical or workable in the Exchange environment. Concerns were raised regarding the volume of the

reports the requirement would generate and whether over-reporting would undermine the ability to present a thoughtful, comprehensive plan of action and result in an overall lowering of the security visibility of the system.

The commenters suggested a range of recommended alternatives to allow more flexibility in what was reported. Additional suggestions for alternatives from commenters included aligning the proposal with a variety of other Federal standards for reporting incidents such as the IRS standards, the Medicare two day standard, or HIPAA, which allows up to 60 days to publicly report an incident.

A number of State Exchanges asked for clarification on what the reporting requirement meant in terms of their obligation to require adherence from the non-Exchange entities associated with their State Exchange. State Exchanges suggested that requirements for States should be set as part of the framework of the system security template developed by HHS.

Response: Similar to our response to the comments regarding the definitions of incident and breach above, we note that the timeline for reporting privacy and security incidents and breaches that we proposed to codify in this regulation has also been included in the computer matching, information exchange and other data sharing agreements, as authorized under sections 1413(c) and 1413(d) of the Affordable Care Act. In addition, legal agreements executed pursuant to § 155.260(b) between CMS and non-Exchange entities required to comply with the privacy and security standards established and implemented by an FFE pursuant to § 155.260 include the one hour timeframe for reporting all privacy and security incidents and breaches. Because the one hour incident response timeline has been included in all the data sharing agreements required under the Affordable Care Act, we have deleted the timing for incident reporting from regulation, proposed in § 155.280(c)(3), and expect it to be addressed through separate agreement.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.280 of the proposed rule regarding oversight and monitoring of privacy and security requirements with the following modifications: To improve the precision of the language used, we are removing references to “non-Exchange entities associated with the Federally-facilitated Exchanges” in § 155.280(a) and are instead referring to these entities as “non-Exchange entities required to comply with the privacy and security standards established and

implemented by a Federally-facilitated Exchange pursuant to § 155.260.” Because these standards are included in other legal documents, we are not finalizing §§ 155.280(c)(1)(i) and 155.280(c)(1)(ii), which would have defined the terms incident and breach; § 155.280(c)(2) which would have required an entity where an incident or breach occurs to manage the incident or breach in accordance with the entity’s documented incident handling and breach notification procedures; and § 155.280(c)(3), which would have required that incidents and breaches be reported within one hour of discovery.

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

a. Eligibility Process (§ 155.310)

In § 155.310(k), we proposed a standardized process for handling applications that are submitted without information that is necessary for determining eligibility. We noted that we intended to work with States to implement these procedures and in 2014 to accommodate States with processes established for handling incomplete applications that did not match the process described in these regulations.

Specifically, we proposed that if an application filer does not provide sufficient information on an application for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange, or for insurance affordability programs (if the application includes a request for an eligibility determination for insurance affordability programs), the Exchange would provide notice through the eligibility determination notice described in 45 CFR 155.310(g). The notice would indicate that information necessary to complete an eligibility determination is missing, specify the missing information, and include instructions on how to provide the missing information.

We proposed that the Exchange would provide the applicant with a period of no less than 15 days and no more than 90 days from the date this notice is sent to the applicant to provide the necessary information. Further, we proposed that during this period, the Exchange will not proceed with the applicant’s eligibility determination or provide eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, or cost-sharing reductions, unless an application filer has provided sufficient

information to determine his or her eligibility for enrollment in a QHP through the Exchange, in which case the Exchange must make a determination for enrollment in a QHP through the Exchange.

We sought comment on this proposal, including whether Exchange flexibility is appropriate; whether 15 days and 90 days are appropriate lower and upper limits; and whether additional language was needed to ensure coordination between the Exchange, Medicaid, and CHIP.

Comment: Commenters were generally supportive of the flexibility offered regarding the timeline for handling incomplete applications through the Exchange. Some commenters suggested 15 days was too short of a timeframe and recommended a minimum initial timeframe of no less than 30 days to account for applicants who may need to turn to a third party for additional information or assistance. Some commenters suggested allowing the Exchange to proceed with the applicant’s eligibility determination even if there is missing information in the application. One commenter suggested a timeframe of 30 to 45 days with the ability for individuals to request additional time for good cause. Another commenter recommended aligning the timeframe for incomplete applications with the 90 day inconsistency period. One commenter requested flexibility to use a shorter time period of 10 days to align with their current Medicaid program’s response deadline.

Response: We agree with commenters in support of maintaining flexibility in the timeframe for resolving incomplete applications. We also acknowledge that States may want to maintain a consistent timeframe across the Exchange and Medicaid and as such, we modify § 155.310(k) to set a lower limit of 10 days, rather than 15 days, to resolve an incomplete application in order to allow for this consistency. As indicated in the proposed rule, we intend to work with States to implement these procedures and in 2014 to accommodate States with processes established for handling incomplete applications that do not match the process described in these regulations.

Comment: Several commenters suggested the date the incomplete application is received should be considered a protected filing date for enrollment, or create a special enrollment period such that individuals who submit an incomplete application during open enrollment and receive a final determination after open

enrollment ends could still select a plan and enroll in coverage.

Some commenters raised concern that some employers may refuse to provide information to their employees or may significantly delay providing the necessary information to their employees, which could result in the employees having difficulty submitting complete applications, resulting in such individuals not being able to access advance payments of the premium tax credit or cost-sharing reductions, or to access them in a timely fashion.

Commenters also suggested the transition relief provided to employers in 2014 with respect to the employer reporting and shared responsibility provisions under the Code may constrain the ability of employees to obtain information on employer-sponsored coverage needed to submit a complete application for insurance affordability programs.

Response: We appreciate the suggestions from commenters regarding the date on which an incomplete application is received as a protected filing date and the suggestion to create a special enrollment period, for the purposes of plan selection outside the open enrollment period. We note that Exchanges retain authority to provide a special enrollment period to individuals who experience exceptional circumstances on a case-by-case basis as provided in 45 CFR 155.420(d)(9). We also note that the application date is used to establish the effective date of coverage in Medicaid, and this provision does not otherwise modify existing Medicaid rules regarding the relationship between the application filing date and the effective date of coverage.

We continue to work closely with the Department of Labor to help educate employers about making information regarding employer-sponsored coverage they offer available to employees for the purpose of submitting an application for insurance affordability programs in a timely fashion. As part of the Administration's efforts to streamline employer efforts to educate their workforce and meet the requirements under section 18B of the Fair Labor Standards Act, as added by section 1512 of the Affordable Care Act, on May 8, 2013, the Department of Labor released a model notice to help employers inform their employees of coverage options, which can be found at <http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf>. Employers have the option of combining the employer coverage tool with the section 18B notice.

Comment: One commenter supported the provision that requires the Exchange to determine eligibility for enrollment in a QHP through the Exchange if enough information is included in the application to do so. Another commenter raised concern that QHP eligibility without advance payments of the premium tax credit or cost-sharing reductions may be confusing for some individuals. Another commenter suggested that some applicants may not want to be responsible for full premiums while they are working to obtain the information needed to obtain an eligibility determination for advance payments of the premium tax credit. Another commenter suggested that enrollment in a QHP through the Exchange during the timeframe for incomplete applications should be optional.

Response: It is important to have clear messages so individuals are informed of their financial responsibilities at the time of plan selection. The Exchange will provide actual premium information to consumers as part of the plan compare and select process, and consumers will be provided with this information again as a part of the premium payment process. While we believe it is important to provide individuals with the opportunity to enroll in a QHP through the Exchange if they are otherwise eligible, we acknowledge that some individuals may not want to purchase an unsubsidized QHP and we clarify that enrollment in a QHP is always optional and only occurs based on a consumer's choice, including when an application does not contain the information needed to make an eligibility determination for insurance affordability programs.

Comment: One commenter suggested that in addition to the notice the Exchange sends to individuals who have an incomplete application, the Exchange be required to make a follow-up phone call to the application filer to attempt to complete the application. Another commenter suggested additional standards for handling incomplete applications, including that notices should include language that informs individuals that the Exchange will assist them in completing the application. The commenter suggested notices to applicants be provided in multiple languages and forms.

Response: Follow-up by the Exchange could be helpful for consumers, although we believe that the Exchange should have flexibility to develop and implement the procedures that are most effective and efficient. Accordingly, we do not require an Exchange to take steps beyond what was proposed. However,

we encourage Exchanges to explore the most effective and efficient approaches to reducing the number of incomplete applications and facilitating completion of incomplete applications, and share those best practices with other Exchanges. Additionally, we clarify that the notice described in § 155.310(k) will follow the general standards for notices set forth in 45 CFR 155.230, including accessibility requirements.

Comment: One commenter recommended more clearly delineated, objective standards for determining whether or not an application is complete.

Response: We note that an application is considered incomplete if information necessary for conducting an eligibility determination for enrollment in a QHP or for insurance affordability programs (if requested) is missing, and that these eligibility standards are described in subpart D of this part. We intend to provide instructions to inform individuals of the required and optional fields on the application, including "help text" on the dynamic online application, and believe these tools will help reduce the number of incomplete applications submitted to the Exchange.

Comment: One commenter recommended that advance payments of the premium tax credit be applied prospectively from the date of eligibility for advance payments of the premium tax credit and not retroactive to eligibility determination for enrollment in a QHP through the Exchange.

Response: We clarify that if an individual completes an application and requests an eligibility determination for insurance affordability programs, the effective date for advance payments of the premium tax credit is not retroactive, but follows the effective date policy outlined in 45 CFR 155.330(f).

Summary of Regulatory Changes

We are finalizing the provisions in § 155.310(k) as proposed with one minor modification. We modified paragraph (k)(2) to specify that the Exchange must provide the applicant with a period of no less than 10 days from the date on which the notice is sent to the applicant to provide the information needed to complete the application to the Exchange.

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

As finalized in the Exchange Establishment Rule, § 155.320(b) specifies standards related to the verification of eligibility for minimum

essential coverage other than through an eligible employer-sponsored plan. We proposed to redesignate paragraph (b)(1) as (b)(1)(i) and (b)(2) as (b)(1)(ii) to consolidate the standards for Exchange responsibilities in connection with verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan. In paragraph (b)(1)(i), we also proposed to add the phrase “for verification purposes” to the end of existing text. We clarified that the Exchange would submit specific identifying information to HHS to compare applicant information with information from the Federal and State agencies or programs that provide information regarding eligibility for and enrollment in minimum essential coverage, including but not limited to the Veterans Health Administration, TRICARE, and Medicare.

We noted that HHS will work with the appropriate Federal and State agencies to complete the appropriate computer matching agreements, data use agreements, and information exchange agreements which will comply with all appropriate Federal privacy and security laws and regulations. The information obtained from Federal and State agencies will be used and re-disclosed by HHS as part of the eligibility determination and information verification process set forth in subpart D of part 155.

We noted that in connection with the proposal to redesignate paragraph (b)(2) to paragraph (b)(1)(ii), we did not propose any change to the text of the provision as previously finalized. Consistent with the authorizations for the disclosure of certain information under 42 CFR 435.945(c) and § 457.300(c), the proposed regulation provided for an Exchange to verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the Basic Health Program, if applicable, using information obtained from the agencies administering such programs.

Finally, we proposed to add paragraph (b)(2) to be consistent with 45 CFR 164.512(k)(6)(i) and 45 CFR 155.270. We sought comment on this proposal.

Comment: One commenter expressed support for the verification process outlined in § 155.320(b). Another commenter raised concern that HHS has not described how verification information described in § 155.320(b) will flow between the Exchange and QHPs and requested clarification that the Exchange will be responsible for reporting errors related to eligibility for minimum essential coverage and

assuming any relevant financial liability that results from such an error.

Response: The verification approach outlined in § 155.320(b) does not provide for an information flow between the Exchange and QHPs. As stated in previous final rulemaking and also in the proposed rule, the Exchange would submit specific identifying information to HHS. HHS would return information from the Federal and State agencies or programs that provide eligibility and enrollment information regarding minimum essential coverage to the Exchange, and the Exchange would use this information to complete the verification as part of the application process.

Summary of Regulatory Changes

We modify language in paragraph (b)(2) to clarify that the disclosure of information regarding eligibility and enrollment in a health plan is expressly authorized, for the purposes of verification of applicant eligibility for minimum essential coverage, as part of the eligibility determination process for advance payments of the premium tax credit or cost-sharing reductions. We note that this provision does not enable the disclosure by entities described in 45 CFR 164.512(k)(6)(i) of clinical or other health records to the Exchange, as this information is not used in eligibility determinations for enrollment in a QHP through the Exchange or for insurance affordability programs.

c. Coordination With Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Plan (§ 155.345)

As finalized in the Exchange Eligibility and Enrollment Rule,⁸ § 155.345 specifies standards for coordination across insurance affordability programs. After adding a new paragraph (h) regarding the Exchange's adherence to a State decision regarding Medicaid and CHIP, we noted in the amendatory text that we re-designated previous paragraphs (h) and (i) as new paragraphs (i) and (j), but made a drafting error in failing to include these re-designated paragraphs as part of the revised regulation text. As such, we make a technical correction to include new paragraphs (i) and (j) as part of the regulation text. Furthermore, we make a technical correction in paragraph (i)(1) to change the cross-reference to § 155.320(b)(1)(ii) in order

⁸ Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 FR 42160 (July 15, 2013).

to align with the redesignation of § 155.320(b)(2) finalized in this regulation.

Summary of Regulatory Changes

We make a technical correction in § 155.345 to clarify that paragraphs (i) and (j) are included as part of the regulation text, and make a technical correction in paragraph (i)(1) to change the cross-reference to § 155.320(b)(1)(ii) to align with the redesignation within § 155.320(b).

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

a. Allowing Issuer Customer Service Representatives To Assist With Eligibility Applications (§ 155.415)

We proposed to add § 155.415 that would, at the Exchange's option and to the extent permitted by State law, permit issuer customer service representatives who do not meet the definition of agent or broker in § 155.20 to assist qualified individuals in the individual market with: (a) applying for an eligibility determination or redetermination for coverage through the Exchange; (b) applying for insurance affordability programs; and (c) facilitating the selection of a QHP offered by the issuer represented by the customer service representative, provided that such issuer customer service representatives meet the proposed requirements set forth in § 156.1230(a)(2).

We received the following comments concerning the proposed issuer customer service representatives provisions. As stated earlier in this preamble, for purposes of clarity, we will refer to “issuer customer service representatives” as “issuer application assisters” for the rest of this section.

Comment: One commenter expressed concern regarding excluding agents and brokers from acting as issuer application assisters. The commenter indicated that certain States require an issuer application assister that assists in enrollment in a health plan to be a licensed agent under State law. We received another comment recommending that we continue to ensure that individuals involved with assisting applicants and enrollees comply with any existing State laws related to enrollment assistance. Another commenter recommended making application assisters a requirement for Exchanges. Lastly, we received a comment seeking to clarify issuer application assisters' rule in post-enrollment activities.

Response: We introduced the term “issuer customer service representative”

to allow individuals who are not licensed as agents or brokers, but employed or contracted by an issuer to assist applicants and enrollees with the application and enrollment process. Agents and brokers may also work for issuers, as many do today, but they must follow the standards set forth in § 155.220. We note that, in some States, a license may be required to assist an applicant for applying for an eligibility determination or redetermination. We continue to defer to existing State laws related to enrollment assistance when deciding which individuals may assist applicants and enrollees. If State law requires a license to enroll applicants in coverage, then issuers would need to follow State law for licensure of application assisters.

We note that there are certain functions that issuers currently have their staff perform, such as answering general information about plans, and we intend to allow those individuals to continue to perform those functions without meeting additional standards. Rather, if the issuer wants those individuals to perform additional functions outlined in this section, such as helping consumers as they apply for an eligibility determination, seek a redetermination for coverage through the Exchange, and apply for insurance affordability programs, those individuals will be considered issuer application assisters and be subject to the standards in section 156.1230(a)(2). Accordingly, we are not finalizing the language indicating that facilitating selection of a QHP would be a function of an issuer application assister. Rather, we are clarifying that it would be a typical function of issuer staff. Issuer staff would be able to perform post-eligibility functions such as plan compare and selection, if permitted by State law. However, the issuer staff would not be allowed to help QHP enrollees with reporting changes to an Exchange or be able to support them in the redetermination process. Those are functions of the issuer application assister, agent, broker, or other qualified assister.

Comment: Several commenters stated it is essential that issuer application assisters who assist applicants and enrollees with applications and enrollment in QHPs do so without imposing discriminatory barriers to coverage. Accordingly, they have suggested adding nondiscrimination standards for issuer application assisters.

Response: We note that § 156.200(e) prohibits a QHP issuer, which includes issuer application assisters, from discriminating against an applicant. For

this reason, we are not adding additional language on nondiscrimination standards.

Comment: We received a comment seeking that the Exchange enforce parameters to ensure that information being provided by issuer application assisters is accurate. We also received several comments that issuers should be held responsible for any misconduct by their application assisters assisting applicants and enrollees with enrollment in addition to strengthening conflict of interest standards.

Response: We plan to consider over time, based on experience with this function, whether more specific standards are needed in these regulations. Additionally, § 156.1230(a)(2)(iii) of the final rule clarifies that issuer application assisters must comply with applicable State and Federal laws regarding conflicts of interest. We also note that the issuer should be monitoring its application assisters and that we believe the State DOI would act as the primary oversight source.

Comment: One commenter expressed concern that an increase in issuer involvement would lead to a decrease in consumer protections. The commenter believed that issuer application assisters should only have access to consumer information needed to enroll a consumer in a QHP. A commenter expressed concern that application assisters could use PII obtained during intake to steer consumers to QHPs offered by other issuers. Another commenter wanted to clarify that issuer application assisters' compliance with FFE privacy and security requirements applies only to their FFE assistance activities. Additionally, commenters wanted clarity on whether information given to issuers during the application process could be stored in an issuer's database system. If so, commenters asked us to clarify whether that would be considered HIPAA PHI and those issuers would not be expected to create and maintain separate, FFE-established privacy and security policies and procedures for such data.

Response: In the final rule at § 156.1230(a)(2), we attempt to reduce administrative burden imposed by the proposed requirement for issuer application assisters to comply with the terms of an agreement between the issuer and the Exchange. We clarify that issuers need to ensure its application assisters follow the standards outlined in the proposed rule, but this would not be done through an agreement. The agreement in the proposed rule was not a privacy agreement and removing this agreement in no way weakens

previously established agreements on standards for privacy and security for individuals accessing others PII. Issuers and their application assisters will still be subject to Exchange privacy and security standards, as well as all other applicable laws and regulations protecting consumer information, which may include, but is not limited to the HIPAA Privacy and Security Rules, as applicable. Issuers and their application assisters may only use Exchange application information for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and may not disclose the information to any other person except as provided by applicable law or regulation in connection with those purposes.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.415 of the proposed rule, with a few modifications. For purposes of clarity, in finalizing this policy, we will use the term "issuer application assisters" in place of "issuer customer service representatives" to more clearly articulate the role of such individuals and, for consistency, will refer to the definition of "issuer application assisters" being finalized at § 155.20. Accordingly, we are not finalizing the language indicating that facilitating selection of a QHP would be a function of issuer application assisters.

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

This subpart was proposed to provide standards for eligibility appeals, including appeals of individual eligibility determinations and employer determinations as required by section 1411(f) of the Affordable Care Act, which makes clear that the Secretary will provide for an appeals process. We proposed to provide Exchanges with options for coordinated appeals to align with the options for eligibility determinations. In addition, we proposed standards for appeal requests, eligibility pending appeal, dismissals, informal resolution and hearing requirements, expedited appeals, appeal decisions, the appeal record, and corresponding provisions for employer appeals.

Comment: We received many comments in support of subpart F and

the proposed eligibility appeals process and standards. Many commenters encouraged a streamlined, transparent, consumer-centric appeals process. In addition, we received comments in support of the proposed coordination measures with Medicaid and CHIP agencies and the due process protections afforded to appellants. Many comments reflected approval of the shared requirements between Exchange and Medicaid appeals, which commenters anticipate will ease the implementation of Exchange appeals and create efficiencies by having matching standards.

Response: We provided a flexible, consumer-friendly process that limits the burden on consumers and Exchanges. We have also worked to develop a process that largely parallels the Medicaid fair hearing process and standards, including the requirements to provide notice of appeals procedures, access to the record, and robust due process and hearing rights. In the final rule, we generally maintain this approach while also adding additional flexibilities for Exchanges as they implement the eligibility appeals process.

Comment: A few commenters, many representing States establishing Exchanges, encouraged HHS to provide additional flexibilities for implementation timelines in order to allow Exchanges time to establish and implement the appeals provisions. For example, one comment recommended a January 1, 2015 effective date to allow Exchanges, including the Federally-facilitated Exchange, more time to complete systems builds and update existing appeals processes to meet the standards proposed in the January 22, 2013 proposed rule. Another commenter noted that the proposed rule will require administrative changes including Medicaid State-plan amendments, State regulation changes, and significant system changes to support the new flow of electronic information between the Exchange and Medicaid. Commenters noted that it would be advantageous to have a longer period of time to ramp-up to meet the appeal requirements.

Response: We have evaluated the provisions of the January 22, 2013 proposed rule, and after consideration of the public comments received, in this final rule we are providing additional flexibility for Exchanges to implement a paper-based appeals process for the first year of operations (October 1, 2013 through December 31, 2014). We understand that many Exchanges have tight timeframes for system development and the paper-based

process will allow Exchanges to operate the appeals process as current business requirements allow, while providing a timeline to modernize an appeal program. We have opted for this approach after balancing the interests of both appellants and Exchanges. This approach will assist Exchanges in setting up efficient, effective appeals processes that will positively impact appellants who use these processes; moreover, this flexibility does not abridge the rights of appellants provided in this rule and we do not anticipate that they will be materially adversely affected.

We will continue to work with Exchanges to support their appeals implementation efforts and ensure successful coordination between all relevant entities administering insurance affordability programs and the appeals entities for such programs. We will also continue to provide guidance and technical assistance to Exchanges to promote and facilitate the sharing of experiences and best practices regarding the establishment and implementation of the eligibility appeals process.

Comment: Several commenters desired greater clarity about which provisions apply to State Exchanges and which apply to Federally-facilitated Exchanges or to State Partnership Exchanges, including determination and assessment eligibility models.

Response: Unless specifically indicated in the rule, the standards we are finalizing apply equally to all Exchanges, or, where a requirement is specified to apply to the Exchange appeals entity, to all Exchange appeals entities, including the HHS appeals entity. We have attempted to keep the rules uniform whenever possible to provide a consumer-friendly, efficient process no matter what type of Exchange or appeals process is in place in a given State and to ensure that consumers are protected with a standard set of due process rights.

Comment: Some commenters found the interplay between Medicaid and the Exchange cumbersome and difficult to follow in the proposed rules and requested the process be further simplified.

Response: We developed an appeals process and standards that closely align with Medicaid fair hearing processes in hopes of allowing States to leverage existing appeals processes and simplify implementation. However, alignment was not possible in all cases due to different statutory requirements and operational considerations. In those instances, we attempted to provide standards that balanced consumer

protections and process efficiencies. In developing the final rule, we have worked with the Center for Medicaid and CHIP Services (CMCS) to align or provide State flexibility where appropriate. We encourage States to provide questions to CMS about the rules and the interaction between Exchange and Medicaid appeals, so that we may provide further guidance, as appropriate.

Comment: Another comment asked that we balance a consumer-friendly approach with a process that does not impose excessive administrative burden on administering agencies.

Response: As noted above, we appreciate the effort and time it takes to build and operationalize a new appeals process. Where possible, our rules are aligned with existing Medicaid fair hearing standards to provide Exchange appeals entities and consumers a consistent, efficient process. In addition, we understand that many States will leverage existing appeals processes to provide Exchange appeals to limit the administrative burden and streamline processes as they implement Exchange appeals processes. Finally, we reiterate that Exchange appeals entities will be provided flexibility in the first year to provide a paper-based appeals process in order to complete system builds and incorporate modern technology.

Comment: A few comments recommended that the appeals standards be specifically aligned with the due process protections set forth in *Goldberg v. Kelly*.⁹ Commenters highlighted that *Goldberg's* due process protections are extended to Medicaid beneficiaries and that, because of the close alignment and interplay between the Exchange and Medicaid programs, Exchange appeals should adopt the same standards.

Response: As in the proposed rule, we have aligned the majority of our Exchange appeals provisions with existing or new Medicaid standards. Although we do not specifically cite to the *Goldberg* due process standards, the final rules provide comprehensive due process protections for appellants in the tradition of Medicaid fair hearings and *Goldberg*. We have closely analyzed specific comments submitted on the proposed due process standards and we have carefully designed these provisions to provide sufficient due process protections for appellants throughout the process.

Comment: We received general comments recommending that we ensure that all notices and appeals processes comply with the applicable

⁹ *Goldberg v. Kelly*, 397 U.S. 254 (1970).

non-discrimination laws, including section 1557 of the Affordable Care Act.

Response: We note that the all Exchange processes, including the eligibility appeals processes, are required to comply with applicable non-discrimination laws, including section 1557 of the Affordable Care Act as specified in § 155.120(c).

Comment: A few commenters sought additional guidance on topics that were not covered in the proposed rule. For example, one sought guidance on appealing benefit and service coverage, including recourse to a Federal appeals process where appropriate. Another comment requested strong oversight and monitoring of the appeals process. Finally, another commenter requested training standards on appeals topics for consumer assistance entities.

Response: These comments are outside the scope of this final rule and, therefore, we decline to address them here.

Comment: One commenter expressed general concern over the proposed rule, related to the provisions requiring coordination between two separate programs, Medicaid and the Exchange, which are operated by two separate agencies. The commenter noted instances where the Exchange appeals rules appear to differ from what is allowed for Medicaid, including the reasons an appeal can be dismissed and the time to vacate a dismissal, and differences in certain timeframes. The commenter suggested that after a consumer completes the first level of the appeals process, the Medicaid and Exchange appeals process will diverge, regardless of the coordination option exercised by the State and that this will cause confusion.

Response: We have addressed coordination of the two processes throughout the appeals provisions in the final rule, including in § 155.510. We also encourage States and consumers to review the Medicaid rules regarding appeals delegation authority at 42 CFR 431.10, 431.205(b), 431.206(d) and (e), 431.240. We note that, depending on the operational configuration of the Exchange, including delegations regarding eligibility and the appeals process as noted above, the Exchange and Medicaid processes may be fully integrated, thereby optimizing the appellant experience. Even upon elevation of an appeal to the HHS appeals entity, Medicaid and Exchange issues may be reviewed together, although State agencies have the option to review the HHS appeals entity's application of Federal and State Medicaid law pursuant to 42 CFR 431.10(c)(3)(iii).

Comment: We received one comment suggesting that calendar days should be changed to working days for deadlines that are less than five days throughout the rule.

Response: The timelines established throughout the rule are set in terms of calendar days. As a result of modifications in this final rule to the proposed expedited appeals process in § 155.540, the rule no longer contains timeline standards of less than five days.

Comment: Several comments, particularly those from the issuer community, encouraged HHS to revisit timelines associated with the appeals process. For example, a few comments suggested that providing 90 days to request an appeal, 90 days to issue a decision, 30 days to elevate a State Exchange appeals entity appeal decision to the HHS appeals entity, and 45 days for Medicaid to render a decision could result in a timeline of over 11 months, if all timeframes are fully exhausted. We were urged to explore alternatives to the proposed timeline that might reduce the length of the process.

Response: We anticipate that very few appeals will fully exhaust all timeframes. Furthermore, we are modifying proposed § 155.520 in this final rule to provide additional flexibility for State Exchanges to adjust the timeframe for accepting appeal requests, such that States may choose to implement a timeframe consistent with the State Medicaid agency's requirement for submitting fair hearing requests, provided that timeframe is no less than 30 days. This State option could help shorten the overall timeframe for an appeal in a State Exchange. We also note that although consumers will have a specific timeframe in which to request an appeal, many will submit appeal requests well before the expiration of the timeframe. In addition, informal resolution processes should assist in resolving appeals quickly, before the 90-day timeframe to issue an appeal decision closes. Finally, many appellants may be satisfied with the appeal decision made by a State Exchange appeals entity and not pursue the appeal with the HHS appeals entity. Therefore, apart from the modification to proposed § 155.520 to provide State flexibility for appeal request timeframes, we have maintained the majority of the other timeframes originally proposed and expect most appeals to be resolved without fully exhausting the maximum possible timeframe.

Comment: One commenter requested that the relationship between the inconsistency period described in

subpart D and appeals be described more clearly.

Response: The inconsistency period is an important aspect of the eligibility process offering applicants and enrollees the opportunity to assist in the verification of eligibility information before receiving a final eligibility determination. Applicants and enrollees to whom an inconsistency period applies may only appeal upon the closure of that period when the applicant or enrollee receives a final eligibility determination. However, because the applicant or enrollee provides information directly to the Exchange during the inconsistency period, we anticipate that this process will help alleviate dissatisfaction with the final eligibility determination and, therefore, will reduce the volume of eligibility appeals that would otherwise be made, in the absence of an inconsistency process.

Comment: We received a few general comments regarding notices. Some commenters recommended notices for the appeals process be simple, clearly written, and shared electronically. We also received a comment noting that many applicants and enrollees fail to report address changes, which increases the returned mail rate. The commenter recommended finalizing the rule with the option for States to eliminate paper notices at the consumer's option.

Response: Notices must meet the standards established in § 155.230. We also note that § 155.230(d) specifies that electronic notices must be provided at the individual's option but reiterate that a paper-based process, as discussed above, is acceptable for the first year of operations.

Comment: We received several comments recommending that QHP issuers should be notified as to the status of an appeal at the same time an appeal entity sends a notice to an Exchange or an individual because an issuer will be affected if an enrollee enters the appeals process. For example, the commenter requested that issuers be notified at the time an appeal is acknowledged, dismissed, informally resolved, and when a decision has been made. One comment also specified that issuers should not be required to respond or otherwise acknowledge receipt of the notices, limiting the administrative burden on issuers and the Exchange.

Response: We are finalizing the rule without providing notice to issuers throughout the appeals process. Although we acknowledge that issuers will be affected by various aspects of the appeals process, including whether an appellant qualifies for eligibility while

an appeal is pending and whether an appeal decision provides for retroactive enrollment, the communication mechanisms already established between the Exchange and issuers will be sufficient to accommodate issuers' needs for notification.

Comment: One commenter expressed concern that there was minimal guidance within the proposed rule regarding coordination of modified adjusted gross income (MAGI) appeals with non-MAGI Medicaid appeals. The commenter suggested that HHS should require that appeals information included in MAGI determination notices clearly explain timeframes and processes for appealing MAGI decisions with respect to an individual whose eligibility is concurrently being determined, or who subsequently wishes to have his or her eligibility determined, on the basis of non-MAGI criteria for Medicaid eligibility; determinations on non-MAGI bases should explain the difference between appealing a MAGI versus non-MAGI eligibility decision, and clarify that only a Medicaid agency may hear a non-MAGI appeal.

Response: The Medicaid eligibility contemplated as part of the Exchange appeals process is limited to MAGI-based Medicaid eligibility as described in § 155.302(b). Non-MAGI Medicaid determinations will not be issued by the Exchange and, therefore, communications regarding those determinations will be handled by State Medicaid agencies. Exchange eligibility determination notices that involve eligibility for Medicaid based on MAGI will include information about an individual's option to apply for Medicaid benefits on a non-MAGI basis, including information about eligibility under the medically frail category. We encourage appeals entities to also include this information in appeal decisions, where applicable.

Comment: We received a comment requesting clarification that all Medicaid appeals can be referred to the State for handling according to the State's existing processes, regardless of which entity made the eligibility determination. Similarly, the commenter requested clarification that all appeals related to the determination of eligibility or amounts of advance payments of the premium tax credit or cost-sharing reductions could be handled by HHS. The commenter proposed that the final rule be written in a way that allows States to have this flexibility and the commenter noted that individuals should have the opportunity to appeal a determination with the

entity that "owns" the program in question.

Response: The rules established in this final rule, in 45 CFR part 155, subpart D, and at 42 CFR 431.10, 431.206(d) and (e), 431.240, 435.907(h) and 457.340(a) provide flexibility for States to delegate authority to the Exchange to determine Medicaid and CHIP eligibility as well as make a separate delegation to the Exchange or HHS to hear eligibility appeals of those determinations. States may choose to delegate eligibility determinations and appeals to the Exchange or HHS, based on an individual State determination. Further, we note in response to the question above, that appeals of the advance payment of the premium tax credit and cost-sharing reductions can be heard by, or escalated to, the HHS appeals entity.

The foregoing reflects general comments we received on the proposed rule or that discuss policies that have broad implications across the proposed appeals rules. Included below is a section by section discussion of the proposed regulations, and any modifications or amendments we are making to those proposed regulations in this final rule.

a. Definitions (§ 155.500)

In § 155.500, we proposed definitions for terms used in subpart F of part 155. Additionally, we proposed to incorporate terms defined in § 155.20 and § 155.300. The terms we proposed to define were "appeal record," "appeal request," "appeals entity," "appellant," "de novo review," "evidentiary hearing," and "vacate."

Comment: We received several comments that broadly supported HHS providing definitions for "appeal record," "appellant," "de novo review," and "evidentiary hearing." We similarly received several comments regarding the definition of "appeal request." Most comments indicated approval for the inclusion of both oral and written expressions to indicate a request to have an eligibility determination or redetermination reviewed. However, one commenter requested that the definition of "appeal request" be narrowed to only written expressions to request an appeal or include oral expressions only at State option.

Response: Defining these terms will assist Exchanges and consumers in clearly understanding the appeals process and standards laid out in subpart F. The ability to request an appeal orally is a factor that makes appeals more accessible to those who seek them. Many applicants and enrollees may not have easy access to

computers to submit an electronic appeal request or otherwise may not be able to submit a written request. In addition, it is an important goal of the appeals process to provide methods for requesting an appeal that mirror the methods required for accepting Exchange applications, which includes both written and telephonic submissions. However, we understand the concern that accepting oral requests for an appeal may be burdensome to Exchange appeals entities that do not already provide this option as a means to appeal other public benefits determinations, and we discuss additional flexibilities related to this requirement for the first year of operations in the discussion of § 155.520 in this final rule. We maintain the definition for "appeal request" in the final rule with both oral and written expressions to reflect the variety of possibilities for submitting an appeal request.

Comment: We were asked in several comments to ensure that all actions that can be appealed are included in the definitions for "appeal request" and "appeal entity." Commenters were concerned that the proposed definitions were written too narrowly by only referencing specific notices rather than all actions that are appealable. In addition, one commenter recommended we also revisit § 155.355 which, similar to subpart F's definitions, specifically cites notice provisions rather than broadly referring to the actions that are appealable.

Response: In the proposed rule definitions for "appeal request" and "appeals entity," we referenced determinations that are appealable by citing to the notices that accompany those appealable final determinations. We drew the connection to the determination notices rather than citing directly to the eligibility determinations in subparts D and G because the notice informs the individual of his or her determination, establishes that the determination is final, and communicates the right to appeal the determination. In addition, the original eligibility appeals provision in § 155.355 similarly referenced the determination notices rather than the determination provisions directly. Thus, we continue to believe that our approach is appropriate, and we are finalizing the definitions as proposed in this regard.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.500 with the following modifications. We modified the definition of "appeal request" by

removing “pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act” and replaced it with “§ 155.610(i).” This change was made to update the reference to exemption determinations following the publication of the exemptions final rule issued on July 1, 2013, codified at 45 CFR part 155, subpart G. We made a similar modification to the definition of “appeals entity.” We also made a minor modification to “evidentiary hearing” by removing “new” from the definition to clarify the scope of evidence that may be presented.

b. General Eligibility Appeals Requirements (§ 155.505)

In § 155.505, we proposed the general standards for eligibility appeals. In paragraph (a), we proposed that the requirements of subpart F would apply to both State Exchange appeals processes and the HHS appeals process, except where otherwise specified. In paragraph (b), we proposed the scope of determinations that an applicant or enrollee may appeal, including initial determinations and redeterminations of eligibility made in accordance with 45 CFR part 155, subpart D; determinations for exemptions; or a failure by the Exchange to provide timely notice of an eligibility determination. Options for providing individual eligibility appeals processes were proposed in paragraph (c). We proposed that appeals may be provided by a State that elects to provide an appeals process or HHS, if a State elects not to provide a process or upon exhaustion of a State Exchange appeals process. In paragraph (d), we proposed standards for entities eligible to conduct eligibility appeals. Finally, in paragraphs (e) through (g), we proposed standards for appellant representation in an appeal, accessibility requirements for the appeals process, and the right to pursue judicial review to the extent it is available by law.

Comment: We received comments supportive of broadly applying consistent appeals standards across eligibility appeals processes for the individual market, regardless of whether the appeals process is conducted by a State Exchange appeals entity or the HHS appeals entity.

Response: We are finalizing the provisions of paragraph (a) without changes from the proposed rule in this regard. We intend the State Exchange appeals entity and the HHS appeals entity to be held to the same standards and meet the same requirements except where otherwise noted. We believe this consistency will provide for a smooth, transparent, consumer-friendly process.

Comment: We received several comments that the right to appeal as proposed in paragraph (b) is too narrowly defined and may limit the issues or actions that can be appealed. Similar to the comments we received about § 155.500 regarding the definitions for “appeal request” and “appeals entity,” some commenters expressed concern that, as proposed, paragraph (b) does not broadly apply appeal rights to all actions taken by the Exchange, Medicaid, or CHIP.

Response: Paragraph (b) details the determinations and other circumstances that are appealable through the eligibility appeals process, including all initial determinations and redeterminations of eligibility as well as failure to take action on the part of the Exchange. We are finalizing paragraph (b) largely as it was proposed with some minor exceptions. In the text of paragraph (b), we are removing “In accordance with § 155.355 and future guidance on section 1311(d)(4)(H) of the Affordable Care Act.” We have replaced the references to future guidance on exemption determinations in paragraphs (b)(2) and (3) to refer to the final rules published on July 1, 2013, codified at 45 CFR part 155, subpart G 155.605 and 155.610(i), respectively. We also added new paragraph (b)(4) to clarify that a denial of a request to vacate dismissal made by a State Exchange appeals entity may be appealed.

Comment: Commenters sought greater clarification as to the meaning of a “failure by the Exchange to provide timely notice of an eligibility determination” in (b)(3) and, specifically, what “timely” means in this context.

Response: The appeal right in § 155.505(b)(3) is based on the requirement in § 155.310(g) for Exchanges to provide timely written notice to an applicant of any eligibility determination made in accordance with subpart D. Because this provision does not define “timely,” we also decline to do so in this final rule and are finalizing the provision as proposed.

Comment: A comment requested clarification regarding appeals of Medicaid determinations through the Exchange appeals process. Specifically, the commenter questioned whether the Exchange appeals process would review other components of a Medicaid determination beyond the MAGI standard.

Response: The Exchange appeals process for eligibility determinations does not include review of non-MAGI-based Medicaid eligibility determinations. Rather, the scope of the Exchange appeals process mirrors the

scope of the Medicaid eligibility determination described in § 155.305(c) which is limited to eligibility based on MAGI criteria. Non-MAGI-based Medicaid eligibility determinations will be provided directly by the State Medicaid agency, and appeals of these eligibility determinations must be adjudicated through procedures prescribed by the State Medicaid agency, not the Exchange appeals process.

Comment: We received many comments in general support of the flexibility offered to State Exchanges to provide an individual eligibility appeals process or defer to the HHS appeals process.

Response: Like the commenters, we anticipate the opportunity for a “local” appeal is beneficial to both the Exchange that provided the eligibility determination and the appellant, who may find it easiest to work directly with the Exchange to resolve the issue. We are retaining this flexibility in the final rule with changes to provide greater clarity in response to the comments discussed below.

Comment: Many commenters sought clarification regarding paragraph (c)’s proposed options and, specifically, which appeals processes may be delegated to HHS and which must be handled by State Exchanges. For example, commenters questioned whether HHS would review MAGI-based Medicaid and CHIP appeals, employer appeals, or SHOP appeals.

Response: Paragraph (c) provides options for individual market eligibility appeals. Options for conducting employer and SHOP eligibility appeals are addressed and discussed in their respective sections, § 155.555(b) and § 155.740(b). In terms of individual eligibility determinations, we are finalizing the rule as proposed, providing State Exchanges the option to manage an eligibility appeals process that would hear appeals prior to the HHS appeals process (if an appellant elects to proceed to the HHS appeals entity), or to delegate the individual eligibility appeals function to the HHS appeals entity. A State Exchange’s appeals process for individual eligibility determination would hear appeals of all the determinations listed in § 155.505(b)(1)–(3), including Medicaid and CHIP eligibility determinations, except that a State Exchange appeals entity would not hear appeals of exemption eligibility determinations under § 155.605 and § 155.610(i) if the Exchanges elects to delegate exemption appeals to the HHS appeals entity pursuant to paragraph (c)(2) of this

section, as described below. We are finalizing § 155.505 with modification.

Comment: Several commenters sought clarification as to whether some individual eligibility determination appeals could be delegated to HHS. For example, a commenter questioned whether a State Exchange could opt to provide an eligibility appeals process for all individual determinations except exemption appeals, which would be appealed directly to the HHS appeals process. Similarly, other commenters asked whether a State Exchange with its own eligibility appeals process could defer questions regarding verification of employer-sponsored coverage to the HHS appeals process if it is relying on HHS to perform verifications of employer-sponsored coverage.

Response: We appreciate the need to clarify paragraph (c) with regard to which specific individual eligibility determinations may be delegated to the HHS appeals entity where a State Exchange appeals entity is also providing some individual eligibility appeals. In an efficient appeals process, the entity determining eligibility is, ideally, also the entity adjudicating an appeal of that determination. Therefore, we believe that it is more efficient for consumers in a State served by a State Exchange to appeal exemption determinations made by HHS directly to HHS, and to permit States to make this delegation to the HHS appeals entity. We are modifying paragraph (c) to provide this option.

With regard to States choosing to rely on HHS to verify enrollment in coverage in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, we refer commenters to § 155.320(d), which provides standards for this process. We note that this option is available for eligibility determinations that are effective on or after January 1, 2015. Because this service will provide verification only and not a complete eligibility determination, states that establish a State Exchange appeals process will not be permitted to delegate appeals of this verification to the HHS appeals entity. The State Exchange appeals entity should treat the HHS verification as having conclusively established the appellant's enrollment in or eligibility for qualifying coverage in an eligible employer-sponsored plan as a matter of fact; if an appellant wishes to contest the HHS verification, he or she may do so by escalating the appeal. We are finalizing § 155.505(c) as proposed in this regard.

Comment: Some commenters sought additional details regarding the HHS appeals process, particularly following

the exhaustion of a State Exchange appeal. For example, commenters wanted to understand the relationship and finality between a decision by a State Exchange appeals entity and a subsequent decision by the HHS appeals entity. This question was of particular importance in States where Medicaid appellants have additional avenues for State judicial review that may only be pursued within a specific window of time.

Response: The State Exchange appeals entity decision is considered final and binding unless the appellant pursues the appeal through the HHS process, consistent with these final rules. If that occurs, the HHS appeals entity will review the appellant's case *de novo*, as specified in § 155.535, and render a new decision. The decision of the HHS appeals entity is the final administrative decision in the matter, and is binding on all parties concerned.

As provided in § 155.505(g) of this final rule, appellants may seek judicial review to the extent it is available by law. We recognize that State law could provide for judicial review of State Exchange appeals entity decisions even where further administrative recourse to the HHS appeals entity is available to the appellant, and we clarify that nothing in this final rule precludes an appellant from pursuing any form of available judicial review. However, regardless of other avenues for obtaining review, if an appellant wishes to escalate a State Exchange appeals entity decision to the HHS appeals entity, the appellant must make that appeal request to HHS within 30 days of the date of the notice of the State Exchange appeals entity decision.

Comment: We received a few comments recommending that applicants and enrollees should receive the same opportunities for initial and secondary appeals, regardless of whether the Exchange has its own appeals process. Another comment suggested giving appellants in State Exchanges with an eligibility appeals process the option to elect pursuing an appeal either through the State Exchange process or the HHS appeals process but not both processes. Finally, a commenter requested that appellants not be provided with the option to appeal to HHS after an SBE appeal and that HHS should not be able to override an SBE appeal decision.

Response: We are finalizing § 155.505(c) as proposed, providing access to the HHS appeals process to all appellants regardless of whether a State Exchange, State Partnership Exchange, or Federally-facilitated Exchange is operating in their State, because section

1411(f)(1) of the Affordable Care Act generally requires that Federal review of Exchange individual eligibility determinations be available to applicants and enrollees. We acknowledge that, because of the potential for review by a State Exchange appeals entity and the HHS appeals entity, some appellants will receive two levels of review while others will receive one; however, we believe all appellants, regardless of levels of review, will have access to a robust appeals process and comprehensive due process rights. Therefore, we believe § 155.505(c) provides an appropriate level of flexibility for Exchanges and appellants while fulfilling the requirement of section 1411(f)(1) of the Affordable Care Act that Federal review of Exchange individual eligibility decisions must generally be available to applicants and enrollees.

Comment: One commenter requested that paragraph (c)(2) permit States to opt out of providing appellants a second-level appeal to the HHS appeals entity upon a showing that the State Exchange appeals entity provides comparable measures for administrative or judicial review at the State level. The commenter highlighted that introducing a new Federal level of appeals would necessitate changes to States' established review and appeals processes to accommodate the Federal review and introduce the potential for differing decisions at the State and Federal level. The commenter suggested that, to the extent that States have significant numbers of Medicaid-eligible individuals whose eligibility determinations are made outside of the Exchange, the Federal review requirement for Medicaid eligibility determinations made by the Exchange results in inconsistent treatment and potential confusion as to which procedural rights are available. Finally, we also received a comment that expressed the belief that HHS will not provide administrative review of appeals for all types of Exchange appeals, specifically Medicaid and CHIP determinations.

Response: First, we clarify that the HHS appeals entity may adjudicate appeals of all types of eligibility determinations, including Medicaid and CHIP eligibility determinations where the relevant State agency has delegated appeals authority to the Exchange. Second, we share the concerns that State Exchanges have in establishing and coordinating Exchange appeals processes with existing appeals processes. As noted above, we are providing Exchanges additional flexibility in the first year of operations

to complete system builds, develop operating protocols, and establish secure electronic interfaces that align with the requirements of the final rule. Moreover, State Exchanges that do not wish to operate their own appeals process may delegate all individual eligibility appeals to the HHS appeals entity. In addition, we note that we have largely aligned appeals process requirements with the existing Medicaid fair hearing standards, and we have designed this final rule to minimize administrative and operational burdens to the greatest extent possible. State Exchanges are encouraged to leverage existing appeals processes and functions where possible to ease these burdens. However, we are unable to permit State Exchanges to opt out of providing appellants of individual eligibility decisions the opportunity to appeal to the HHS appeals entity because section 1411(f)(1) of the Affordable Care Act generally requires that Federal review be available to these individuals. Therefore, we are finalizing the provision as proposed.

Comment: Commenters questioned whether Exchanges would face a cost for the appeals conducted by HHS, particularly State Exchanges that opt not to provide a State Exchange appeals process for individual eligibility appeals.

Response: HHS does not intend to levy a fee for the costs associated with the adjudication of individual eligibility appeals from State Exchanges because HHS is required by section 1411(f)(1) of the Affordable Care Act to provide an appeals process.

Comment: We received several comments requesting details on how HHS anticipates the escalation process from the State Exchange appeals entity to the HHS appeals entity will work, and what particular information HHS may need from a State Exchange in order to carry out an individual eligibility appeal.

Response: We appreciate the concerns with the operational processes involved in adjudicating Exchange appeals and will address these technical issues in future guidance.

Comment: We received several comments expressing general support for the provisions in paragraphs (d) through (f).

Response: We have largely maintained these provisions as proposed. To the extent we are modifying the final provisions, we discuss those changes below.

Comment: We received many comments regarding the standards for eligible entities under § 155.505(d). Foremost, commenters wanted to know

whether the flexibility offered to States Exchanges in paragraph (c) of this section to provide a State Exchange appeals process included the ability to delegate a State Exchange appeals process to an entity outside the Exchange. Comments in this vein included questions about delegation to non-governmental entities with CMS approval, State Medicaid or CHIP agencies, or a State's central administrative hearings office. We also received comments supporting the prohibition of delegation to entities that do not have demonstrated experience in making the types of determinations subject to appeal.

Response: The proposed rule did not provide direct guidance on the Exchange's ability to delegate the appeals function, except to provide that an appeals process established under 45 CFR part 155, subpart D must comply with the requirements of 42 CFR 431.110(c)(2) for Medicaid eligibility appeals. However, we are making changes to provide greater clarity about this issue in the final rule at paragraphs (c) and (d) to explicitly allow delegation of individual eligibility appeals to an eligible entity where specific standards are met.

We are modifying paragraph (c) by clarifying paragraph (c)(1) to state that the provision is applicable to the "State Exchange appeals entity, or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart." In paragraph (c)(2), we clarified the ability of an Exchange to delegate exemption appeals to the HHS appeals entity. Also in paragraph (c)(2), we are clarifying that appeals may be handled by the HHS appeals entity upon exhaustion of the State Exchange appeals process, if the Exchange has not established an appeals process in accordance with the requirements, or if the Exchange has delegated appeals of exemption determinations made by HHS pursuant to § 155.625(b) to the HHS appeals entity, and the appeal is limited to a determination of eligibility for an exemption.

We are modifying paragraph (d) to remove references to the Medicaid standards and align standards for entities eligible to carry out Exchange functions under § 155.110(a) because we do not want to further limit the ability for Exchanges to delegate functions to eligible entities. Inclusion of the Medicaid standard would prevent Exchanges from delegating appeals functions to non-governmental entities, whereas the Exchange standard that we

have retained does not include this restriction. We think it is in the best interest of Exchanges to have this flexibility. This means that the entity must: (1) Be incorporated under and subject to the laws of one or more States, including State agencies; (2) must have demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and (3) must not be a health insurance issuer, or a member of the same controlled group of corporations as or under common control with a health insurance issuer. We anticipate that many State Exchanges will delegate the individual eligibility appeals function to an eligible entity, such as the State Medicaid or CHIP agency or a central administrative hearings office within the State. An eligible entity may be a non-governmental entity. We interpret these requirements broadly and plan work with states that wish to delegate the individual eligibility appeals function to ensure that the designated entity satisfies these requirements.

Comment: In response to paragraph (d), one commenter recommended that the rule specify that a State Exchange appeals entity can staff hearings with contract attorneys or other staff paid on a per-case or hourly basis rather than full-time Exchange staff.

Response: We understand that some States may currently rely on contracted staff to assist with existing appeals processes and we acknowledge that staffing a new appeals process can be difficult when the volume of appeals is not yet known. We do not regulate the staffing of Exchange appeals entities in this final rule but we note that Exchange appeals process must meet the same standards provided in subpart B of Part 155 for the establishment of an Exchange, including § 155.110 which allows the Exchange "to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange." We are finalizing paragraph (d) without changes in this regard.

Comment: We received general support for the provisions regarding the use of authorized representatives proposed in paragraph (e).

Response: We are modifying the provision slightly to provide additional clarity. We have retitled the paragraph "Representatives" and clarified the language to state, "An appellant may represent himself or herself, or be represented by an authorized representative under § 155.227, or by legal counsel, a relative, a friend, or another spokesperson, during the

appeal.” The modifications clarify the scope of representation and more closely parallel Medicaid standards in this regard.

Comment: We received numerous comments supporting our accessibility standards for individuals with disabilities and limited English proficiency (LEP) individuals. Many of these commenters requested that we explicitly include such protections in other appeals provisions, apart from our specification of these protections in § 155.505(f). Many commenters suggested including additional accessibility features and protections as part of the process. For example, several emphasized the need for notices and other communications to contain plain language for the process to remain accessible to appellants with special needs. We were encouraged to provide clearly written examples of notices and seek stakeholder input as materials are developed.

Several commenters requested that the appeals process adopt the same requirements for accessibility for LEP individuals as are provided for Exchange programs and consumer assistance tools in § 155.205, which includes provisions for oral interpretation, written translation, and taglines. In addition, particular accommodations for hearings were requested, such as providing appropriate augmentative or assistive communication devices for individuals with disabilities at no cost.

Response: We appreciate the unique and vulnerable position that appellants with disabilities and LEP appellants face. For that reason, we proposed the requirement that all appeals processes be accessible to such individuals. We are finalizing the rule as proposed because the provisions of paragraph (f) are sufficient to safeguard against the concerns shared by the commenters, particularly because it applies to all parts of the appeals process.

Comment: In response to paragraph (f), some commenters also requested that we ensure that any actions undertaken during the appeals process that do not comport with the accessibility standards must be voided and the process cease until cured. Similarly, some commenters recommended that only where meaningful notice has been given (e.g., in an LEP individual’s preferred language or in an alternative format for an individual with a disability who cannot read regular print) should the notice, or any actions pursuant to it, be valid. The commenters viewed this approach as comporting with Title VI of the Civil Rights Act, the Rehabilitation

Act of 1973, the Americans with Disabilities Act, and section 1557 of the Affordable Care Act.

Response: Individuals with disabilities and LEP individuals whose distinct needs are not met during the appeals process are at risk for suffering adverse consequences. The value of an appeal is diminished where an appellant is unable to fully understand or participate in the process because of a failure on the part of the appeals entity to provide required accommodations. However, paragraph (f) and the associated statutory provisions noted by the commenters provide sufficient protection without the need to modify paragraph (f). Therefore, we are finalizing the provision as proposed.

Comment: Several commenters requested various clarifications to the judicial review provision proposed in paragraph (g). Many commenters focused on clarifying in which court an Exchange appellant may seek judicial review. Other commenters focused on the operational aspects for seeking judicial review of an appeal decision by the HHS appeals entity. One commenter requested the final rules clarify that an appellant may either seek judicial review or an appeal to the HHS appeals entity, but not both. Another commenter highlighted the concern that States’ laws often provide specific timeframes in which an individual may file a State judicial action and that these timeframes may not match up with the timeframe for seeking review of a State Exchange appeal decision by the HHS appeals entity and receiving an appeal decision. The commenter sought further clarification on the interaction between the State Exchange appeals process, the HHS review, and State judicial processes including when HHS review would commence relative to a State judicial review.

Response: Section 1411(f)(1) of the Affordable Care Act generally requires that applicants and enrollees be afforded the opportunity to access a Federal administrative appeals process for individual Exchange eligibility appeals, without regard to the availability of judicial review. Accordingly, we are not implementing the commenter’s suggestion that review by the HHS appeals entity and judicial review should be mutually exclusive. Additionally, State and Federal law regarding judicial review of administrative decisions generally require the exhaustion of available administrative remedies; accordingly, we do not expect judicial review of individual Exchange eligibility appeal decisions generally to be available before exhaustion of the administrative

process, which provides for appeal to the HHS appeals entity. We encourage the commenters to research applicable State and Federal laws regarding judicial review of administrative decisions to determine under which circumstances appellants will have access to judicial review. We are finalizing the provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions of § 155.505 with modifications to several paragraphs. In paragraph § 155.505(a) and throughout the provisions of final rule, we note that we have replaced “State-based” with “State Exchange” for greater consistency across the Exchange rules. In § 155.505(b), we streamlined the language by removing “In accordance with § 155.355 and future guidance on section 1311(d)(4)(H) of the Affordable Care Act.” Additionally, we edited paragraph (b)(2) to remove “with future guidance on exemptions pursuant to section 1311(d)(4)(H) of the Affordable Care Act” and replaced it with a reference to § 155.605. In § 155.505(b)(3), we edited the provision to include the additional reference to the exemption determination notice by inserting, “or § 155.610(i)” at the end of the provision. This addition reflects the finalization of the exemption rules in 45 CFR part 155, subpart G. Finally, we are adding new paragraph (b)(4) to state that “[a] denial of a request to vacate dismissal made by a State Exchange appeals entity in accordance with § 155.530(d)(2), made pursuant to paragraph (c)(2)(i) of this section” may be appealed.

We made a minor modification to paragraph (c)(1) to provide greater clarity that the provision is applicable to the “State Exchange appeals entity, or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.” We are similarly amending paragraph (c)(2) to read “[t]he HHS appeals entity” rather than “HHS.” In paragraph (c)(2), we specifically provided the ability of an Exchange to delegate exemption appeals to the HHS appeals entity by separating the original language into two subparagraphs and adding a third subparagraph (c)(2)(iii), which reads, “If the Exchange has delegated appeals of exemption determinations made by HHS pursuant to § 155.625(b) to the HHS appeals entity, and the appeal is limited to a determination of eligibility for an exemption.”

In paragraph (d), we amended the requirements that must be met by an

entity to be eligible to conduct individual eligibility appeals by removing reference to Medicaid standards at 42 CFR 431.10(c)(2) and replacing it with Exchange standards at § 155.110(a). We also streamlined paragraph (d) by removing “the requirements of.”

In paragraph (e), we are modifying the proposed provision slightly to provide additional clarity. We are retitling § 155.505(e) “Representatives” and are modifying the provision to state, “An appellant may represent himself or herself, or be represented by an authorized representative under § 155.227, or by legal counsel, a relative, a friend, or another spokesperson, during the appeal.” We are modifying the provision to clarify the scope of representation and more fully align with Medicaid standards in this regard.

c. Appeals Coordination (§ 155.510)

In § 155.510, we proposed coordination requirements between the Exchange appeals entity and agencies administering insurance affordability programs in order to minimize burden on appellants and ensure prompt issuance of appeal decisions. Included within this section are proposed requirements for agreements between the appeals entity or the Exchange and agencies administering insurance affordability programs regarding appeals as well as standards for coordination with Medicaid and CHIP appeals, including where the relevant State agencies have or have not delegated Medicaid or CHIP eligibility appeals authority to the Exchange appeals entity. We sought comment on options regarding when to inform the applicant or enrollee of his or her right to appeal to a denial of Medicaid or CHIP directly with the Medicaid or CHIP agency. Finally, paragraph (c) of this section proposed standards for data exchanges as part of the appeals process.

Comment: Many commenters expressed support for paragraph (a), in which we proposed to require agreements between the Exchange appeals entity or the Exchange and agencies administering insurance affordability programs. Several commenters specifically expressed support for paragraph (a)(1), in which we proposed that the agreements minimize the burden on appellants in the appeals process. Some commenters also shared support for paragraph (a)(2), in which we proposed that the agreements ensure the prompt issuance of appeal decisions. Several commenters requested that the agreements be available to the public to promote accountability and transparency. We

also received comment requesting that HHS make an agreement template available for State Exchanges to adopt or modify for State-specific circumstances. We received one comment recommending that the agreement explicitly provide for compliance with monitoring and reporting requirements and the specific information to be reported. Finally, we received comment on paragraph (a)(3) supporting the requirement that agreements comply with the Medicaid program’s single State agency requirements.

Response: In the proposed rule, we did not specify whether the agreements must be public and we are not finalizing this provision with any such modification. Similarly, in the proposed rule, we did not propose to require that the agreements include specific compliance with monitoring and reporting requirements, and we are not finalizing the provision with any such modification. We anticipate that appeals entities or Exchanges may wish to include those important issues in the agreements. Finally, we do not intend to provide a template for the agreements, but we may consider providing further guidance on this issue at a later date.

Comment: Some commenters requested additional clarification regarding the respective roles of Medicaid and Exchanges in appeals.

Response: In both the proposed rule and this final rule, CMS has worked to ensure that the roles of the Exchange and Medicaid in the eligibility appeals process are clear throughout the Exchange rules and the Medicaid rules. We also understand the desire to have a simple process for Exchanges to implement and appellants to use. We have provided the simplest, most coordinated options whenever possible.

Comment: Subparagraph (b)(1) proposed that individuals who have been denied eligibility for Medicaid or CHIP be provided an opportunity to opt-in to having an appeal of that denial heard directly by the Medicaid or CHIP agency. We specifically sought comment as to when an individual should be notified of this option. Some commenters responded by endorsing an approach where the individual is informed at the time the eligibility determination is made by the Exchange because this option provides greater protection for individuals. We also received comment that the option for a hearing before the State agency could be offered during the Exchange appeal request. In addition, some commenters encouraged us to require that the information about opting-in to a hearing before the State agency be provided in writing.

Other commenters opposed the option entirely and instead supported allowing an appellant only one hearing at the Exchange. Similarly, a few commenters shared their concern that the option to appeal a denial of Medicaid, where the applicant or enrollee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions, is inefficient, costly, and will cause appellant confusion. These commenters requested that the provision be struck from the rule or that the decision to include the option for individuals to opt-in to a Medicaid fair hearing be left to the States.

Response: We are required to provide applicants and enrollees the option to pursue an appeal of a denial of eligibility for Medicaid directly with the Medicaid agency in accordance with section 1902(a)(3) of the Social Security Act and 42 CFR 431.10(c)(1)(ii). We note that we are modifying the regulation text to remove reference to CHIP in this provision; the requirement to provide an appellant an opportunity to pursue a denial of eligibility with the State agency is only relevant to Medicaid denials. There is no corresponding requirement under Federal CHIP laws. In order to provide flexibility to Exchanges, we have elected not to include specific direction as to when and how notice of the option to have an appeal of a denial of Medicaid eligibility heard by the State agency must be provided to appellants, though we note that the notice, like Exchange notices generally, must comport with § 155.230. We are finalizing the rule with the modification discussed above and also note that this provision has been relocated to § 155.510(b)(1)(ii).

Comment: We also received comments regarding how the opt-in policy should be operationalized. One commenter urged us to ensure that individuals who pursue an appeal of a denial of Medicaid eligibility with the Medicaid agency also have the option to request that the Medicaid hearing occur first to prevent any delays in coverage.

Response: We are finalizing the rule as proposed, continuing to provide flexibility for an Exchange to determine how to operationalize the requirement to make a hearing before the State agency available to appellants appealing a denial of Medicaid eligibility. Exchanges and appeals entities may contact us for assistance in this area, as required.

Comment: We received several comments about delegation of appeals authority. Some commenters expressed support for both the flexibility offered to States to delegate Medicaid and CHIP

appeals to the Exchange, thereby allowing States to offer one coordinated appeals process across all insurance affordability programs, as well as the option for State Medicaid and CHIP agencies to retain fair hearings at the State agency. We were asked to clarify that the delegation of appeals authority by a Medicaid or CHIP agency is separate from the delegation to determine Medicaid and CHIP eligibility. We were also asked to provide information on timeframes and information transfers where Medicaid and CHIP eligibility appeals authority is delegated, and where it is not. Some commenters also sought clarification as to how the proposed delegation provisions impact existing agreements of State Medicaid and CHIP agencies, including interagency agreements and vendor contracts.

Response: State Medicaid and CHIP agencies have the flexibility to delegate authority to make eligibility decisions and, separately, to conduct eligibility appeals. The authority to delegate eligibility determinations is located in 42 CFR 431.10(c)(1)(i) and § 457.1120 for Medicaid and CHIP, respectively, and the authority to delegate eligibility appeals is located in 42 CFR 431.10(c)(1)(ii) and § 457.1120, respectively. We anticipate that many States may have an interest in delegating these two functions in tandem; however, we also acknowledge that States may wish to retain the appeals functions at the relevant State agency. More information on delegations by the Medicaid and CHIP agency can be found in the final rule published July 5, 2013 (78 FR 42160). We are not providing additional guidance in this rule with regard to timeframes and data exchanges in the delegation context beyond what we have already addressed in this subpart in order to preserve flexibility for Exchanges in these areas. We also note that the provisions we are finalizing in § 155.510 do not speak to existing agreements between State Medicaid and CHIP agencies.

Comment: A few commenters shared support for the acknowledgement provided in paragraph (b)(2) that, even in cases where the Medicaid or CHIP agency has delegated appeals authority to the Exchange, the appellant may still opt to have a denial of Medicaid or CHIP eligibility heard by the Medicaid or CHIP agency. We also received comment expressing support for the requirement that where the Medicaid or CHIP agency has delegated appeals authority to the Exchange, the Exchange will issue a final, binding appeal decision, including regarding Medicaid

or CHIP eligibility. Finally, one commenter questioned the use of “may” in subparagraph (b)(2), under which Exchange appeals entities may include in the appeal decision a determination of Medicaid and CHIP eligibility under specified conditions.

Response: We appreciate the support the delegation provisions in paragraph (b)(2) received. We also agree that the use of “may” in the proposed provision was incorrect, and we are replacing that word with “must” in this final rule. In addition, we are restructuring § 155.510(b) in this final rule to emphasize that the Exchange appeals entity will conduct delegated Medicaid and CHIP appeals in accordance with standards applicable to Medicaid and CHIP.

Comment: We received support for the proposed provision in subparagraph (b)(2)(ii) proposing that notices required in connection with an eligibility determination for Medicaid or CHIP provided by the Exchange appeals entity align with the standards identified in subparts D and F, and by the State Medicaid or CHIP agency.

Response: Maintaining the notice standards established by Medicaid and CHIP agencies is important when communicating with appellants about Medicaid or CHIP determinations. Therefore, we are finalizing this provision with minor clarifying modifications described below. As noted above, the provisions of § 155.510(b) have also been restructured, and this provision is now located in clause (b)(1)(i)(B).

Comment: In response to the proposed provisions of paragraph (b)(3), one commenter recommended a minor change to include reference to transmitting all “relevant information” as part of the “initial application” and appeal. The commenter also suggested the inclusion of a timeframe for transmitting the information.

Response: We are finalizing the provision to provide that the appeals entity must transmit the eligibility determination and “all relevant information provided as part of the initial application or appeal, if applicable.” We decline to provide a more specific timeframe to preserve necessary administrative flexibility for Exchanges and appeals entities, and we anticipate that the Exchange and appeals entity will act in good faith to transmit such information promptly and without undue delay. As noted above, the provisions of § 155.510(b) have also been restructured, and this provision is now located in paragraph (b)(2).

Comment: We received many comments regarding paragraph (b)(4). A

handful of commenters endorsed the proposed provision considering it efficient to treat an appellant determined or assessed as not potentially eligible for Medicaid or CHIP to be considered ineligible for those programs for purposes of determining eligibility for advance payments of the premium tax credit.

We also received many comments urging HHS to reconsider this provision, as well as the treatment of an appeal of an eligibility determination for advance payments of the premium tax credit as an appeal of the eligibility determination for Medicaid and CHIP. Some commenters noted that many appellants may only be concerned with the tax credit, with no interest in or connection to Medicaid; these commenters feared that this linking of tax credits and Medicaid could create a burden on States to process appeals for individuals who clearly may not be eligible for Medicaid or may have been satisfied with the Medicaid eligibility determination. Some commenters suggested that the rules require the Exchange to offer the opportunity to file an appeal of any Medicaid denial, which would be less confusing to consumers. A few commenters suggested that, if this is not feasible, the requirement to treat an appeal of the denial of an eligibility determination for advance payments of the premium tax credit as an appeal of eligibility for Medicaid and CHIP should be delayed until Jan. 1, 2015. Some commenters felt strongly that this “automatic appeal” will cause agencies to expend significant resources to process appeals that are neither intended nor desired by the appellant.

Response: We are finalizing paragraph (b)(4) as paragraph (b)(3) as part of the restructuring of § 155.510(b). While we acknowledge the commenters’ concerns regarding the pairing of Medicaid and CHIP appeals with appeals concerning advance payments of the premium tax credit, our goal is to provide a streamlined, coordinated appeals process for appellants, while minimizing the administrative burden on the Exchange, appeals entity, and State Medicaid and CHIP agencies. We believe our approach accomplishes this goal and we are finalizing the provision as proposed.

Comment: We received one comment regarding the standards for data exchange proposed in paragraph (c). The commenter was supportive of paragraph (c) serving as a goal for modernizing appeals processes through the use of electronic interfaces but expressed concern that the appeals systems would not be sufficiently

developed to accommodate electronic interfaces upon initial open enrollment. The commenter recommended a phased-in approach to establishing a secure electronic interface between the Exchange, Exchange appeals entities, and other insurance affordability programs.

Response: We understand that many Exchange appeals entities may lack the system functionality for secure electronic data exchanges in current system builds for the first year of operations. Instead, Exchange appeals entities may utilize a secure, paper-based process for exchanging data and information that conforms to information privacy and security standards incorporated in § 155.510(c)(1) for the first year of operation.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.510 with the following modifications. In § 155.510(a)(3), we deleted “42 CFR 431.10(d)” and added two new subparagraphs, (a)(3)(i) and (ii). New subparagraph (a)(3)(i) refers to Medicaid standards for delegating appeals authority to the Exchange or HHS, stating, “42 CFR 431.10(d), if the State Medicaid agency delegates authority to hear fair hearings under § 431.10(c)(ii) to the Exchange appeals entity.” New subparagraph (a)(3)(ii) refers to CHIP standards for delegating appeals authority to the Exchange or HHS, stating, “42 CFR 457.348(b), if the State CHIP agency delegates authority to review appeals under § 457.1120 to the Exchange appeals entity.”

We restructured § 155.510(b) and made minor modifications throughout. We have moved the requirements formerly in (b)(2), with minor changes to (b)(1), which now contains two subparagraphs. Thus, § 155.510(b)(1) and (b)(1)(i) provide, “Where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR 431.10(c)(1)(ii) or § 457.1120, and the Exchange appeals entity has accepted such delegation—[t]he Exchange appeals entity will conduct the appeal in accordance with” the standards identified in new clauses (A) and (B), namely, “Medicaid and CHIP MAGI-based income standards and standards for citizenship and immigration status, in accordance with the eligibility and verification rules and procedures, consistent with 42 CFR parts 435 and 457” and “Notice standards identified in this subpart, subpart D, and by the State Medicaid or CHIP agency, consistent with applicable law.” We

have moved the opt-in provision previously located in § 155.510(b)(1) to § 155.510(b)(1)(ii), and we have made a minor modification to remove references to CHIP, as the opt-in policy does not apply to denials of CHIP eligibility. We also clarified “the appellant” as “the appellant who has been determined ineligible for Medicaid” and we have added “eligibility” before “determination.”

We are finalizing proposed § 155.510(b)(3), with modification, at § 155.510(b)(2). In this paragraph, we are replacing “appeal” with “initial application or appeal, if applicable” and we are adding the word “relevant” before “information.” We are finalizing proposed § 155.510(b)(4) at § 155.510(b)(3) without modification. Finally, in § 155.510(c)(1), we updated the citation from § 155.345(h) to § 155.345(i) to accurately reference the current location of the relevant data exchange requirements.

d. Notice of Appeal Procedures (§ 155.515)

In § 155.515, we proposed standards for providing notice of appeal procedures at both the time of application and in the eligibility determination notice. This section also proposed the content of that notice.

Comment: Many commenters showed support for the notice of appeal procedures provisions in § 155.515. We received several comments requesting a modification to paragraph (a) to require that the notice of appeal rights be provided in writing.

Response: In the proposed rule, we did not explicitly state that the notice of appeals procedures must be provided in writing; however, the requirement in paragraph (a) states that the appeals language appear within specific eligibility notices, including eligibility determination notices, redetermination notices as a result of a mid-year change or annual redetermination, and exemption determination notices. The notice provisions specified in paragraph (a) specifically require the notice to be written, and § 155.230(a) generally requires that any notice sent by an Exchange to applicants, qualified individuals, enrollees, and others must be written. Therefore, it is not necessary for § 155.515(a) to reiterate the requirement that the notice of appeals procedures be provided in writing.

Comment: Regarding paragraph (b), one commenter sought clarification regarding the meaning of paragraph (b)(5), in which we proposed to require the notice of appeals procedures to contain an explanation that an appeal decision may result in redetermination

for other household members. Another commenter requested the language provide more certainty regarding whether or not an appeal would result in a redetermination for other household members.

Response: During an appeal, appellants have the opportunity to submit information to be considered by the appeals entity. In addition, the appeals entity will reexamine the information used to make the eligibility determination. In some cases, the appeals entity will find the eligibility determination was incorrect or that information, newly supplied by the appellant, will result in a change to the original determination. Such changes, particularly those that impact household income information, may require an eligibility redetermination for all household members whose own eligibility was determined by reference to the changed information. The requirement in paragraph (b)(5) is intended to alert individuals that an eligibility appeal by one household member may impact the eligibility of other household members. We agree with the commenter that the language used in paragraph (b)(5) calls for greater clarity regarding whether other household members' eligibility will be redetermined as a result of a change in an eligibility determination as a result of an appeal by one household member. Therefore, we are finalizing this provision with minor modification to clarify that an appeal decision for one household member may result in a change in eligibility for other household members and such changes will be handled as a redetermination of eligibility for all household members in accordance with the standards specified in § 155.305.

Comment: We received comments requesting information as to how § 155.515 interacts with the general standards for Exchange notices found in § 155.230 and whether the notices specified in part 155 subpart F would include the content required by § 155.230.

Response: Section 155.515 provides specific requirements regarding when notice of appeal rights and procedures must be provided to individuals and what content that notice must include. Section 155.230 provides general standards for Exchange notices, which includes the notices described in subpart F. Thus, notices under subpart F must meet the requirements of § 155.230, such as providing contact information for customer service resources, identifying the regulation supporting the action, and conforming to accessibility standards.

However, we note that the notice under § 155.515 does not necessarily require a free-standing notice. The requirements of § 155.515 may be met by providing the required content (notice of appeal rights and procedures) within another notice. For example, the notice of appeal rights and procedures may be included within the eligibility determination notice and does not need to be issued in a separate notice. The requirements of § 155.230 are applicable to any notice in which the content required by § 155.515 (notice of appeal rights and procedures) is included.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.515 of the proposed rule with the following modifications. We are making a minor modification to paragraph (a)(2) to include reference to the exemption eligibility determination notice under § 155.610(i). We are modifying paragraph (b)(5) to make the provision mandatory rather than permissive. We have replaced “may be handled” with “will be handled” to clarify that the notice of appeal procedures must contain an explanation that an appeal decision for one household member may result in a change in eligibility for other household members and such a change will be handled as a redetermination. We also added “that such a change” and “of eligibility for all household members” to the provision.

e. Appeal Requests (§ 155.520)

In § 155.520, we proposed the modes through which the Exchange and appeals entity must accept appeal requests, including requests submitted by telephone, by mail, in-person (as applicable), and via the internet. Additionally, we proposed the Exchange and appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the eligibility determination notice or 30 days from the date of a State Exchange appeals entity’s notice of appeal decision. We further proposed the requirement to issue a notice acknowledging the receipt of a valid appeal request and requirements to obtain and transmit information concerning the appeal upon receipt of an appeals request, and confirm receipt of this information. Finally, we proposed that appellants must be notified of invalid appeal requests and may submit amended appeal requests.

Comment: Many commenters expressed broad support for the flexibilities we proposed § 155.520 to allow appellants several methods to request an appeal. However, many

States commented with concern that accommodating all of the appeal request modes would be burdensome and require significant administrative updates to systems and staffing levels. Telephonic appeal requests were highlighted as particularly problematic. Many States’ Medicaid agencies are not currently set up to accept telephonic appeal requests and, therefore, do not have the sophisticated voicemail systems, record keeping protocols, and staff training to accommodate telephonic appeal requests. Similarly, commenters viewed requesting an appeal via the Internet as another mode that would require significant systems development to ensure appeal requests and supporting documentation are captured and transmitted properly. We also received many comments seeking an expansion of the modes allowed to request an appeal to include via email, fax, text, and other commonly available electronic means.

Several commenters expressed concern over the implementation of the proposed appeal request modes and supported allowing additional time for Exchange appeals entities to implement these provisions. For example, one comment suggested that accepting appeal requests via internet in the initial year will create a large burden on Exchange appeals entities because system builds and testing schedules are already tight. Some commenters encouraged us to consider implementing the appeal request methods under a delayed timeframe or, alternatively, eliminating the requirement from the rule altogether.

Response: The proposed rule proposed to require an Exchange and appeals entity to accept appeal requests through a variety of modes in an effort to match the avenues through which an application for Exchange coverage can be submitted. The modes include via telephone, mail, in person (as applicable), or via the Internet. In addition, the proposed rule proposed to offer flexibility for Exchange appeals entities to provide an in-person route to request an appeal only if the Exchange or the appeals entity were capable of receiving in-person requests, assuming that some Exchanges and appeals entities might not have a wide geographic physical presence. We note that the rules of subpart F do not apply to Medicaid agencies, except insofar as a State may delegate Exchange appeals to a State Medicaid agency. We are finalizing this provision as proposed but reiterate that a paper-based process, as discussed above, is acceptable for the first year of operations. All other appeal request modes may be provided at the

Exchange appeals entity’s option until the second year of operations.

Comment: We received comments requesting that the rule include the requirement that Exchanges must accept requests for appeals in languages other than English. It was noted that without such a requirement, Exchanges may create a barrier to filing an appeal that would result in discrimination.

Response: As noted above, we consider the provisions for accessibility in § 155.505(f) to be sufficient protection to LEP individuals and individuals with disabilities. We intend for Exchanges and appeals entities to make accommodations for these individuals so that the appeals process is accessible to all applicants and enrollees. Although we are not altering the provisions of § 155.520 in this regard, we note that appellants to the HHS appeals process will be able to submit appeal requests in languages other than English. Finally, we note that we have made a minor modification to paragraph (a)(2), changing “may” to “must” to require the Exchange and the appeals entity to assist the applicant or enrollee in making the appeal request, “if requested,” as an extra protection for applicants and enrollees who may require assistance.

Comment: Many commenters provided general support for the 90-day timeline to request an appeal. However, other commenters also shared significant concern about the timing and sequencing of appeal requests and decisions and the potential length of the appeals process. For example, some commenters expressed concern that Medicaid and Exchanges have different timelines for requesting an appeal. Specifically, certain State Medicaid Agencies have shorter time periods during which an individual can submit an appeal request, whereas the Exchange proposes a 90-day timeframe. A few commenters recommended limiting the amount of time to request an appeal to 30 days. Other commenters noted a 90-day request period could leave some appellants who have been denied eligibility without coverage for several months, if the appeal originates in a State Exchange appeals process and escalates through the HHS appeals process.

Response: We are finalizing the provision in paragraph (b) with a modification regarding the 90-day timeframe. We understand that State Medicaid and CHIP agencies may elect to set timeframes for requesting an appeal shorter than 90 days and that a State may want to leverage existing appeals processes and infrastructure within the State to provide Exchange

eligibility appeals or otherwise align Exchange and Medicaid appeal processes. Therefore, we are modifying the provision to provide a choice: the Exchange and appeals entity must either allow an applicant or enrollee to request an appeal within 90 days or within a timeframe consistent with the State Medicaid agency's requirement for submitting fair hearing requests, provided that the timeframe is no less than 30 days, measured from the date of the notice of eligibility determination. If a State agency delegates appeals authority to HHS, HHS will provide an applicant or enrollee with 90 days to request an appeal, in accordance with the proposed timeframe.

Comment: Many commenters expressed support for the proposed provision in § 155.520(c). However, we also received support for a longer timeframe for elevating an appeal decision of a State Exchange appeals entity to the HHS appeals entity. Suggested timeframes range from 60 days to 90 days (the latter in order to keep the timeframe uniform with the initial appeal request).

Response: We are finalizing the provision in § 155.520(c) as proposed without extending the timeframe to request an appeal before the HHS appeals entity following exhaustion of the State Exchange appeals process. We consider 30 days to be a fair balance between providing the appellant sufficient time to determine whether to elevate his or her appeal and avoiding delay of the resolution of the appeal, and implementation of the appeal decision.

Comment: We also received comment noting that the proposed rule is silent about the interaction of State law and the timeline for escalating an appeal decision of a State Exchange appeals entity to the HHS appeals entity. For example, some States currently provide an opportunity for administrative or judicial reconsideration of a State administrative hearing decision but only within a specific timeframe, and it was not clear in the proposed rule how this timeframe might interact with the timeframe for elevating an appeal to the HHS process.

Response: We are aware that State law may provide appellants additional avenues for review, beyond escalating their appeal to the HHS appeals entity as provided in this final rule, including the opportunity to request further State administrative or judicial review. Such alternative for State-level review follow State-specific timeframes and rules, which makes it challenging to provide a Federal process (as generally required for individual Exchange eligibility

appeals by section 1411(f)(1) of the Affordable Care Act) that will seamlessly integrate with all States' existing rules and procedures. Recognizing the regulatory limitations in this area, the procedure for escalating of an appeal to the HHS appeals entity does not preclude an appellant from seeking other avenues for review that may be available under State law. However, appellants should be mindful of the 30-day timeframe for escalating a State Exchange appeals entity decision to the HHS appeals entity, as this period will not be stayed while an appellant pursues alternative State law avenues for review. If the appellant does request an appeal with HHS, the HHS appeals entity will review the appellant's case *de novo*, as specified in § 155.535(f), and render a new decision that will constitute the final administrative decision.

Comment: We received a few comments regarding the use of "timely" and "prompt" in several proposed provisions, with some commenters suggesting the substitution of a specific timeframe, such as two business days, with the expectation that relevant action would be taken sooner, if possible.

Response: We understand the benefits specific timeframes can provide for appeals entities, including providing a clear window during which actions should be completed to provide appropriate protections for appellant rights. However, we also anticipate that appeals entities may require flexibility in some cases due to operational considerations. The Exchange rules sometimes provide timing requirements that allow a reasonable amount of flexibility, such as "promptly," "without undue delay," and "timely" for many transactions that occur between administering agencies. The transactions that are required in § 155.520 between appeals entities, Exchanges, insurance affordability programs, and HHS can benefit from a reasonable degree of flexibility, and therefore, we are finalizing the provisions as proposed in this regard and note that this is applicable to similar requirements in the employer and SHOP appeals sections below.

Comment: A few commenters noted that implementing the requirement to provide a notice acknowledging the receipt of an appeal request creates administrative burden and expense. One comment viewed the acknowledgement notice as duplicative of the notice of hearing found in § 155.535(b), which the commenter thought acted sufficiently as an acknowledgement of receipt. We received comment that electronic appeal requests should provide confirmation of

receipt automatically and, if the individual prefers to request an appeal in writing, he or she should send the request by certified mail with a return receipt requested as a means to confirm the receipt of the request.

Response: The notices required by the rule, including the appeal request acknowledgment notice, communicate important information to the appellant that a certified mail return receipt cannot provide. First, the acknowledgment confirms that the appeal has been accepted and not dismissed. Second, it informs the appellant of his or her qualification for eligibility while the appeal is pending. Third, the notice reiterates that any advance payments of the premium tax credit accepted while an appeal is pending are subject to reconciliation. Additionally, appeals entities may wish to include other information about the appeals process or frequently asked questions to assist the appellant with the process. We disagree with the assertion that the acknowledgement notice duplicates § 155.535(b)'s notice of hearing because, while State Exchanges have the option to provide an informal resolution process, pre-hearing, we anticipate that most appeals entities will implement such a process in order to resolve appeals as efficiently and expeditiously as possible. Only those appellants who remain dissatisfied with the informal resolution outcome will then receive the notice of hearing; accordingly, the acknowledgement of appeal requests is not duplicative of the notice of hearing. We are finalizing the provision as proposed in this regard.

Comment: We received comment questioning the utility of providing a transcript, recording, or summary of the State Exchange appeal under paragraph (d)(4) when the HHS appeals entity will be reviewing the appeal *de novo*.

Response: We note that paragraph (d)(4) requires the transmission of the appeal record to the HHS appeals entity when an appellant elevates his or her appeal from a State Exchange appeals entity. The appeal record, as defined in § 155.500, includes information beyond the transcript of the State Exchange appeals entity hearing. We include this requirement to lessen the burden on an appellant who is elevating his or her appeal to provide duplicative information, consistent with § 155.510. In addition, the transmission will include the information used to make the appellant's initial eligibility determination, which the HHS appeals entity otherwise would not possess. Finally, the transmission of the State Exchange appeals entity's appeal

decision and record will include evidence presented during the appeal, including at hearing. Therefore, we are finalizing the provision as proposed in this regard.

Comment: We received comments supportive of the proposed provision that an applicant or enrollee may cure an invalid appeal request. In addition, several commenters requested that the proposed requirement in paragraph (d)(2)(i) regarding the written notice of the "invalid" appeal request inform the applicant or enrollee that he or she can cure the defect and resubmit the appeal again as long as the new appeal request meets the timeliness requirement in this section.

Response: In addition to protecting applicants' and enrollees' due process rights, the ability for an applicant or enrollee to cure an invalid appeal request within the 90-day timeframe will decrease dismissals and, subsequently, requests to vacate dismissals, which in turn should lessen the burden on appeals entities overall. To that end, we agree that the notice informing an individual that he or she submitted an invalid appeal request should also include an explanation that he or she may cure the defect and resubmit the request within the appropriate timeframe. We anticipate that the more informed an individual is of the appeals process and of the next steps applicable to him or her, the less time and resources the appeals entity will spend per appeal. We are modifying the proposed provision to include the requirement that the applicant or enrollee be informed that he or she can cure the defect and resubmit the appeal request within the applicable timeframe.

We note that we view this provision as a tool to clearly define for appeals entities how to handle appeal requests that are out of scope, untimely, or submitted improperly. We clarify the intent of this provision is to address these instances and provide a method for an individual to resubmit the request or, if resubmission is not possible because the amended appeal request would be untimely, a method to request the appeals entity review the dismissal of the appeal request. The provision is not intended to prevent or limit the acceptance of appeal requests for minor technical deficiencies, such as an appeal request that is missing a phone number or does not state why the individual is appealing with exacting precision. We intend that only more fundamental deficiencies should make an appeal request invalid, such as where an applicant is seeking to appeal a coverage

claim rather than an eligibility determination.

Comment: We received one comment regarding the interaction of the acknowledgement of appeal request, the ability to cure an invalid appeal request, and the dismissal of an invalid appeal. The commenter found the provisions to be contradictory and suggested that they can only be reconciled if there is a time limit upon the right to amend an invalid appeal request under § 155.520(d)(2)(ii). Absent such a deadline, the commenter thought an appeals entity that issued a notice of a defective appeal request will not know when it can comply with its obligation to dismiss the appeal for being invalid under § 155.530(a)(3) without violating its obligation to allow an appellant to cure a defective appeal request. The commenter suggested that HHS either permit the appeals entity to impose a reasonable deadline for amendment or establish a uniform deadline of 15 days after service of notice under § 155.520(d)(2)(i).

Response: The proposed rule proposed to require that the appeals entity accept an amended appeal request only if the amended request met "the requirements of this section [155.520]," including the timing requirements in § 155.520(b) or (c), as applicable. However, we agree with the commenter that an invalid appeal request submitted toward the end of the 90-day appeal request timeframe would pose a timing issue in terms of informing the individual that he or she may cure the defect and dismissing the appeal because it does not comport with the requirements of a valid appeal request. We have revised § 155.520(d)(2)(i)(C) to provide appeals entities the flexibility to impose a reasonable deadline for amending appeal requests.

Comment: We received comment requesting that we clarify which data elements and date ranges encompass an "eligibility record" as described in paragraph (d)(3)(ii).

Response: The eligibility record is critical in the adjudication of an appeal because it will contain the information the appeals entity will need to make an accurate appeal decision. We are finalizing the definition of "appeal record" in § 155.500, and we refer the commenter to that definition.

Comment: The proposed regulations establish a requirement that an Exchange must transmit the appeal record and eligibility record via secure electronic interface. However, one commenter noted that some Exchanges and Medicaid agencies will share a single, electronic eligibility system; therefore, there is nothing to transmit as

both entities have access to the single system that holds all the relevant information. The commenter requested that the final language be amended to recognize integrated State systems.

Response: We recognize that States may take advantage of the flexibility we are providing to structure interactions between the agencies administering the Exchange and the State Medicaid program in different ways. Moreover, we recognize that State agencies administering the Exchange and the State Medicaid program will be operating with various information technology systems, and some States may feature an integrated system that serves both the Exchange and Medicaid (such as where the same agency administers the Exchange and the State Medicaid program). However, even where this integration exists, it is critical that the components responsible for eligibility determinations and appeals communicate and are granted access to the appropriate information. Therefore, we decline to modify the proposed rule, although we clarify that transmission of information is not necessary when both the eligibility entity and the appeals entity share access to systems that store the relevant information.

Comment: A commenter inquired whether HHS plans to require State Exchange appeals entities to transmit the appeal record to HHS exclusively through the Hub?

Response: We will work closely with State Exchange appeals entities to establish a secure, efficient mechanism for exchanging data.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.520 of the proposed rule with the following modifications. Regarding paragraph (a), we are modifying the provision by changing the "or" preceding § 155.520(a)(1)(v) to "and," and the permissive "[m]ay" to "[m]ust" in § 155.520(a)(2).

In § 155.520(b), we are adding a new provision to allow State Exchanges to provide a timeframe for requesting an appeal consistent with the State Medicaid agency's requirements for submitting a fair hearing request. Specifically, we are adding a new paragraph at (b)(2) stating that the Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within, "[a] timeframe consistent with the State Medicaid agency's requirement for submitting fair hearing requests, provided that timeframe is no less than 30 days, measured from the date of the notice of eligibility determination." In paragraph

(c), we are adding language to provide that an appeal may be requested at the HHS appeals entity within 30 days of the date of a State Exchange appeals entity's notice of appeal decision "or notice of denial to vacate a dismissal."

In paragraph (d)(1), we are amending the provision by inserting "must" preceding subparagraph (d)(1)(i), and removing the word from subparagraphs (d)(1)(i) and (d)(1)(ii). In subparagraph (d)(2)(i), we added clauses to more clearly explain what is required of the appeals entity when it receives an invalid appeal request. We placed the requirement to inform the appellant that his or her appeal request has not been accepted, which was proposed in the proposed rule, in clause (d)(2)(i)(A). Similarly, we placed the requirement to inform the appellant about the nature of the defect in the appeal request, which was proposed in the proposed rule, in clause (d)(2)(i)(B). Finally, we added clause (d)(2)(i)(C) to include a new requirement that the appeals entity include an explanation "[t]hat the applicant or enrollee may cure the defect and resubmit the appeal request by the date determined under paragraph (b) or (c) of this section, as applicable, or within a reasonable timeframe established by the appeals entity." This new provision addresses situations in which an appellant submits an invalid appeal request near the end of the timeframe to request an appeal, which would pose a timing issue in terms of providing the individual with an opportunity to cure the defect, and provides Exchange appeals entities the flexibility to impose a reasonable deadline for amending appeal requests.

f. Eligibility Pending Appeal (§ 155.525)

In § 155.525, we proposed the standards by which certain appellants may receive benefits while an appeal is pending. We proposed that the Exchange, or Medicaid or CHIP, as applicable, must continue to consider an individual eligible if he or she is appealing a redetermination, consistent with the standards proposed in § 155.525 or as determined by the Medicaid or CHIP agency, as applicable. Regarding eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, we proposed that an appellant or tax payer who accepted eligibility pending appeal should be pended eligibility in accordance with the level of eligibility in effect immediately before the redetermination being appealed.

Comment: Several commenters expressed support for the provisions providing eligibility pending appeal.

Although a few commenters thought it would be advantageous for new applicants to receive eligibility pending appeal, especially if the applicant receives eligibility during the inconsistency period, these commenters also noted the justifications for not doing so. Specifically, these commenters highlighted the difference between pending benefits for those completely new to coverage as opposed to those who had been enrolled and were redetermined ineligible; for example, enrollees have an existing relationship with an issuer and can be pended in the coverage they already receive while new applicants must being a relationship with an issuer and newly enroll in coverage to obtain pended benefits. These commenters also thought it should be made clear that, after the inconsistency period has ended, the applicant's eligibility will be determined, and the applicant will be eligible to receive the determined level of eligibility while an appeal is pending. For example, if an applicant entered an inconsistency period after submitting an application to the Exchange and, during that inconsistency period, was determined eligible for advance payments of the premium tax credit, these commenters thought we should clarify that this individual would qualify for eligibility pending appeal if the individual appealed his or her eligibility determination.

Response: We are finalizing the provision as proposed. Because new applicants who receive an eligibility determination notice under § 155.310(g) that they are eligible for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, or Medicaid or CHIP, may remain in coverage while they appeal that determination, it is not necessary to provide these individuals with eligibility pending appeal. In accordance with our proposed policy, we will not extend pended eligibility to new applicants who are denied eligibility, either outright upon initial application or at the close of an inconsistency period. It is not a common practice to provide pended benefits to new applicants who are not currently receiving benefits and we model that policy in our final rule.

Comment: A few commenters requested that appellants be explicitly informed of the potential for reconciliation of advance payments of the premium tax credit when accepting eligibility pending appeal and that pended eligibility may be waived. One commenter suggested that confirmation that the appellant understands the potential tax liability associated with

benefits pending appeal be part of the initial appeal request. Finally, we received comment that pended benefits should be an elected option, not an automatic benefit. Therefore, in the example, the individual could opt to appeal without receiving eligibility while the appeal is pending.

Response: We share the concerns of commenters regarding the choices appellants must make regarding pended benefits. We noted in the proposed rule's preamble at 78 FR 4651 that subpart D's § 155.310(d)(2) states that the Exchange must permit an individual to accept less than the maximum advance payment of the premium tax credit for which the tax filer is determined eligible; this includes accepting none of the advance payment of the premium tax credit. We also noted that receipt of advance payments of the premium tax credit are subject to reconciliation. To illustrate using the example from the previous comment-response: If the individual receives advance payments of the premium tax credit while the appeal is pending, those payments would be subject to IRS reconciliation after the close of the tax year, and the individual could be liable to repay tax credits received on an advance basis for which the IRS determines the individual was not eligible (the individual could also receive a tax refund if the IRS determines that he or she was eligible for a larger premium tax credit).

We agree that the proposed regulation language did not state that receipt of pended eligibility is at the option of the appellant and are modifying the text of § 155.525(b) in the final rule to require that pended eligibility must be continued only if the tax filer or appellant accepts eligibility pending the appeal. Our intent is to ensure that appellants receive the choice to accept pended eligibility and that the Exchange does not pend eligibility that will include advance payments of the premium tax credit unless the tax filer affirmatively elects to receive them during the appeal. We agree that tax filers must be notified that receipt of advance payments of the premium tax credit is subject to reconciliation; however, we decline to add specific language to § 155.525 because informing individuals of this information is already required by § 155.310(d)(2)(ii).

Comment: A few commenters noted the proposed provision's relationship with Medicaid and CHIP. Commenters noted a discrepancy between Medicaid and Exchange pended eligibility rules in that, unlike Medicaid, the Exchange does not limit pended eligibility to those appellants who request it within

10 days of an appealable action. In Medicaid, an appeal must be requested within 10 days of the action, and benefits continue until the end of the 10-day period to ensure there is no break in coverage if a beneficiary requests an appeal during the 10-day period. Under the Exchange provision, the decision to terminate advance payments of the premium tax credit and cost-sharing reductions could have been effectuated by the time the individual requests an appeal. We also received comment questioning why Medicaid and CHIP are referenced in the proposed provision when the provision applies to annual or mid-year redeterminations conducted by Exchanges; the commenter noted that once an individual is determined eligible for Medicaid, the Medicaid agency will control the case and conduct redeterminations. Finally, one commenter sought clarification of the pended eligibility policy where a redetermination is initiated in Medicaid, which results in a Medicaid denial, and then the account is transferred to the Exchange for an eligibility determination, which also results in a denial. The commenter questioned which benefits the appellant would receive while the appeal is pending. The commenter expressed concern that the State would not have a mechanism to audit and verify when Exchange appeals are completed if the appellant is supposed to receive Medicaid benefits while the appeal is pending.

Response: We have coordinated the Exchange appeals provisions with the Medicaid fair hearing rules whenever possible. However, we determined that it would be in the best interest of appellants to provide a pended benefits policy that does not incorporate a window in which an appellant must request pended benefits that is shorter than the overall timeframe for requesting an appeal. Therefore, we offer pended benefits on appeal of a redetermination, regardless of when the appellant requests the appeal within the 90-day appeal request timeframe and we are finalizing the provision as proposed in this regard. We included reference to Medicaid and CHIP because our rules provide flexibility for States to choose to fully integrate Exchange and Medicaid and CHIP operations, and we wanted to highlight that, in such situations, Medicaid and CHIP-specific rules must still be followed where applicable.

We appreciate the comment seeking greater clarity on the approach for handling pended benefits when a redetermination of Medicaid eligibility results in a denial and the transfer of the

account to the Exchange, where eligibility to purchase a QHP through the Exchange and/or for advance payments of the premium tax credit and cost-sharing reductions is also denied. This comment highlights the intersection of the Exchange and Medicaid rules. In a situation where a Medicaid recipient is ineligible for Medicaid upon redetermination, the individual is afforded appeal rights with the State Medicaid agency and the State Medicaid agency's rules for pended eligibility apply. When the State Medicaid agency transfers the individual's account to the Exchange to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, the Exchange must determine the individual's eligibility as an initial application. If the individual is determined ineligible to participate in the Exchange or for Exchange insurance affordability programs, the individual is generally afforded appeal rights through the Exchange. However, the individual would not be eligible for pended benefits from the Exchange, as initial applicants to the Exchange are not eligible for pended benefits during appeal. We understand that not all States will delegate authority for Medicaid and CHIP eligibility determinations and appeals similarly and, therefore, States may have a variety of questions about how the intersection of Exchange and Medicaid and CHIP appeals policies impacts their specific State arrangement. We encourage States to contact us so that we can address questions as they relate to each State's delegation choices.

Comment: One commenter noted that, depending on how the pended eligibility provisions are administered, individuals might be permitted to migrate between different QHPs during an appeal, or in and out of Medicaid or CHIP coverage, which would not be in the best interest of individuals and might serve to undermine the goal of the provision. The commenter expressed concern that this could lead to an appellant experiencing discontinuity of coverage and could create administrative challenges for any the issuers involved. The commenter urged HHS to consider placing additional parameters around the provisions of § 155.525 to avoid unnecessary discontinuities in coverage.

Response: Receiving eligibility while an appeal is pending does not provide an individual with an unchecked ability to enroll in new coverage or make changes to existing coverage.

Enrollment is regulated by the provisions of subpart E.

Comment: Many of the comments we received regarding pended eligibility during an appeal related to how such a benefit would be implemented. Commenters expressed concern for the operational aspects of the proposed provision. For example, we received a comment recommending that pended benefits should not be implemented until after the appellant has paid his or her portion of the coverage premium, including any retroactive payments for pended eligibility in cases where an appellant's pended eligibility is not immediately implemented at the time of the appeal request and must be retroactively implemented; for example, where there is some delay because the tax filer must decide whether to accept pended eligibility that includes advance payments of the premium tax credit. Similarly, a commenter questioned how non-payment of premiums affects pended eligibility and recommended that QHP issuers be allowed to proceed with a non-payment termination regardless of an individual's pended status.

Response: Pended eligibility is a status that we intend for the Exchange, or Medicaid or CHIP, as applicable, to implement when the appeals entity indicates the appellant qualifies for it and the appellant or tax filer, as applicable, has accepted it. However, for an appellant who is pended eligibility to receive coverage, the appellant must enroll in coverage and pay premiums, as would any other enrollee. Consequently, if an individual receives pended eligibility, enrolls in coverage, but fails to pay premiums, the issuer may terminate coverage as provided in § 155.430(b)(2)(ii).

Comment: We received one comment expressing concern that the timing and sequencing of pended eligibility will lead to applicants and enrollees with overlapping program eligibility, such as simultaneous eligibility for Medicaid and for Exchange insurance affordability programs, which will result in confusion about payment responsibilities. The commenter requested that HHS issue guidance about how costs and payment of services will be handled when overlapping program eligibility occurs.

Response: We do not share the commenter's concern that pended eligibility will lead to overlapping program eligibility. Individuals can never qualify for Medicaid and advance payments of the premium tax credit or cost-sharing reductions simultaneously. Section 155.305(f)(1)(ii)(B) establishes that advance payments of the premium

tax credit and cost-sharing reductions are not available to support the purchase of coverage for an individual who is eligible for other minimum essential coverage, with the exception of coverage in the individual market in accordance with section 26 CFR 1.36B-2(a)(2) and (c), or coverage in an eligible-employer sponsored plan that is unaffordable or does not meet the minimum value standard. Therefore, advance payments of the premium tax credit and cost-sharing reductions would not be provided to support the purchase of coverage for an individual enrolled in Medicaid, including while his or her Medicaid fair hearing is pending. We are confident that, regardless of the particular coordination arrangement for the Exchange and Medicaid in a State, there are sufficient requirements to prevent overlapping eligibility.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.525 of the proposed rule with the following modifications. In § 155.525(b), we are adding, "If the tax filer or appellant, as applicable, accepts eligibility pending an appeal," to indicate that pending eligibility must be afforded only if the tax filer or appellant accepts eligibility pending the appeal.

g. Dismissals (§ 155.530)

In § 155.530, we proposed the circumstances under which an appeals entity must dismiss an appeal, including when the appellant withdraws the appeal request in writing, fails to appear at a scheduled hearing, fails to submit a valid appeal request, or dies while the appeal is pending. We also proposed the content for dismissal notices provided to the appellant and to the Exchange, or Medicaid or CHIP agency, as applicable. Finally, we proposed the appeals entity may vacate a dismissal if an appellant submits a written request to vacate the dismissal within 30 days of the date of the dismissal notice and shows good cause.

Comment: We received general support for the provisions of § 155.530. Several commenters noted the proposed provisions provide crucial protections against inappropriate dismissals. We also received comments noting that the Exchange appeals provisions provide more reasons to dismiss an appeal than the current Medicaid rules and the commenter recommended that the two rules be reconciled.

Response: We are making only minor modifications to the proposed rule, in response to the comments below.

Comment: We received comments requesting additional protections from dismissals for all appellants as well as appellants with special needs. For example, before allowing a dismissal as a result of a withdrawal or failure to appear, some commenters suggested that the appeals entity should confirm that necessary information was provided to the appellant in a language he or she understands. Several commenters also suggested that for an appellant who has indicated that English is not his or her preferred language, the appeals entity must document in the appellant's record what appropriate language services were provided before permitting the dismissal of such an appellant's appeal. Similarly, we received one comment that no appellant should be allowed to withdraw his or her appeal without proof that the appellant was provided information about his or her rights in the appeals process. Finally, a commenter requested that no dismissals for failure to appear be allowed unless an appellant is first provided notice and a hearing to address the dismissal.

Response: As noted above, we received many comments requesting that provisions providing special accommodations for limited English proficient (LEP) and disabled individuals be included in various provisions in subpart F in part 155. We appreciate the difficulties individuals with special needs face during an administrative process. We are modifying paragraph (a)(2) by adding "without good cause" to the end of the provision requiring an appeal be dismissed if the appellant fails to appear at hearing in order to provide additional protection to appellants who have a compelling reason for missing a scheduled hearing. We also believe the requirements of § 155.505(f) provide sufficient protection to such individuals throughout the appeals process. Section 155.505(f) requires the appeals process comply with the accessibility requirements of § 155.205(c). Section 155.205(c) requires information be provided in plain language and in a manner that is accessible and timely to individuals with disabilities, including accessible Web sites and the provision of auxiliary aids and services in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act, and individuals who are limited English proficient, including oral interpretations, written translations, an taglines in non-English languages. We are finalizing the provisions of this section with modification as noted above.

Similarly, we are not modifying the dismissal process to require proof that the appellant was provided information about his or her rights in the appeals process or to require that appellants be permitted a hearing to address dismissals. The rule already provides for notice of appeal rights and procedures per § 155.515, which requirement is sufficient for this purpose. In addition, appellants will be notified of the dismissal of their appeal, which notice must contain specific information about the reason for the dismissal as well as information about the process to vacate a dismissal. Therefore, we anticipate that the appellant will receive adequate information from the appeals entity and can also seek assistance from the appropriate customer service center or legal counsel. Given the required notice and opportunities for additional assistance, counsel, and vacating the dismissal, the protective measures we have provided for appellants whose appeals are dismissed are adequate.

Comment: Commenters supplied several recommendations for modification for paragraph (b). One comment recommended that the notice of dismissal not have to be in writing to ease the burden on appeals entities while ensuring that notice is provided. Alternatively, we received several comments that the notice should be in writing and understandable by LEP and disabled individuals. Another commenter focused on the content of the notice and requested that we amend paragraph (b)(3) to state that the explanation of the dismissal should include examples of any pertinent materials related to the individual's case that would assist the applicant in proving good cause for vacating a dismissal.

Response: We agree with the comment that notice of dismissal should be provided in writing because the dismissal of an appeal is a significant action of which an appellant should have record that he or she can easily reference, if needed. Appellants, particularly those who have special needs or may have limited understanding of administrative proceedings, will benefit from having a hard copy or electronic notice that shows the date of the dismissal, the reason, and an explanation of how he or she may request the dismissal be vacated. Therefore, we are finalizing the provision with a corresponding modification to require written notice. However, we are not requiring that dismissal notices provide examples of materials that might assist the appellant in requesting to vacate the dismissal.

Appeals entities may independently opt to provide additional information as a customer service function.

Comment: We received several comments requesting that we clarify the meaning of “timely notice” as used in the proposed provisions of § 155.530.

Response: We are confident that the requirement that the dismissal notice be “timely” will help ensure that appellants’ due process rights are not compromised. We note that “timely notice” is used throughout the Exchange provisions and in many public benefit programs; therefore, we anticipate that Exchanges are prepared to establish operating rules that implement appropriate timeliness requirements across the Exchange functions to ensure compliance. We are finalizing the provision as proposed in this regard, without providing specific timeframes for the dismissal notice, in order to leave appeals entities the flexibility to operationalize these requirements in the way that works best for them and the appellants they serve, but we note that we are modifying paragraph (c)(2), by adding “if applicable” to the provision to discontinue eligibility pending an appeal in the case of a dismissal.

Comment: We received several comments regarding the timeline we proposed for an appellant to request that a dismissal be vacated. A few commenters suggested that the proposed timeframe is too short, particularly for individuals who seek such a remedy where they may be incapacitated or otherwise justified in receiving more time. One commenter recommended the provision be modified to allow 90 days to make the request to vacate. Alternatively, we received one comment that 10 days is sufficient to request that a dismissal be vacated. The commenter noted that a shorter timeframe promotes efficient disposition of cases and will help to shorten the overall timeline for appeals.

Response: We share the concern that the appeals process not be unnecessarily prolonged, which could create unintended coverage issues for appellants and be burdensome on administering agencies. To extend this window of time to the suggested 90 days would prolong the appeals process excessively; 30 days is sufficient for an appellant to provide the appeals entity a written request demonstrating good cause to vacate the dismissal of an appeal. Therefore, we are finalizing the timeframe in paragraph (d) as proposed.

Comment: Commenters provided several suggestions regarding technical aspects of vacating dismissals. We received comment suggesting that vacating dismissals should be

mandatory if the appellant makes a timely request and shows good cause. In addition, one commenter questioned the use of “may” in paragraph (d) and urged HHS to use “shall,” suggesting that, if good cause is shown, there is no reason to not vacate the dismissal. Finally, a commenter noted that the proposed rule did not include an opportunity to oppose the showing of good cause.

Response: We agree that the permissive language used in the proposed provision should be replaced with mandatory language. If an appellant successfully demonstrates good cause for vacating a dismissal within the appropriate timeframe, the appeals entity must vacate the dismissal. However, we are not modifying the provision to provide an opportunity for an adverse party to oppose the showing of good cause by an appellant. A request to vacate a dismissal is not intended to be an adversarial process, but simply an opportunity to ensure that the appellant receives due process. If the appeals entity determines that the appellant has not shown good cause why the dismissal should be vacated, the appeals entity will not reinstate the appeal. We are finalizing paragraph (d) with a minor modification in this regard at paragraph (d)(1). We also note we are adding a new provision at § 155.530(d)(2) which states the appeals entity must “provide timely written notice of the denial of a request to vacate a dismissal to the appellant.”

Comment: We received one comment requesting clarification as to how a request to vacate a dismissal with a State Exchange appeals entity impacts the timeline for appealing an adverse decision from the State Exchange appeals entity to the HHS appeals entity.

Response: Sections 155.505(c)(2) provides that an appellant may escalate an appeal to the HHS appeals entity upon exhaustion of the State Exchange appeals process. A refusal by the State Exchange appeals entity to reinstate a dismissed appeal constitutes exhaustion of the State Exchange appeals process; accordingly, an appellant may escalate his or her appeal to the HHS appeals entity upon such a refusal. We are modifying the final rule to specifically permit this by adding § 155.505(b)(4), as noted above.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.530 of the proposed rule with the following modifications. We are modifying paragraph (a)(2) to align more closely with Medicaid fair hearing rules by adding “without good

cause” to the end of the provision requiring that appeals be dismissed if the appellant fails to appear at a scheduled hearing. In paragraph (b), we are inserting “written” into the provision to clarify that notice of dismissal to the appellant must be provided in writing. In paragraph (c)(2), we are amending the paragraph about by adding “if applicable” to the provision requiring instructions about discontinuing eligibility pending appeal in the case of a dismissal. In paragraph (d), we are replacing “may” with “must” to indicate that the appeals entity is required to vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated, as determined by the appeals entity. We are also splitting § 155.530(d) into two subsections, (d)(1) and (2). Section 155.530(d)(1) codifies the requirement just described, § 155.530(d)(2) requires that the appeals entity must “[p]rovide timely written notice of the denial of a request to vacate a dismissal to the appellant, if the request is denied.” This new requirement facilitates providing appellants from State Exchange appeals entities notice that they may elevate the dismissal of their appeals to the HHS appeals entity for review as stated in § 155.505(b)(4).

h. Informal Resolution and Hearing Requirements (§ 155.535)

In § 155.535, we proposed informal resolution and hearing requirements for adjudicating individual eligibility appeals. We proposed that informal resolution will be offered to appellants in the HHS appeals process, and may be offered to appellants in a State Exchange appeals process. We proposed standards for the provision of an informal resolution process in § 155.535(a). In § 155.535(b), we proposed that, when a hearing is scheduled, the appeals entity must send written notice to the appellant no later than 15 days prior to the date of the hearing. In paragraph (c), we proposed requirements for conducting hearings and in paragraph (d) we proposed the procedural rights afforded to an appellant in connection with the hearing. We proposed, in paragraph (e), that the appeals entity must consider the information used to determine the appellant’s eligibility and any relevant evidence presented during the course of the appeal, including at the hearing. Finally, in paragraph (f), we proposed that the appeals entity must review appeals *de novo*.

Comment: We received a variety of comments supporting the provision of an informal resolution process. We also

received many comments submitting questions or requesting modification to the proposed provision for the informal resolution process. For example, we received comment questioning whether State Exchanges will have control or input on how to conduct the informal resolution process within a State Exchange.

Response: We note that States do have flexibility to implement an informal resolution process in the way that best fits each State's needs, to the extent the process meets the standards provided in this final rule and in any future guidance. States with questions about the implementation of an informal resolution process may contact CMS for technical guidance.

Comment: We also received a comment requesting that we ensure that agencies are bound to follow a determination made through the informal resolution process, and particularly those that reverse a determination made by that agency. Another commenter thought the informal resolution decision should only be final and binding if the appellant agrees to it. We were also encouraged to reiterate in regulation that the appellant's right to a hearing is preserved regardless of participation in, or the outcome of, an informal resolution process.

Response: We appreciate the comment that informal resolution decisions must be final and binding on the Exchange and agencies administering insurance affordability programs; this was our intent in the proposed rule. We included language to this effect in the proposed rule in § 155.535(a)(4), which we are finalizing without modification. We also note that the proposed rule included in § 155.535(a)(2) the requirement that the appellant may advance to hearing if he or she is dissatisfied with the informal resolution decision. We believe the appellant is in the best position to determine whether further review after the informal resolution is appropriate.

Comment: Several commenters also requested clarification that the informal resolution process does not cause the applicant to lose any rights to timely request a separate Medicaid fair hearing.

Response: As discussed in § 155.510 and in 42 CFR 431.10(c)(ii), where an individual has both Medicaid and Exchange appeal rights, the individual will be presented the option to pursue an appeal of a denial of Medicaid eligibility directly with the Medicaid agency. (We note an exception that, where States delegate Medicaid appeals to the Exchange through an Intergovernmental Cooperation Act

process, Federal law does not require that the appellant be provided an option to pursue his or her appeal of the denial of Medicaid eligibility directly with the State agency.) If the individual does opt to pursue two separate appeals (Medicaid eligibility before the relevant agency, and all other aspects of the appeal before the Exchange), we are maintaining flexibility in this final rule for States to determine how best to sequence the appeals.

Comment: A commenter found paragraph (a)(4) confusing and questioned whether failure to appear is the same thing as an appeal that does not advance to hearing.

Response: We note the provision in § 155.530 that allows dismissal for failure to appear is intended to address situations in which the appellant fails to appear at a scheduled hearing without good cause. An appellant who accepts an informal resolution decision and does not wish to pursue the appeal through to the hearing stage is not required to request a hearing and will not be subject to this ground for dismissal.

Comment: Commenters provided several thoughts about the timeframe of the informal resolution process. One commenter requested modification to the rule to indicate that informal resolution may not consume the entire 90-day period under proposed § 155.545(b)(1). Another commenter suggested that the 90-day appeal period does not provide sufficient time to conduct a comprehensive informal process while ensuring the appellant's right to a formal hearing. The commenter suggested that a minimum of 60 days to conduct an adequate informal resolution process and requested that we extend the overall timeframe for an appeal to conclude within 120 days.

Response: The 90-day timeframe provided to resolve an appeal is intended to encompass both the time spent on both informal resolution and a hearing, as applicable. If a State Exchange appeals entity opts to provide an informal resolution process, pre-hearing, we provide the appeals entity flexibility to determine how to operationally apportion the 90-day timeframe between the two processes. We anticipate that the informal resolution process will provide an efficient means to resolve appeals but caution State Exchange appeals entities to preserve enough time to schedule and conduct a hearing, and issue an appeal decision, should the appeal involve a hearing. We decline to extend the timeframe to resolve an appeal and are

finalizing the informal resolution provision as proposed.

Comment: We received many comments concerning the notice of hearing required in paragraph (b). We received comments supportive of the 15-day timeframe proposed for sending notice of the hearing to appellants. We also received comments supportive of the preamble discussion of acceptable hearing formats, including telephone and video teleconference, which an appeals entity may want to utilize and we were encouraged to include regulation text specifying that hearings may be offered in multiple formats.

Response: We appreciate the support we received for this provision and the proposed timeframe of 15 days to send notice of the hearing to appellants. We also encourage appeals entities to consider alternative hearing formats as noted in the preamble, such as in-person, telephonic, and video teleconference, but decline to provide that level of operational specificity in the final rule.

Comment: We also received many comments urging the treatment of an appeal request as a request for a hearing. Some commenters expressed concern that the proposed approach to schedule a hearing following an appellant's indication that he or she is dissatisfied with the informal resolution decision, if an informal process is offered, would delay the appellant's right to a hearing. Similarly, some commenters requested that the informal resolution process timeline run concurrently with the hearing timeline unless the appellant withdraws the hearing request; thus, the appeals entity would provide an informal resolution process while simultaneously preparing for a hearing, unless the appellant indicated that he or she did not wish to continue on to the hearing and ended the appeal by withdrawing the request for hearing. These commenters saw this as critical to ensure that the informal process does not delay the appellant's due process right to a hearing or cause the appellant to stop pursuing the appeal.

Response: We understand that in the Medicaid fair hearing context, a request for an appeal is the functional equivalent of a request for hearing. In Exchanges that do not establish an informal resolution process, we intend appeal requests to be treated as requests for hearing. We note the value of informal resolution processes in terms of efficiency and cost for the appeals entity as well as the ease that such a process may provide to the appellant as compared to a formal hearing and, therefore, we encourage appeals entities and appellants to take advantage of the

informal resolution process prior to a hearing. We have also taken precautions in our requirements for the informal resolution process as described in paragraph (a) to ensure that participation in the informal resolution process does not in any way prevent an appellant from proceeding to a hearing. In response to these comments to the proposed rule, we will consider an appeal request a request for a hearing, but the option to offer the informal resolution process prior to the hearing is retained. Flexibility is provided to the appeals entities to determine whether the hearing is scheduled prior to or after informal resolution.

Comment: We received several comments on paragraph (b) regarding the scheduling of a hearing. Several commenters expressed concern about the ability of a hearing to be rescheduled if the original date or time is prohibitive of participation. Several comments noted concern with the preamble discussion providing that an appeals entity is expected to work with the appellant to set a "reasonable and mutually convenient date and time." Some commenters cautioned that the preamble language broadened the common standard of "reasonable date" to "mutually convenient date," which could encourage fraudulent delay of the hearing by an appellant in order to continue to receive pending benefits.

Response: The preamble discussion regarding the scheduling of hearings was meant to ensure that appellants are provided a reasonable opportunity to participate in the hearing. We share the concern regarding inappropriate dilatory tactics and understand that a "mutually convenient date and time" may not reflect a clear standard. Therefore, we are clarifying in this final rule that if the appellant informs the appeals entity that the designated date and time for the hearing are prohibitive of participation, we expect that the appeals entity will work with the appellant to set a reasonable date and time for the hearing.

Comment: Many commenters expressed general support for the provisions of paragraph (c), which we largely modeled after the Medicaid fair hearing provisions. With regard to these provisions, one commenter sought clarification as to whether appellants in States where an FFE is operating will receive in-person hearings. One commenter was concerned with the exact meaning of "in the same matter" as used in subparagraph (c)(4). The commenter thought the phrase could become a point of legal dispute in subsequent judicial reviews of hearing decisions and could lead to Exchange

decisions being overturned in court on strictly procedural grounds just because an official was in some arguable way involved in a prior Exchange decision "in the same matter." The commenter recommended that the rule simply state that all hearings must be conducted by one or more impartial officials who have not been directly involved in the eligibility determination. Similarly, another commenter did not see a reason for requiring a hearing to be conducted by an official who has not been involved in "any prior Exchange appeal decisions in the same matter." The commenter noted that if a decision is remanded to the Exchange and an appeal is filed after the decision on remand, it would be more efficient to assign the same official to decide the new appeal. The commenter requested that the rule require only that an "impartial official" decide.

Response: In response to the commenter's question about in-person hearings, we note that the appellants to the HHS appeals entity, regardless of whether they are appealing from an eligibility determination by an Federally-facilitated Exchange or an appeal decision by a State Exchange appeals entity, will most often receive a hearing via telephone or video teleconference. Within State Exchange appeals entities, we leave the hearing format to the discretion of appeals entity. With regard to the comments about the use of "in the same matter" in subparagraph (c)(4), we do not share the commenters' concerns. This provision mirrors the requirements for impartial review in the Medicaid fair hearing context and is meant to ensure that the appellant receives an independent and unbiased review of his or her eligibility determination. We are finalizing the provision as proposed.

Comment: We received a few comments indicating general support for the provisions proposed in paragraphs (d) through (f), including the procedural rights of the appellant, information and evidence to be considered, and the standard of review for appeals.

Response: We are finalizing these provisions as proposed, as we explain below.

Comment: We received many comments on the provisions proposed in paragraph (d). We received a general comment advising HHS against extending a Medicaid fair hearing process to non-Medicaid appellants. In contrast, another commenter recommend including language in paragraph (d) stating that a State Exchange shall provide all procedural due process afforded Medicaid recipients in the State.

Response: We determined that aligning our Exchange appeal requirements with Medicaid's fair hearing standards would create process efficiencies because States are already operating Medicaid fair hearing processes. In addition, we support the protections to the appellant that are provided through the Medicaid fair hearing process and believe that they are important when an appeal concerns eligibility to purchase a QHP through the Exchange and related insurance affordability programs, as well. We agree that flexible standards often result in innovative and efficient processes; however, in this context, where the due process rights involved are related to access to affordable, quality health care coverage, we consider it important to implement a standard framework for appeals processes with explicit appellant rights and protections to ensure that appellants receive full and fair review. Therefore, we are maintaining the alignment with Medicaid fair hearing rights and are finalizing the provisions as proposed.

Comment: We received comment on the issues of burden of proof and, relatedly, the role of representatives of the entity that made the eligibility determination in an appeal. Some commenters noted that eligibility representatives are occasionally part of Medicaid fair hearings and did not want the Exchange rule to foreclose the possibility of cross examination in cases where an adverse witness is present. We also received a comment noting a State's intent to have government attorneys present to participate in Medicaid hearings and to process new information presented by the appellant at hearings. Another commenter wanted clarification that eligibility representatives could be present where State law either mandates the presence of an adverse party who has the burden of proof or requires a hearing officer to give significantly less weight to certain types of evidence if it is contradicted by live testimony of a witness who is available for cross-examination. Finally, a commenter suggested that an applicant bear the burden of proof in any challenge to an initial eligibility determination, but that the Exchange bear the burden of proof in any challenge to a redetermination of eligibility or to a failure to provide timely notice.

Response: Eligibility determinations are based on clear statutory and regulatory requirements and the appeals process will resolve appeals by applying these rules to the eligibility information before it, including the information used to make the eligibility determination

and any relevant information provided by the appellant during the appeals process. As a result, and as noted in the preamble to our proposed rule at 78 FR 4652, we anticipate that most hearings will be conducted in a non-adversarial manner and see no need for Exchange representation in an appeal of an Exchange determination.

We understand that Medicaid and CHIP fair hearings sometimes do include representatives of the State agency and we anticipate that States may want to continue that practice. We also understand the benefits to the integrity of the process and to the appellant to have a representative of the entity that made the eligibility determination present and available to participate at a hearing, and our provisions do not foreclose the use of such representatives or the ability for the appellant or the hearing officer to examine them. However, we will not require that a representative of the eligibility entity must be present at eligibility hearings for the reasons stated above and we are finalizing the appeals rules without such a requirement. We similarly decline to provide guidance regarding burdens of proof; instead, we reiterate that the appeals entity will conduct a *de novo* review of the appeal and will proceed as though it were the first decision-maker in the matter, considering all the information in the eligibility and appeal records, as applicable, as well as any additional relevant evidence adduced before it during the appeal. Appellants should provide as much relevant information as possible to ensure that an accurate appeal decision can be rendered expeditiously.

Comment: We received a few comments about the appellant's right to access the appeal record, as proposed in subparagraph (d)(1). One commenter recommended that the phrase "appeal record" be deleted as legally incorrect because the commonly understood term "appeal record" refers to documents that have been entered into evidence during an appeals process. The commenter suggested the key due process element is met by eliminating the term "appeal record." We also received comment on the same provision recommending that the appellant be able to access to his or her electronic account in the same way Medicaid appellants have had access to a written case file.

Response: We understand that "appeal record" may have a different meaning outside the Exchange context. However, we do not believe that the difference is so great that it will cause significant confusion for appellants,

appellants' representatives, or appeals entities, and we are finalizing paragraph (d)(1), as proposed. "Appeal record" is defined in § 155.500 as "the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing." In the context of § 155.535(d)(1), this term means the appeal record as it exists as of the relevant date. For example, a transcript or recording of hearing testimony will not exist before the hearing is held, but the appellant still must be permitted to examine all papers and requests filed in the proceeding to date, including the eligibility record relied upon for the initial eligibility decision, at a reasonable time before the date of the hearing and during the hearing. Finally, we appreciate the comment that electronic access to files is ideal in terms of saving space, time, and cost, but we decline to add that level of specificity to this final rule; we leave such operational decisions to appeal entities.

Comment: A few commenters sought modification of the provision for the appeal standard of review. Some commenters shared the opinion that the *de novo* standard should be used at the election of the appellant, assuming that the appellant best knows whether to have past relevant information used in the process. Another commenter suggested there may be instances where the appeals entity finds that deference to a prior decision would be appropriate and a *de novo* hearing would not be needed; therefore, the commenter recommended that the review should be *de novo*, unless the appeals entity determines that a *de novo* hearing is not needed.

Response: We do not anticipate that most appellants will be in a position to determine the appropriate standard of review for their appeal. Many appellants will neither be familiar with the concept nor understand the impact of selecting one standard over another. We also disagree that the standard of review should be at the discretion of the appeals entity. We believe it is in the best interest of both appellants and appeals entities to use a consistent standard. The *de novo* standard of review protects the integrity of the process and ensures the fairest review for the appellant. We are finalizing the provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.535 of the proposed

rule with the following modification. In § 155.535(e) and (f), we are changing "appeal" to "appeals process" for additional clarity.

i. Expedited Appeals (§ 155.540)

In § 155.540, we proposed the standards for expedited appeals. Specifically, we proposed that the appeals entity must establish and maintain an expedited appeals process for appellants to request where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. We also proposed that if an appeal entity denies a request for an expedited appeal, it must handle the appeal under the standard process and notify the appellant of the denial.

Comment: We received general support for the inclusion of an expedited appeals process in the proposed rule from many commenters. Supporters viewed the provision as preventing gaps in coverage or access to vital care while the appeal is being adjudicated. However, we also received comments that the expedited appeal provisions should be removed or, alternatively, offered as a State option. Many of these commenters shared a variety of concerns. For example, some commenters expressed concern that the availability of an expedited process may create an unchecked incentive for individuals to claim medical need in order to expedite an appeal, thereby increasing the volume and burden associated with the expedited process. We received comment that the definition of those who qualify for expedited hearings is too broad and should be removed from the rule. Another commenter noted that the proposed process does not parallel Medicaid's provisions because, unlike Medicaid, the Exchange facilitates the purchase of coverage rather than providing it directly. Finally, we received comment that the expedited appeals process would require the appeals entity to evaluate questions of fact (whether there is actually an immediate need for health services, as contemplated in the proposed rule, which the commenter viewed as having no relation to the appellant's eligibility; thus, the expedited process would unnecessarily deplete resources and distract from the main purpose of the appeals entity).

Response: We consider access to and continuity of coverage to be an important factor in health care, particularly for those individuals who require immediate care. Many

individuals will not be able to pay for urgently needed health services without coverage, and will not be able to access affordable coverage except through an Exchange eligibility determination; therefore, we see a clear link between eligibility appeals and the need to offer an expedited timeframe for those individuals facing an immediate need for health care services. However, maintaining an appeals process to address these situations requires significant investment by the appeals entity first to determine which cases fit the standards for an expedited appeal, and then to swiftly adjudicate the appeal. As a result, we are finalizing the expedited appeals provisions with modification, requiring Exchange appeals entities to provide an expedited appeal process, but removing the two-day timeframe to issue notices of the denial of a request for an expedited appeal and requiring instead that the notice be issued "within the timeframe established by the Secretary." We will publish guidance regarding the establishment of an expedited appeal timeframe that recognizes the appellant's immediate need for health services while acknowledging administrative constraints.

Comment: Several commenters provided many suggestions as to how the expedited appeals process could be modified. For example, one commenter proposed that the informal resolution process could be used as a venue to quickly address an expedited appeal request and help appellants understand why an eligibility decision was made.

Response: Although we see the advantages to quick resolution through the informal resolution process, the expedited appeals process should provide the same level of due process as the standard appeals process. Therefore, we clarify that the expedited process must make the right to a hearing available to the appellant.

Comment: Another commenter recommended that the rule for expedited appeals state that the appellant bears the burden to demonstrate that he or she meets the definition for an expedited appeal and must provide medical documentation to that effect. Similarly, one commenter suggested that any person seeking an expedited appeal should be required to submit specific information, including medical documentation, showing how he or she satisfies the standard, subject to a page limit or other limitation on the amount of documentation submitted to avoid inundating the appeals entity with material as it makes its decision whether to expedite the appeal.

Response: We agree that an appellant requesting an expedited appeal must provide sufficient information to the appeals entity to enable the appeals entity to determine whether the appellant meets the standard for an expedited appeal. We are not providing specific regulatory language specifying the information or types of information an appellant must provide to substantiate an expedited appeal request. We expect appeals entities to establish appropriate measures to determine which appellants seeking an expedited appeal meet the standard for an expedited appeal.

Comment: We received comments seeking examples of situations that qualify for expedited appeals.

Response: We expect appeals entities to make decisions about requests for expedited appeals on a case-by-case basis, based on the totality of all the relevant information provided to the appeals entity about the need for immediate health services. Because each case must be judged on an individual basis, we decline to provide specific examples of situations that would qualify for an expedited appeal.

Comment: We received many comments requesting that access to the expedited appeals process be limited. One commenter recommended that expedited appeals be limited to initial denials of eligibility or redeterminations resulting in a loss of eligibility to more adequately address the issue of continuity of coverage. We also received a few comments that expedited appeals should not be available for individuals who receive determinations for advance payments of the premium tax credit or cost-sharing reductions. Finally, a request was made to delineate that individuals with serious and complex medical conditions, including HIV and viral hepatitis, automatically qualify for an expedited process because delaying or disrupting treatment or access to affordable medications can result in serious medical consequences for these individuals.

Response: We understand that expedited appeals will require an investment of resources by the appeals entity and, consequently, understand the desire to limit the volume of expedited appeal requests. However, expedited appeals can provide an important mode of access to coverage and care that some individuals will be heavily reliant upon for immediate or continuing care. We encourage appeals entities to educate consumers on the purpose of an expedited appeal so that individuals can assess which process is appropriate for their situation. An expedited appeal is meant to assist

individuals whose health might be harmed by the length of time required for the standard appeal process, and we do not anticipate that such harm will be limited to individuals who have received specific eligibility or ineligibility determinations. We note that we are finalizing the provision with minor modification by removing "seriously" from § 155.540(a) because we believe "jeopardize the appellant's life" sufficiently states the standard for an expedited appeal.

Comment: We received many comments regarding the timeframe for denying requests for expedited appeals. Some commenters supported the proposed two-day timeframe. Other commenters expressed concern over the proposed timeframe and how its brevity might limit effective review of the expedited appeal request. Some commenters recommended alternative timeframes ranging from three to seven days. Finally, we received a comment requesting that we specify the timeframe for denying expedited appeal requests in paragraph (b)(2) in terms of business days rather than calendar days.

Response: As noted above, we are modifying the final rule from the proposed rule by eliminating the two-day requirement and requiring instead that the notice of denial of an expedited appeal request be issued "within the timeframe established by the Secretary."

Comment: With regard to the content of the notice denying a request for an expedited appeal, we received comments requesting that we require such notice to state the reason for the denial, the fact that the appeal will be heard on the standard timeframe, and any options the appellant may have if he or she disagrees with the decision.

Response: Notices provide valuable information to individuals about the actions being taken, the reason for actions taken, the individual's rights and available protections, as well as next steps. We agree that individuals who are denied an expedited appeal would benefit from a detailed denial notice. Paragraph (b) proposed that notice of a denial could be provided orally or electronically as long as the appeals entity followed oral notification with a written notice within two days of the denial. We are modifying paragraph (b) to require specific content in the written notice for the denial of an expedited appeal request, including the reason for the denial, an explanation that the appeal request will be transferred to the standard process, and an explanation of the appellant's rights under the standard process. We are not modifying this provision to require the appeals entity to include in the notice

an explanation of the options available to the appellant if he or she disagrees with the decision regarding the request for an expedited appeal, because there is no administrative appeal of the denial of an expedited appeal request. Although nothing in this final rule limits any judicial review that may be available under the law, we note that the appellant will likely receive the quickest relief through the standard appeal process.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.540 of the proposed rule with the following modifications. In paragraph (a), we are removing “seriously” from the standard for an expedited appeal because meeting the requirement that a standard appeal could “jeopardize the appellant’s life” is sufficient. In subparagraph (b)(2), we restructured the provision and removed the proposed requirement that the written follow-up notice after oral notification of the denial of an expedited appeal request be provided within “2 days of the denial.” We are replacing this proposed timeframe with the requirement that the notice be issued “within the timeframe established by the Secretary.” We are also replacing, “if notified orally” with “if notification is oral,” for clarity. The provision now states, “Inform the appellant, promptly and without undue delay, through electronic or oral notification, if possible, of the denial and, if notification is oral, follow up with the appellant by written notice, within the timeframe established by the Secretary. Written notice of the denial must include—.” We are adding a new subparagraph (b)(2)(i) to require that the written notice of the denial include the reason for the denial of the expedited appeal request. Similarly, new subparagraph (b)(2)(ii) requires that the written denial notice contain an explanation that the appeal request will be transferred to the standard appeals process and new subparagraph (b)(2)(iii) requires that the denial notice include an explanation of the appellant’s rights under the standard process.

j. Appeal Decisions (§ 155.545)

In § 155.545, we proposed requirements for the basis, content, notice, and implementation of appeal decisions. In § 155.545(a), we proposed standards for appeal decisions, including the scope of information a decision may be based upon and the decision content. In § 155.545(b), we proposed timeframes for issuing notice of the appeal decision and instructions for sending the appeal decision to the

appellant and to the Exchange or Medicaid or CHIP agency, as applicable. Finally, in § 155.545(c), we proposed standards for implementing appeal decisions, including the effective date of implementation, as well as requirements for redetermining eligibility for other household members whose eligibility may be affected by the appeal decision.

Comment: We received support for the appeals provisions in § 155.545(a). A few commenters recommended the contents of the appeal decision also include language explaining the time limits to escalate an appeal from a State Exchange appeals entity to HHS. Another commenter encouraged us to require State Exchange appeals entities to include information that the decision is final, unless the individual pursues further review by HHS.

Response: We agree with commenters’ suggestions, and are finalizing the provisions of § 155.545(a) with minor modification in response to the comments above. We are moving the proposed requirement to provide an explanation of the right to pursue the appeal at HHS, including the applicable timeframe, to new subparagraph, § 155.545(a)(6)(i). In addition, we are adding new subparagraph § 155.545(a)(6)(ii) to require appeal decisions from State Exchange appeals entities to indicate that the decision is final unless the appellant escalates the appeal to the HHS appeals entity. We anticipate that this additional information will assist an appellant in a State Exchange appeals process to better understand the impact of the escalation decision and his or her options for further to appeal to HHS. Finally, we also note we are modifying paragraph (a)(1) by adding reference to subpart G and “and if the Medicaid or CHIP agencies delegate authority to conduct the Medicaid fair hearing or CHIP review to the appeals entity in accordance with 42 CFR 431.10(c)(1)(ii) or 457.1120, the eligibility requirements under 42 CFR parts 435 and 457, as applicable” to address appeal decisions involving appeals delegated by State Medicaid or CHIP agencies.

Comment: We received many comments on the proposed timeframe for adjudicating eligibility appeals in § 155.545(b)(1). Some commenters suggested a longer timeframe, while others recommended a shorter timeframe; many commenters indicated support for State flexibility in this area. Some commenters indicated that the 90-day timeframe to resolve an appeal is not sufficient to conduct a comprehensive informal process while ensuring the appellant’s right to a formal hearing. We received the

recommendation that appeals entities be provided 120 days to issue the final appeal decision. Alternatively, one commenter urged us to limit the timeframe for issuing an appeals decision in order to mitigate the adverse effects of a prolonged appeals process and lessen the period of uncertainty for an appellant. Similarly, one commenter recommended the timeframe be shortened to less than 90 days as a means to limit the amount of retroactive adjustments in eligibility, as discussed below. Finally, other commenters supported the proposed 90-day timeframe, and some encouraged us to require decisions to be made as expeditiously as possible within the required timeframe.

Response: Because we must balance the pressing interests of the appellant and the administrative concerns of the appeals entity, we are finalizing the provision as proposed with the 90-day timeframe. This aligns with the current Medicaid fair hearing timeframe for issuing appeal decisions and provides an adequate timeframe in which the appeals entity can complete its review while not delaying resolution beyond acceptable limits. We understand that appellants who elevate State Exchange appeal decisions to HHS may face longer timeframes for resolution due to the second level of appeal, but we reiterate that section 1411(f)(1) of the Affordable Care Act requires this Federal review to be available for individual eligibility appeal decisions by State Exchange appeals entities, for appellants who choose to avail themselves of it. In all cases, we encourage appeals entities to resolve appeals as expeditiously as possible.

Comment: Commenters did not support the inclusion of the phrase “as administratively feasible” in § 155.545(b)(1). Commenters saw the phrase as creating a loophole that allows standards to be ignored. In addition, commenters saw this as creating problems in getting a timely Medicaid fair hearing decision, for example when the appellant opts to pursue a Medicaid appeal before the State Medicaid agency instead of the Exchange appeals entity. Commenters urged HHS to maintain the standard for completing the appeal within 90 days of the date of the request. Some commenters also encouraged us to add language to establish an expectation for timely decision-making to ensure an efficient process.

Response: We share the commenters’ concerns for timely adjudication of appeals. As noted in our discussion of other sections in this final rule, we also understand the pressures Exchanges

face to build appeals systems, connect with the Federal process and other agencies administering insurance affordability programs, establish appeals protocols, and ultimately process appeals, the volume of which is not yet known and many of which may be complex. Because administrative realities must be taken into account, we are finalizing the provisions as proposed in this regard, allowing some reasonable administrative flexibility as concerns the 90-day timeframe for issuing an appeal decision. However, we note that, though we are maintaining this administrative flexibility, we fully expect appeals entities to adjudicate appeals within the 90-day timeframe in every case in which it is reasonably administratively feasible to do so.

Comment: One commenter noted that if a State does not delegate Medicaid or CHIP appeals authority to the Exchange, States require additional guidance to define the State's responsibility for these types of appeals when the Exchange appeals entity cannot issue an appeal decision within 90 days.

Response: We encourage those States that do not delegate Medicaid or CHIP appeals authority to the Exchange to anticipate situations where the non-delegation may jeopardize the efficiency of administrative processes and work to ensure adequate communication and timely processes to prevent unnecessary delay for the appellant and the agencies and appeals entities concerned.

Comment: The proposed timeframe for issuing an expedited appeal decision received many comments. We received support for the proposed timeframe of three working days as well as many recommendations to lengthen the timeframe. Some commenters noted that three working days is too short to allow time for the appellant and the agency to prepare properly for the appeal, including gathering the relevant information and providing a hearing. One commenter recommended the expedited timeframe for a decision be no less than 45 days. Finally, we received a request to clarify whether the three day timeframe begins from the date of the request for appeal or from the date an expedited hearing is held.

Response: We received many comments from States that it would not be administratively possible to provide an appellant a hearing and generate an appeal decision within the proposed three-day timeframe for expedited appeals. Commenters did not address an alternative, reasonable timeframe. In response to the comments received, we are modifying the proposed rule by eliminating the three-day requirement, and instead, in this final rule, we are

requiring that the timeframe for issuing expedited appeal decisions be "as expeditiously as reasonably possible, consistent with the timeframe established by the Secretary." We will publish guidance regarding the establishment of an expedited appeal timeframe that recognizes the appellant's immediate need for health services while acknowledging administrative constraints.

Comment: One commenter requested more information about what would happen if an appeal crosses over benefit years.

Response: Although not addressed in the final rule, it is our intention that an appeal that crosses over benefit years will be treated like any other appeal.

Comment: Several commenters recommended that tax filers who rely in good faith on an eligibility determination by the Exchange or appeals entity should be granted a safe harbor from having to pay back some or all of any advance payments of the premium tax credit they may receive for a coverage year during tax reconciliation, to the extent that the IRS may take a different view regarding the tax filer's eligibility for premium tax credits.

Response: The Exchange's determination takes a prospective look at an applicant's anticipated household income for a coverage year to determine eligibility for advance payments of the premium tax credit. The eligibility appeals process uses the same standards to examine eligibility for advance payments of the premium tax credit, taking into account any new, relevant evidence an appellant may provide. The appeal decision will provide an eligibility determination that is accurate based on the eligibility information to which the appeals entity has access; however, the IRS reconciliation process (which is regulated and administered by the IRS and is outside the scope of these final rules) looks retrospectively at a tax filer's actual income for the tax year to accurately determine the premium tax credit for which the tax filer is eligible. The IRS is the sole authority on the tax reconciliation process that occurs after the close of a tax year.

Comment: A few commenters found it difficult to determine the decision effective date based on the proposed appeal decision implementation provisions in § 155.545(c)(1). Some commenters found the reference to § 155.330(f) confusing. We received the recommendation that § 155.545(c)(1) should require that the effective date of the appeals decision be the date that the incorrect eligibility determination was

made or other adverse action was taken, so as to fully remedy the error.

Response: Section 155.330(f) requires Exchanges to implement changes resulting from an appeal decision, "on the date specified in the appeal decision." In addition, we have slightly modified proposed § 155.545(c)(1) in this final rule to provide that eligibility resulting from an appeal be implemented prospectively, beginning on the first day of the month following the date of the notice of the appeal decision, or retroactively, to the date the incorrect eligibility determination was made, or at the option of the appellant. If an eligibility determination was made in error, the notice of the appeal decision will provide the appellant with the opportunity to choose a retroactive effective date for the correct the eligibility determination, in order to make the appellant whole. If an eligibility determination was correct when made, but new, relevant information provided during the course of the appeal establishes that a different eligibility determination is correct at the time of the appeal, the appeal decision will provide a prospective effective date.

Comment: We received many comments reflecting a spectrum of opinions for the proposed requirement to implement certain appeal decisions retroactively. We note that many of these comments also apply to the pending eligibility provisions proposed in § 155.525, which may require retroactive enrollment, such as where there is a delay between the appellant's appeal request and the tax filer's notification to the appeals entity that he or she wishes to accept pending eligibility, if applicable.

Many commenters supporting retroactive effect for individual eligibility appeal decisions noted that retroactivity can be critical to appellants receiving due process because retroactive effect can serve as both an important consumer protection and a corrective mechanism. In addition, these commenters supported retroactive effect for individual eligibility appeal decisions because it prevents appellants from being harmed by the time required to complete the appeals process.

Several commenters responded to preamble discussion regarding ways to limit the applicability of retroactivity. A handful of commenters recommended that appellants be allowed to "opt out" of retroactive effect because some appellants might not wish to pay back premiums for coverage, such as those who may not have incurred medical expenses for which they might want to be reimbursed. Comments considering

this option questioned the timeframe in which an appellant who opted for retroactive eligibility would be expected to pay back premiums to the issuer. In addition, one commenter recommended that we waive payment of premiums for the appellants who are retroactively enrolled in a QHP through the Exchange because the need for retroactive enrollment is not the fault of the appellant. We also received support for the preamble proposal to limit retroactive effect for appeal decisions to those already enrolled in coverage. Another commenter recommended limiting retroactive effect to only those appellants who do not qualify for eligibility pending appeal. A few commenters noted that, if an appellant opts for retroactive effect for the appeal decision, corresponding benefits should only be made available after the appellant has paid the premium covering the entire period of retroactive effect. We received another comment that retroactive effect for appeal decisions should be optional for Exchanges to implement or, in the alternative, Exchanges should be afforded flexibility in implementing retroactivity.

Comments opposing the proposed provision on retroactive effect for appeal decisions provision largely focused on the operational difficulties associated with retroactive enrollment in a QHP, reimbursements for past health care expenditures, and payment of back premiums, but did not question that retroactive effect for appeal decisions may be, in some cases, a fundamental due process right. First, some commenters felt that retroactive effect will result in unnecessary confusion and complexity for consumers, issuers, and providers, and would add administrative burden and costs to the system. Several commenters specifically mentioned complexity where the appellant was not enrolled in coverage before the appeal decision, and the appeal decision provides the appellant the opportunity to elect retroactive effect. Second, several commenters noted retroactive effect for appeal decisions could result in some adverse selection because many individuals eligible to retroactively enroll in coverage would choose to do so only when they have already incurred claims for medical services. Third, some commenters expressed concern for the timeframe that retroactive effect for an appeal decision could encompass, citing the 90-day period to request an appeal, the 90-day period to issue an appeal decision, and the additional 30 days and 90 days possible in the case of an

escalation appeal to HHS, if the appellant elevates the appeal from a State Exchange appeals entity. These commenters pointed out that issuers could be faced with collecting back premium and reimbursing for past services going back several months. Some commenters recommended shortening the timeframe for which retroactive effect could be given to an appeal decision to only 90 days, rather than back to the date of the incorrect eligibility determination. Similarly, we received comments that some State laws may limit the extent to which these retroactive collections and reimbursements can be made, and these State law timeframes may be shorter than the total timeframe possible in the case of an individual eligibility appeal. Finally, some commenters expressed concern about complexity involved in payments to providers that may be affected by retroactive enrollment in a QHP through the Exchange, and the intersection of this policy with other enrollment policies in the Exchange rules. These comments are further detailed below.

Response: Although we recognize the operational complexities involved with giving retroactive effect to an individual eligibility appeal decision, we are finalizing proposed § 155.545(c) with only minor modification, and we are retaining the concept of retroactive implementation. We believe that appellants must be given the option to choose to give effect to an appeal decision that alters the appellant's original eligibility determination, retroactive to the date that the incorrect eligibility determination was made. The purpose of an appeal is to ensure the appellant receives the appropriate eligibility determination. Thus, in the Medicaid context, State agencies are directed to make corrective payments retroactive to the date an incorrect action was taken under 42 CFR 431.246. Retroactive appeal decisions can also protect appellants from unfairly having to pay the individual responsibility penalty under § 5000A of the Internal Revenue Code, which might otherwise apply if the appellant does not maintain coverage throughout the year.

As noted above, we presented in preamble to the proposed rule at 78 FR 4653 the option that an appellant could choose not to retroactively enroll in coverage to avoid paying past premiums. In response to the comments discussed above, we are now modifying the proposed provision to allow an appellant whose appeal decision reflects that the eligibility determination being appealed was incorrect to choose to have effect given to the appeal decision,

retroactive to the date of the incorrect eligibility determination. This modification is implemented in new § 155.545(c)(1)(ii). Appellants who opt for retroactive effect will be required to pay applicable back-premiums for retroactive coverage to be effective. The technical aspects of this approach will be addressed in future guidance. Appellants who do not opt for retroactive effect will be offered a hardship exemption pursuant to § 155.605(g)(1) and as described in the Center for Consumer Information & Insurance Oversight, Guidance on Hardship Exemption Criteria and Special Enrollment Periods (June 26, 2013), so that these appellants will not be liable to pay the individual responsibility penalty under § 5000A of the Internal Revenue Code for a failure to maintain minimum essential coverage that was associated with an erroneous eligibility determination. Finally, we note a modification to § 155.545(c) in which we removed "or the Medicaid and CHIP agency, as applicable" and "in accordance with the applicable Medicaid or CHIP standards in 42 CFR parts 435 and 457, as applicable" in subparagraph (c)(1)(iii) to clarify that the provision relates to only the Exchange and State Medicaid and CHIP agencies will follow their respective rules for implementation following receipt of the appeal decision notice.

Comment: We received many comments regarding how issuers would manage retroactive enrollments and related payments or reimbursements. Some commenters expressed concern that retroactive eligibility would place liability for inaccurate eligibility determinations made by the Exchange on the issuer. Some commenters focused on the impact retroactive eligibility could have on financial management, including cost-sharing reductions, reinsurance, and risk adjustment. Some commenters also noted that retroactive changes may result in inaccurate calculations for the Medical Loss Ratio (MLR) and risk corridor programs, resulting in inaccurate payments to enrollees, and noted that appellants may have a significant volume of retroactive claims to address, given the timeframe potentially involved in an individual eligibility appeal.

Response: We are finalizing the rule without limiting the ability of an appellant who meets the standards for retroactive eligibility to choose to give his or her appeal decision full retroactive effect. However, we will consider providing further operational guidance on the issues noted above by commenters.

Comment: Regarding implementation of expedited appeal decisions, a commenter recommended that the final rule address the timeline for QHPs to effectuate coverage resulting from an expedited appeal decision to minimize QHP liability to pay for services rendered during the appeals process but for which an expedited appeal process may determine the individual was not eligible.

Response: We neither proposed nor provide for an expedited enrollment process following an expedited appeal decision in the final rule and direct commenters to the standards for enrollment periods established in in part 155 subpart E.

Comment: Several commenters supported the proposed requirement in § 155.545(c)(2) that an appellant's household members' eligibility be redetermined if the appeal decision has implications for the eligibility of other members of the household. These commenters noted that this policy may protect the tax filer from having to pay back advance payments of the premium tax credit made on behalf of other household members at reconciliation.

Response: We are finalizing the provision in § 155.545(c)(2) as proposed. This policy will help ensure that the Exchange provides accurate eligibility determinations for all household members, which is a protective measure for the tax payer as concerns the reconciliation process.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.545 of the proposed rule with the following modifications. In paragraph (a)(1), we are adding reference to subpart G to ensure that appeal decisions concerning exemptions must be based on the eligibility requirements set forth in that subpart. We are also modifying this § 155.545(a) to provide greater clarity regarding appeal decisions involving appeals delegated by State Medicaid or CHIP agencies. Paragraph (a)(1) now provides that appeal decisions must “[b]e based exclusively on the information and evidence specified in § 155.535(e) and the eligibility requirements under subpart D or G of this part, as applicable, and if the Medicaid or CHIP agencies delegate authority to conduct the Medicaid fair hearing or CHIP review to the appeals entity in accordance with 42 CFR 431.10(c)(1)(ii) or 457.1120, the eligibility requirements under 42 CFR parts 435 and 457, as applicable.” We are moving the requirement originally proposed in § 155.545(a)(6) to new subparagraph (a)(6)(i) and inserting

language to require that the notice of appeal decision provided by a State Exchange appeals entity must include an explanation of the appellant's right to pursue the appeal before the HHS appeals entity, “including the applicable timeframe” to submit such an appeal request. We are also adding new subparagraph § 155.545(a)(6)(ii) to require that a notice of appeal decision provided by a State Exchange appeals entity “[i]ndicate that the decision of the State Exchange appeals entity is final, unless the appellant pursues the appeal before the HHS appeals entity.”

In paragraph (b)(1), we are making a minor change to add “of” between “date” and “an.” In § 155.545(b)(2), we are removing the timeframe for providing an expedited appeal decision; the provision now states that expedited appeal decisions must be issued “as expeditiously as reasonably possible, consistent with the timeframe established by the Secretary.”

We are removing from § 155.545(c) “or the Medicaid and CHIP agency, as applicable” along with “in accordance with the applicable Medicaid or CHIP standards in 42 CFR parts 435 and 457, as applicable” in subparagraph (c)(1)(iii) to clarify that the provision relates to only the Exchange. We are modifying proposed § 155.545(c) regarding the implementation date for appeals decisions. In § 155.545(c)(1), we are including language so that the provision now reads, “Implement the appeal decision effective[.]” followed by new subparagraph (c)(1)(i), which states, “[p]rospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with § 155.330(f)(2) or (f)(3), if applicable[.]” New subparagraph (c)(1)(ii) further provides that an appeal decision may be implemented “[r]etroactively to the date the incorrect eligibility determination was made, at the option of the appellant.”

k. Appeal Record (§ 155.550)

In § 155.550, we proposed requirements for accessing the appeal record. The proposed requirements included both appellant and public access to the appeals records. We proposed that all access would be subject to applicable laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

Comment: In response to § 155.550, we received several comments offering general support for the proposed provisions. Some commenters stated that access to the appeals record promotes transparency and accountability in the eligibility appeals process.

Response: We are finalizing § 155.550 with minor modification as outlined below. We consider access to the appeal record to be an important tool for appellants in order to understand the eligibility and appeals process, and their appeal decision. In addition, we agree that public access, subject to laws concerning privacy, confidentiality, disclosure, and personally identifiable information, promotes transparency and accountability, program integrity, and quality.

Comment: We received one comment requesting that we confirm that providing a digital audio recording of the hearing is sufficient to satisfy the requirements of § 155.550(a) to make the appeal record available to the appellant. The commenter expressed concern about increased costs if written transcripts must be provided.

Response: The appeals record is defined in § 155.500. The definition specifies that the appeals record includes “the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.” Therefore, an audio recording of the hearing is sufficient to meet the requirement that a transcript or recording of hearing testimony be included in the appeal record, when a hearing is held. We note that the record must not be limited to an audio recording or transcript of the hearing and must fully comport with the regulatory definition of “appeal record.” Appeals entities that wish to include only an audio recording of any hearing in the appeal record should take into account the needs of appellants who may encounter difficulties accessing or re-playing audio recordings, and make appropriate efforts to ensure that appellants who encounter these barriers are able to meaningfully access their appeal record, consistent with this final rule.

Comment: We received a few comments requesting modifications to 155.550(b) of the proposed rule. Several commenters recommended that the Medicaid fair hearing rules regarding public access to the appeals record be followed to align the programs, including limiting public access to only the redacted appeal decision. A few commenters cited consequences of allowing public access, including discouraging individuals from appealing for fear that information, even if redacted, could be access by anyone and the increased labor and costs associated

with redacting appeal records. Similarly, we received several comments requesting that we confirm that an appeals entity may require the public to reimburse the appeals entity for costs associated with compliance with § 155.550(b).

Response: In response to comments requesting closer alignment with Medicaid rules and concerns about increased costs and burden on appeals entities, we are modifying § 155.550(b) to allow public access to only the appeal decision, subject to all applicable laws concerning privacy, confidentiality, disclosure, and personally identifiable information. We believe this approach will balance the interests of the appellant, appeals entity, and the public to protect information, not overburden appeals entities, and provide for transparency and accountability in the appeals process. Finally, in response to comments regarding reimbursement for costs associated with compliance with § 155.550(b), we note these comments are outside the scope of the proposed rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.550 of the proposed rule with the following modifications. We are modifying the title of § 155.550(b) to read "Public access to the appeal decision," thereby limiting the scope of public access to decisions and not full appeal records. Similarly, we are modifying the text of § 155.550(b) by replacing "records" with "decisions" to specify that the public will only have access to appeal decisions, subject to all applicable Federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

1. Employer Appeals Process (§ 155.555)

In § 155.555, we proposed that an appeals process be established through which an employer may appeal, in response to a notice under § 155.310(h) regarding an employer's potential liability for the shared responsibility payment under section 4980H of the Code, a determination that the employer does not provide minimum essential coverage through an eligible employer-sponsored plan or that the employer does provide such coverage but it is not affordable coverage with respect to the employee referenced in the notice. We proposed that a State Exchange has the flexibility to establish an appeals process for employers and, if the State chooses not to establish an employer appeals process, that HHS would provide the process. Unlike individual eligibility appeals, we did not propose

that employers be allowed to escalate an appeal to HHS if the employer is dissatisfied with the appeal decision of a State Exchange appeals entity.

We proposed the process and standards for requesting an appeal and the standards for providing notice of the appeal request to the employee and to the Exchange. We proposed requirements for transmitting and receiving information related to the appeal between the Exchange and the appeals entity. We proposed standards for dismissing employer appeals and a process for an employer to request that a dismissal be vacated. We proposed the procedural rights of the employer, including the scope of information the employer may review as part of the appeal and the requirement that the Exchange and appeals entity may not share an employee's tax information with an employer. Finally, we proposed standards for adjudication of the appeal, the content and notice of the appeal decision, implementation of the appeal decision, and the appeal record.

Comment: One commenter recommended that Exchanges coordinate the notice under § 155.310(h) with the IRS. The commenter suggested that notices from an Exchange regarding employer liability will cause confusion for employers and unnecessary administrative burden on the Exchange. The commenter recommended a process where the Exchange verifies an employer's tax liability with the IRS prior to the delivery of any liability notice to an employer.

Response: We maintain the existing language in § 155.310(h), which specifies that when an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions, the Exchange will notify the employee's employer, in accordance with section 1411(e)(4)(B)(iii) of the Affordable Care Act. Specifically, § 155.310(h) provides that the notice to the employer will: (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. IRS will be determining employer liability under section 4980H of the Code after tax returns are filed. We clarify that for efficiency in operations, the Exchange can either send the employer notice under § 155.310(h) on an employee-by-employee basis as eligibility determinations are made, or send it to

employers for groups of employees. We also note that the Exchange should adjust notice language to reflect that the employer will not be liable for the payment assessed under section 4980H of the Code for 2014.

Comment: We received a comment sharing concern about the potential impact on employees of a decision that the employer coverage is both affordable and meets minimum value standards, resulting in the employee being redetermined ineligible for advance payments of the premium tax credit and cost-sharing reductions. Specifically, the commenter noted that because of limited open enrollment periods, such an employee might not be able to enroll in the health coverage offered by the employer when the employer appeal decision is issued. The commenter recommended that employees in this circumstance be allowed to stay in a QHP and continue to receive advance payments of the premium tax credit and cost-sharing reductions until the next opportunity to enroll in the employer plan. The commenter argued that because the Exchange initially determined that the employer coverage was unaffordable at the time of the employee's eligibility determination, the safe harbor provisions in section 1.36B-2(c)(3) of the Code should apply to employees at reconciliation. The commenter suggested that the Exchange should complete a full redetermination of the employee's eligibility when an employer's appeal is successful to ensure that the employee may continue to receive any benefits under insurance affordability programs for which he or she may qualify.

Response: We encourage employers to educate their employees about the details of health coverage offered to them and to assist employees in providing information regarding the employer-sponsored coverage available to the employee through the Employer Coverage Tool as part of the single-streamlined application. Additionally, employers should use the Fair Labor Standards Act (FLSA) notice to provide information to employees. Accurate information about employer-sponsored coverage available to the employee helps the Exchange make an accurate determination of the employee's eligibility for insurance affordability programs. If an employee is determined eligible for advance payments of the premium tax credit or cost-sharing reductions, the employer appeal is the opportunity for an employer to correct information about employer-sponsored coverage offered to the employee and for the Exchange to use any additional relevant information provided by the

employer to confirm that the employee's eligibility determination for insurance affordability programs is correct. This process will help to minimize the employee's potential liability to repay advance payments of the premium tax credit that he or she was not eligible to receive, and will help to protect the employer from being incorrectly assessed a tax penalty. Administration of the reconciliation process, employer responsibility payments, and the provisions of section 1.36B-2(c)(3) of the Code are under the jurisdiction of the IRS. Finally, we note that employers can develop policies to allow an employee to enroll in employer-sponsored coverage outside an open enrollment period when the employee is redetermined as ineligible for advance payments of the premium tax credit or cost sharing reductions as a result of an employer appeal decision.

Comment: We received several comments regarding the option for a State Exchange to provide an employer appeals process, or to defer to HHS to provide the process, as provided in § 155.555(b). One commenter sought clarification about the ability for State Exchanges to provide this appeals process. In addition, several commenters requested that the final rule provide the option for employers to elevate their appeal from a State Exchange appeals entity to the HHS appeals entity, similar to the option permitted to individuals in § 155.505. One commenter suggested that not providing an option to an employer to elevate an appeal to the HHS appeals process, while allowing an employee who receives financial assistance through the Exchange to do so in an individual appeal, is unfair. The commenter recommended a process in which both employers and employees have equal opportunities to have appeals heard by the HHS appeals entity. Another commenter recommended that HHS establish an employer appeals process for all Exchanges, rather than allow Exchanges the option to establish their own appeals processes. We also received comment in support of the ability for employers to appeal to the HHS appeals process where a State Exchange has elected not to establish an employer appeals process.

Response: Unlike the individual eligibility appeals process, the Affordable Care Act does not require a Federal process be available to hear employer appeals. Therefore, we have provided States the flexibility to provide a State Exchange appeals process for employers or to defer these appeals to the HHS appeals process. We consider

State Exchanges that have made the employee's eligibility determination to be in the best position to adjudicate an employer's appeal related to that determination. However, the HHS appeals process will be available to employers in those State Exchanges that elect not to provide an employer appeals process. We are finalizing § 155.555(b) as proposed.

Comment: A few commenters expressed concern that giving States the option to provide an employer appeals process may result in disparate outcomes for employers that operate in multiple States. These commenters noted having many State Exchanges adjudicating employer appeals will add complexity to the appeals process and administrative burden for large employers.

Response: We generally consider it a best practice, in terms of safeguarding efficiency and process integrity, to have appeals heard by the entity issuing the eligibility determination concerned in the appeal, wherever possible. We also wish to provide State Exchanges flexibility regarding the process for adjudicating appeals of determinations they have made, given the many operational requirements and considerations involved in developing new eligibility and appeals processes. Because the final rules provide a uniform process and standards by which appeals are adjudicated, we expect appeal decisions to be consistently accurate regardless of whether an appeal decision is issued by a State Exchange appeals entity or the HHS appeals entity. Therefore, we are finalizing § 155.555(b) as proposed, without modification.

Comment: One commenter sought clarification about the timeframe and process for how HHS will relay appeals information to State Exchanges that choose to delegate employer appeals to HHS.

Response: The HHS appeals entity and State Exchange appeals entities are subject to same requirements set forth in § 155.555. If the HHS appeals entity hears an employer appeal from a State that does not elect to provide its own employer appeals process, HHS will communicate information about the appeal and request information from the Exchange through the processes described throughout § 155.555, including paragraphs (d), (f), (k), and (l).

Comment: We received comment recommending that the final rule provide employees the right to appoint a representative during an employer appeal.

Response: The proposed rule in § 155.555(b) addressed the ability of the

employer to designate an authorized representative pursuant to the provision in § 155.505(e), but did not expressly address the ability of the employee to designate an authorized representative. We are modifying § 155.555(b) to remove the reference to § 155.505(e), retitled "Representatives," because § 155.227 does not contemplate representation for employers. However, we note that nothing in § 155.555 prevents employers or employees from relying on a representative or other assistance from a third party during the employer appeal.

Comment: Similar to the comments we received for § 155.520, we received comment expressing concern over the modes proposed to accept employer appeal requests, which included via telephone, mail, in person, and via the Internet. The comment specifically requested that the requirement to accept appeal requests by telephone be removed from the final rule or left to State option to reduce the burden on appeals entities.

Response: Consistent with our approach to individual eligibility appeal requests in § 155.520(a), we are finalizing § 155.555(c) as proposed; however, as we note above, during the first year of operations, Exchange appeals entities may use a paper-based process to accept employer appeal requests via mail; all other appeal request modes may be provided at the option of the appeals entity until the second year of operations.

Comment: We received one comment regarding the intersection between acknowledging appeal requests, the ability to cure a defective appeal request, and dismissing appeals. The commenter recommended, first, that employers be notified of the ability to cure a defective appeal request and, second, that HHS permit the appeals entity to impose a reasonable deadline for amendment of a defective appeal request. Absent such a deadline, the commenter indicated that an appeals entity would not know when it could comply with its obligation to dismiss the appeal for being invalid under § 155.555(f)(1).

Response: The proposed rule proposed to require that the appeals entity accept an amended appeal request only if the amended request met "the requirements of this section [155.555], including the timing requirements in § 155.555(c). However, we agree that employers who submit invalid appeal requests toward the end of the appeal request timeframe will likely not have sufficient opportunity to cure the defect in their appeal request and resubmit it within the time

remaining to request an appeal. Therefore, we are finalizing § 155.555(d)(4) with modification to provide specifically that the appeals entity must inform the employer of the ability to cure the defect and we have provided appeals entities the flexibility to impose a reasonable deadline for submitting an amended appeal request.

Comment: One commenter recommended that the scope of the employer appeals process be limited only to appeals concerning whether the employer offered insurance to the employee-applicant that constitutes minimum value, and the employee share of the premium cost. The commenter suggested that appeals concerning whether the coverage was affordable implicates confidential information about the employee's income and should not be a part of the employer appeal because the employer does not have access to the employee's household income information.

Response: The scope of employer appeals process is defined consistent with the requirements of section 1411(f)(2) of the Affordable Care Act, which requires an appeal process for employers that are notified there has been a determination that the employer does not provide minimum essential coverage through an eligible employer-sponsored plan, or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. We have delineated standards for an appeals process that comports with this requirement. Section 155.555(g) explains the information an employer may review as part of an employer appeal, and § 155.555(h) safeguards employee information, including the confidential income information about which the commenter expressed concern, by requiring that neither the Exchange nor the appeals entity may disclose an employee's tax return information to an employer. These provisions adequately protect confidential employee information during the employer appeal process. We are finalizing the provisions of § 155.555 as proposed in this regard.

Comment: Several commenters opposed the requirement in § 155.555(g)(2)(iii) that the appeals entity must provide the employer an opportunity to review "other data used to make the determination described in § 155.305(f) or (g) to the extent allow by law." The commenters suggested that "other data" is overly broad and makes it unclear whether the employer has the right to review eligibility information for the employee or the employee's entire household. The commenters

recommended deleting § 155.555(g)(2)(iii).

Response: Section 1411(f)(2)(A)(ii) of the Affordable Care Act requires that an appealing employer be provided "access to the data used to make the determination [about the employer's failure to provide qualifying coverage or affordable qualifying coverage] to the extent allowable by law." The statutory limitation is reflected in the regulatory text we are finalizing in this final rule at § 155.555(g). As noted in the preamble to the proposed rule at 78 FR 4655, the amount of information an employer may access is limited, including by section 1411(f)(2)(B) of the Affordable Care Act, which generally prohibits disclosure of taxpayer return information with respect to an employee in the course of an employer appeal. Accordingly, the employer's right to review information about the employee's eligibility is minimal, as noted in § 155.555(g) and (h). We are finalizing the provisions of § 155.555(g) and (h), as proposed.

Comment: We received many comments supportive of § 155.555(h), in which we proposed that the Exchange and the appeals entity may not share tax return information with an employer in the course of an employer appeal.

Response: We are finalizing the provisions of § 155.555(h) without modification. As noted above, the scope of information available to an employer as part of the appeal is limited by section 1411(f)(2) of the Affordable Care Act and implementing regulations. Safeguarding personal information provided as part of the eligibility determination process is an integral aspect of all Exchange processes.

Comment: We received a comment regarding the standards proposed for the officials reviewing employer appeals. One commenter recommended deleting the term "implicated in the appeal" in § 155.555(i)(1) because the phrase may become a possible point of legal dispute in subsequent judicial reviews. The commenter noted that a court may overturn an Exchange decision on strictly procedural grounds because an official was in some arguable way involved in the Exchange determination that is subject to the appeal.

Response: This provision helps ensure an independent and unbiased review of the employer appeal. We are finalizing the provision as proposed.

Comment: One commenter sought modification of the provision for the appeal standard of review. The commenter recommended that the *de novo* standard should be used unless the appeals entity finds that a *de novo* hearing would not be needed.

Response: We disagree that the standard of review should be at the discretion of the appeals entity. We believe it is in the best interest of the employer, employee, and the appeals entity to use a consistent standard that does not give deference to prior decisions in the same matter. This standard protects the integrity of the process and helps ensure that the appeal will receive fair review. We are finalizing the provision as proposed.

Comment: We received many comments in response to the two options we proposed in preamble regarding the employee's ability to appeal a redetermination following an employer appeal decision. Comments were received in support of both options, but the majority favored allowing the employee to appeal the redetermination. Those in favor of allowing the employee to appeal highlighted that while an employee can participate in the appeal, he or she may not understand the significance of the process until he or she receives a redetermination notice. Also, while the employee has the opportunity to participate in the employer appeal, other family members do not and may not understand the impact of the appeal until redetermination occurs. Conversely, other commenters saw the ability to submit evidence as part of the employer appeal as sufficient to safeguard the employee's due process rights.

Response: In response to the comments received, we are modifying the final rule to permit employees whose eligibility is redetermined as a result of an employer appeal to appeal that redetermination in accordance with the provisions governing individual eligibility appeals in subpart F of part 155. We do not anticipate many appeals as a result of this provision, but we consider it important to provide the appeal right to the employee and his or her household members because they may not understand the potential impact of an employer appeal at the time when the employee has the opportunity to participate. Furthermore, the appeal provides the employee's household members the opportunity to dispute a redetermination that occurs as a result of an employer appeal process about which they may not have been aware and that did not provide for their participation. Finally, should an appeal of a redetermination find an employee eligible for the advance payment of the premium tax credit and cost-sharing reductions, thus implicating potential employer liability a second time, the employer will have recourse through the IRS appeals process if a penalty is later

levied, consistent with section 1411(f)(2)(A) of the Affordable Care Act.

Comment: Regarding the ability for employers and employees to appeal the same determination, a commenter sought clarification as to the sequencing of the employer appeals process if the employee also appeals his or her eligibility determination through the individual appeals process.

Response: An employee determined eligible for financial assistance through the Exchange may appeal that determination through the individual appeals process pursuant to the requirements in 45 CFR part 155, subpart F. Because of the employer notification required in some circumstances under § 155.310(h), it is possible that an employee and an employer could request appeals concerning the same eligibility determination simultaneously, although we note that this is likely to be a rare occurrence. We did not address this situation in the proposed rule and we decline to do so in the final rule. Instead, we provide flexibility to the State Exchange to determine how best to sequence the appeals.

Comment: We received support for our approach to notices in the employer appeals provisions. One commenter particularly supported the proposed content required for the notice of appeal decision in § 155.555(k), including the requirement for the notice to include an explanation of the appeal decision, factual findings relevant to the decision, and citations to the relevant regulations that support the decision. The commenter also supported the preamble discussion about the need to educate employers about the purpose and scope of the Exchange appeal versus actions taken by the IRS regarding assessment of the employer shared responsibility payment. In addition, the commenter appreciated the preamble discussion about developing notices to help employers understand their potential tax liabilities.

Response: We are finalizing the notice provisions as proposed. We also note that a paper-based process, as discussed above, is acceptable for the first year of operations with regard to notices.

Comment: We received comments recommending that an employee whose eligibility may be affected by the outcome of an employer appeal be granted more substantial rights in the employer appeal proceeding, including the right to review the full record before submitting additional evidence.

Response: We are finalizing the rule as proposed with regard to the procedural rights of the employee and employer. We have not included

additional provisions allowing either party to view or respond to the information submitted by the other. Only limited information is relevant to an employer appeal such as, information about what coverage (if any) the employer makes available to the employee and what the cost of such coverage (if any) is to the employee. We expect the notices sent by the Exchange or appeals entity to the employer and the employee to make clear that only information addressing these items is relevant to the employer appeal. We also expect that the employee already will have submitted all or nearly all available, relevant information as part of the eligibility determination process; however, we anticipate that communications from the Exchange and appeals entity will help the employee understand the information that the appeals entity will be considering, and what additional information it might be helpful for the employee to submit. We note that, as relevant to household income, the employer will only be in a position to submit information about compensation the employer pays to the employee concerned. Moreover, as explained in preamble to § 155.555(k), the employee and members of his or her household, if applicable, will have the right to appeal a redetermination that results from an employer appeal decision, which is an important additional protection for the due process rights of the employee and members of his or her household, if applicable. If the employee or a member of the employee's household does appeal the redetermination, he or she will have access to the information used in that redetermination, which will include information about employer-sponsored coverage.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.555 of the proposed rule with the following modifications. In § 155.555(b), we are removing the references to § 155.505(e) to eliminate the cross-reference to standards for representatives that do not contemplate application to employers.

In § 155.555(d)(4), we are modifying the language using three subparagraphs to provide additional detail about the process for an appeals entity to send a notice of an invalid appeal request to an employer. Paragraph (d)(4) provides, “[p]romptly and without undue delay send written notice to the employer of an appeal request that is not valid because it fails to meet the requirements of this section. The written notice must inform the employer—[.]” Subparagraph (d)(4)(i) has been modified to require the

notice inform the employer “[t]hat the appeal request has not been accepted[.]” We are modifying subparagraph (d)(4)(ii) to require the notice inform the employer “[a]bout the nature of the defect in the appeal request[.]” New subparagraph (d)(4)(iii) requires the notice inform the employer “[t]hat the employer may cure the defect and resubmit the appeal request by the date determined under paragraph (c) of this section, or within a reasonable timeframe established by the appeals entity.” These changes mirror similar modifications made in the individual Exchange eligibility appeals provisions.

We are modifying paragraph (f)(3) to include “as to” before “why,” and paragraph (j)(1) to include “of this section” after “paragraph (i)(2).” In paragraph (l), we are modifying the provision by adding “and the eligibility of the employee's household members, if applicable,” for additional clarity. Finally, we are modifying § 155.555(k)(2) to require the inclusion of additional content in the notice of employer appeal decision to the employee, specifically “[a]n explanation that the employee and his or her household members, if applicable, may appeal a redetermination of eligibility that occurs as a result of the appeal decision.” This modification reflects our policy to provide an employee or a member of an employee's household, if applicable, who receives an adverse redetermination of eligibility as a result of an employer appeal, the ability to appeal that redetermination through the process provided in 45 CFR part 155, subpart F.

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

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

We proposed to amend § 155.700 by defining “SHOP application filer” to mean an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by other law.

Comment: Several commenters to proposed § 155.700 supported the amendment of the definition of “SHOP application filer” to include entities that have traditionally assisted employees in filing applications to provide such assistance, such as authorized representatives, agents or brokers of an employer, or an employer on behalf of its employees. One commenter recommended adding Navigators to the definition.

Response: We disagree with the commenter that Navigators should be included in the definition of "SHOP application filer." Navigators can provide important assistance in helping an employer or employee in filling out an application, but generally speaking a Navigator cannot actually file the application for an employer or employee because under existing guidance, a Navigator generally cannot select a QHP for an applicant—an inherent aspect of filing a SHOP applications.

Summary of Regulatory Changes

We are finalizing the provision as proposed.

b. Functions of a SHOP (§ 155.705)

In § 155.705, we re-proposed a new paragraph (c) to coordinate SHOP functions with the functions of the individual market Exchange for determining eligibility for insurance affordability programs with an exemption for a State operating a SHOP independently of an individual market Federally-facilitated Exchange. Specifically, we proposed that except in the case where a State is operating only a SHOP, a SHOP must provide data to the State's corresponding individual market Exchange related to eligibility and enrollment of qualified employees in the SHOP. This data sharing may improve the accuracy of the individual market Exchange's eligibility determinations for affordability programs.

In § 155.705(d), we proposed that when a State establishes and operates a SHOP independently of an individual market Federally-facilitated Exchange, the SHOP would have the flexibility to allow SHOP Navigators to fulfill their statutory and regulatory obligations under section 1311(i) of the Affordable Care Act and 45 CFR 155.210 to facilitate enrollment in QHPs, and to refer consumers with complaints, questions, and grievances to applicable offices of health insurance consumer assistance or ombudsmen, by referring small businesses to agents and brokers for these types of assistance, so long as State law permits agents and brokers to carry out these functions.

We intend to finalize proposed § 155.705(b)(6)(i) in future rulemaking when we finalize the provisions proposed in § 156.80(d) regarding the frequency of rate updates in the small group market, including coverage offered through the SHOPs.

Comment: Some commenters to proposed § 155.705(c) opposed the exemption from the requirement for SHOPs to share eligibility and

enrollment information of qualified employees with the individual market Exchange in States that operate only a SHOP. Commenters believe that such coordination is necessary even in a bifurcated model where different entities are operating the SHOP and individual market Exchanges.

Response: We note there are technical challenges to seamlessly transmitting such information where the individual market Exchange is Federally operated and the SHOP is State-operated. Additionally, an individual market Federally-facilitated Exchange will still have the capability to retrieve the necessary individual application and enrollment information through other methods, such as paper notifications. As such, we are finalizing this provision as proposed.

Comment: Some commenters to proposed § 155.705(d) opposed allowing certain Navigator duties in the SHOP to be fulfilled through referrals to agents and brokers, because they thought this would weaken standards for Navigators by reducing Navigators' role in assisting small businesses. Some commenters were concerned that some small businesses would not have adequate assistance enrolling and maintaining coverage that meets their needs in States that took this option. These commenters recommended that all Navigators must perform all the Navigator duties. If the proposed policy is retained, some commenters recommend that States that take this option be required to demonstrate how the other Navigator duties will be provided. Other commenters supported the provision as proposed.

Response: Navigators in State SHOP-only Exchanges will still perform directly the duties set forth in 45 CFR 155.210(e)(1), (2), and (5), namely conducting public education activities; providing information and services in a fair, accurate, and impartial manner; and providing information in a culturally and linguistically appropriate manner and ensuring access for individuals with disabilities. SHOP Navigators in such Exchanges will also be required to comply with 45 CFR 155.210(e)(3) and (4) by providing appropriate referrals to state-licensed agents or brokers for consumers seeking help with selection of a QHP or seeking a referral of a complaint, question, or grievance to applicable offices of health insurance consumer assistance or ombudsmen. The individual market Exchanges in States operating only a SHOP Exchange that elect this option will be Federally-facilitated, and HHS will award and manage the grants to those individual market Navigators who

will be required to perform directly all the duties set forth in 45 CFR 155.210(e).

Summary of Regulatory Changes

We are finalizing 155.705(c) and (d) as proposed.

c. Application Standards for SHOP (§ 155.730)

In § 155.730, we proposed amending the SHOP application filing standard to relieve SHOPs of having to accept paper applications and accept applications by telephone. In proposed 155.730(f), we also clarified that an employer or an employee application may be filed by a "SHOP application filer."

Comment: Some commenters to proposed § 155.730 opposed the amendment that would no longer require SHOPs to accept paper applications or applications by telephone. Commenters were concerned that this proposal would disproportionately harm low-wage, rural, minority, and immigrant businesses and would be unfriendly to consumers, especially those without access to computers, resulting in decreased accessibility to the SHOP. Some commenters recommended delaying the provision for a year. One commenter supported the proposal.

Response: We believe that small businesses and employees have options to use in-person assisters, such as Navigators, agents, or brokers for help in completing a SHOP application when a paper or telephone option is not available. Additionally, we believe that making paper and telephone applications optional provides States with more flexibility to receive applications in a way that makes the most sense for the State's applicants, and that this flexibility could reduce operational costs. Finally we believe the inherent limitations of paper applications, such as the inability to provide real time rate quotes and to complete the enrollment process at the same time the application is completed, may lead to low usage of paper applications.

Summary of Regulatory Changes

We are finalizing the provision with a correction to paragraph (f), adding to the final language the provision title "Filing" that is in current regulation but was mistakenly omitted from the proposed rule.

d. Termination of Coverage (§ 155.735)

In § 155.735, we proposed that each SHOP would be required to develop uniform standards for the termination of coverage in a QHP, clarified the

authority for SHOPs to establish termination standards, and set such standards for the FF-SHOP.

Comment: Many commenters supported proposed § 155.735 on terminations and grace periods. One commenter recommended that we clarify termination and reinstatement policies and recommended that SHOPs establish different standards depending on whether a participating employer offers its employees only one comprehensive medical plan or all plans at one metal level. One commenter requested that we clarify which termination and grace period provisions would be effective in 2014.

Response: We believe that grace periods and termination procedures must be standardized in all FF-SHOPs, even after employee choice is implemented in 2015, regardless of whether a participating employer offers its employees only one comprehensive medical plan or all plans at one metal level. Standardizing the timing, form, and manner of a group's termination from the FF-SHOP will simplify the complexity of QHP administration while ensuring that an employer offering coverage will be subject to uniform, predictable termination policies regardless of what coverage options the employer elects to offer its employees. Further, creating uniform termination policies for all FF-SHOPs will reduce the complexity of systems interactions with QHP issuers and therefore ease QHP issuer compliance with FF-SHOP termination policies.

In 2014, for the FF-SHOP and States not implementing employee choice, § 156.285(d)(1)(i)(B) and (d)(1)(iii)(B) reference the requirements in 45 CFR 156.270 as governing termination of coverage.

Summary of Regulatory Changes

We are finalizing the provision as proposed.

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

In § 155.740, we proposed standards for SHOP employer and employee eligibility appeals. We proposed that a State that operates a SHOP must provide a SHOP eligibility appeals process and that the HHS appeals entity will provide a SHOP appeals process for States that do not elect to establish and operate a SHOP. As with employer appeals in § 155.555, we did not propose that SHOP employers and employees be permitted to elevate an appeal to HHS if the State operates a SHOP and

provides a SHOP eligibility appeals process.

We proposed the process and standards for requesting an appeal and the standards for providing notice of the appeal request to the SHOP employer or employee and to the SHOP. We proposed requirements for transmitting and receiving records related to the appeal between the SHOP and the appeals entity. We also provided standards for dismissing SHOP appeals and providing an opportunity for a SHOP appellant to request a dismissal be vacated. We proposed procedural rights for SHOP appellants. Finally, we proposed standards for reviewing the appeal, the content and notice of the appeal decision, and implementing the appeal decision.

Comment: One commenter supported our proposal to enable SHOP employers and employees to appeal determinations of ineligibility even though SHOP appeals were not specifically stipulated in section 1411(f) of the Affordable Care Act.

Response: We are finalizing the requirement to provide an eligibility appeals process for SHOP employers and employees as proposed in § 155.740(b).

Comment: We received comments about which entity should be responsible for providing a SHOP eligibility appeals process. One commenter sought clarification as to whether the SHOP appeals process can be delegated to HHS. Similarly, one commenter recommended that HHS consider performing eligibility appeals for all SHOPs regardless of whether the State operates its own SHOP. The commenter noted that allowing all States to defer SHOP eligibility appeals to HHS would provide for a streamlined appeals process, particularly where States take advantage of the flexibility provided in the operation of individual and employer appeals processes pursuant to § 155.505(c) and § 155.555(b) respectively.

Response: The entity that determined an employer's or employee's eligibility to participate in the SHOP will be in the best position to provide an effective appeal of that determination. We anticipate that the volume of SHOP appeals will be small, and due to the nature of the SHOP eligibility criteria, the appeals will not be complex. In addition, the SHOP was designed with flexibility to meet the individual needs of States. For example, the SHOP eligibility standards allow for a State to require additional verification before providing the employer or employee with an eligibility determination. Therefore, we anticipate that each SHOP

will be in the best position to adjudicate SHOP eligibility appeals. We are finalizing the provisions of § 155.740(b)(1) as proposed.

Comment: We received comment regarding the proposed requirements for accepting SHOP appeal requests. Specifically, one commenter expressed concern over the modes proposed for accepting appeal requests. The commenter noted that the requirement to accept requests by telephone should be removed, or provided only at State option.

Response: As with the individual eligibility appeals rules we are finalizing in subpart F of part 155, we are finalizing § 155.740 as proposed; however, as noted above, appeals entities may use a paper-based process for the first year of operations. By the second year of operations, all SHOPs and appeals entities must accept appeal requests in accordance with the final rule.

Comment: We received one comment regarding the intersection between acknowledging appeal requests, the ability to cure a defective appeal request, and dismissing appeals. The commenter recommended, first, that SHOP employers and employees be notified that they can cure a defective appeal request and, second, that HHS permit the appeals entity to impose a reasonable deadline for amendment of an appeal request. Absent such a deadline, the commenter indicated that an appeals entity that issued a notice of a defective appeal request will not know when it can comply with its obligation to dismiss the appeal for being invalid under § 155.740(i).

Response: We agree that invalid appeal requests submitted toward the end of the 90-day appeal request timeframe creates this risk that the SHOP employer or employee will not have time to cure the error before the 90-day window closes. We are modifying final § 155.740(g)(3) to specifically provide that the SHOP or appeals entity must inform the SHOP employer or employee that they have an opportunity to cure the error and may resubmit the appeal request if it meets the timeliness requirements of paragraph (f), or within a reasonable timeframe established by the appeals entity.

Comment: Commenters cited operational difficulties in implementing retroactive eligibility for the SHOP and requested that retroactive eligibility be limited to specific situations. For example, one commenter suggested that retroactive eligibility should be permitted only for employers already enrolled in coverage, so that issuers will

not have to cancel coverage for that employer and all of its covered employees, and refund payments for claims submitted. Similarly, another commenter noted that retroactive effective dates should not be applied in the case of an appeal decision that would reinstate an entire group. Finally, one commenter requested that initial applicants not be permitted retroactive eligibility.

Response: We anticipate the volume of SHOP appeals, as well as the number of SHOP appeals resulting in retroactivity, will be small given the minimal and straightforward nature of SHOP eligibility for both employers and employees. Because of the SHOP rules provide for rolling enrollment, employers who are denied eligibility for the SHOP will have the ability to reapply immediately upon receiving a denial, which may be quicker than requesting an appeal. For these reasons, we are finalizing the requirements as proposed, offering retroactive eligibility if an employer or employee is determined eligible upon appeal because we consider retroactivity to be an important protective feature of the appeals process.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.740 of the proposed rule with the following modifications. In paragraph (b)(2), we are adding the phrases “that provides for the establishment of a SHOP” in two places to reflect that some States may establish and operate only a SHOP Exchange, while HHS establishes and operates the corresponding individual market Exchange. We are also making this same addition to § 155.740(f)(1)(ii). In paragraph § 155.740(b)(2), we are removing the word “SHOP” and leaving the requirement directed at the “appeals entity.” We are correcting subparagraph (f)(1)(ii) to change the period to a semicolon.

In § 155.740(g)(3)(i), we are modifying the language to provide additional detail about what happens when an appeals entity sends notice of an invalid appeal request. We are adding three subparagraphs to delineate the content requirements, including the addition that the notice must include “an explanation that the employer or employee may cure the defect and resubmit the appeal request if it meets the timeliness requirements of paragraph (f) of this section, or within a reasonable timeframe established by the appeals entity.” These changes mirror similar modifications made in the individual and employer appeals provisions in this final rule. Finally, we

are modifying subparagraph (i)(1)(ii) to remove the reference to (f)(1) and replace it with a reference to (f) as a whole.

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

1. Subpart A—General Provisions

a. Definitions (§ 156.20)

We proposed amending 45 CFR 156.20 by adding the definition for “Exchanges” and adding the definitions for “Delegated entity” and “Downstream entity.”

We received no direct comment on the definition of “Exchange,” though we did receive several general comments and comments to § 155.100 in support of permitting a State to elect to establish just a SHOP.

Comment: One commenter recommended that we broaden the definitions of delegated and downstream entities to include nonprofit community-based organizations whose purpose is health care consumer education and advocacy. The commenter expressed concern that the proposed definitions contemplate oversight of brokers and agents by carriers that may introduce a potential conflict of interest in directly providing administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Response: We believe that broadening the definitions of delegated and downstream entities to include nonprofit community-based organizations whose purpose is health care consumer education and advocacy could be potentially unduly burdensome, as many nonprofit community-based organizations are not currently subject to all regulatory requirements applicable to delegated and downstream entities, due to the limited applicability of such requirements to the activities of these entities. In contrast, the activities of brokers and agents are subject to such regulatory requirements.

Summary of Regulatory Changes

We are finalizing this provision as proposed.

2. Subpart C—Qualified Health Plan Minimum Certification Standards

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

As finalized in the Exchange Eligibility and Enrollment Rule,¹⁰ § 156.270 specifies standards for QHP issuers regarding the termination of coverage for individuals enrolled in QHPs through the Exchange. In paragraph (b), we made a drafting error in providing that if a QHP issuer terminates an enrollee’s coverage in accordance with § 155.430(b)(1)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay, provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination. Rather, the appropriate cross-reference in § 156.270(b) should refer to § 155.430(b)(2)(i), (ii), or (iii), in order to accurately describe situations where the QHP issuer may terminate an enrollee’s coverage, and as such, we make the necessary technical correction.

Summary of Regulatory Changes

We make a technical correction in paragraph (b) to appropriately refer to situations where the QHP issuer may terminate an enrollee’s coverage.

b. Additional Standards Specific to SHOP (§ 156.285)

We proposed to amend § 156.285 to ensure that all QHP issuers offering coverage in a SHOP comply with the termination of coverage requirements proposed at § 155.735 as a condition of certification for plan years beginning on or after January 1, 2015, when § 155.735 will apply to all SHOPs. Some SHOPs may decide to implement employee choice and premium aggregation before January 1, 2015, and § 155.735 would apply in such SHOPs as an operational requirement.

Although we did not receive comments directly on this provision, we received several comments to proposed § 155.735 regarding SHOP termination policies. Those comments are addressed in the discussion of § 155.735 above.

Summary of Regulatory Changes

We finalize the provision as proposed with a technical correction to a drafting error in proposed § 156.285(d)(1)(i)(B). Section 156.285(d)(1)(i)(B) is finalized to properly reference § 156.270(a) and not § 155.270.

¹⁰ Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 FR 42160 (July 15, 2013).

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

a. Standards for Downstream and Delegated Entities (§ 156.340)

We proposed in § 156.340 standards for delegated and downstream entities, similar to existing standards for such entities that contract with Medicare Advantage organizations, described at 42 CFR 422.504(i)(3)–(4). In § 156.340(a), we proposed the general requirement that, notwithstanding any relationship(s) that a QHP issuer may have with delegated or downstream entities, the QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, with all applicable standards, including those we proposed at § 156.340(a)(1)–(4). In paragraphs (a)(1) through (a)(4), we proposed that the QHP issuer be required to comply with Federal standards, specifically the obligations as set forth under: subpart C of part 156, which governs QHP minimum certifications standards; subpart K of part 155, which governs Exchange functions pertaining to QHP certification; subpart H of part 155, which governs the Exchange functions of the SHOP; standards in § 155.220 with respect to assisting with enrollment in QHPs; and standards in § 156.705 and § 156.715 for maintenance of records and compliance reviews for QHP issuers operating in an FFE and an FF-SHOP.

In addition, in § 156.340(b)(1)–(2), we proposed that all agreements among the QHP issuer's delegated and downstream entities be required to specify delegated activities and reporting standards, and either provide for revocation of the delegated activities and reporting standards, or specify other remedies in instances where HHS or the QHP issuer determines that such parties have not performed satisfactorily.

Furthermore, we proposed in § 156.340(b)(3) that all agreements among the QHP issuer's delegated and downstream entities be required to specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under paragraph (a) of this section. In § 156.340(b)(4), we proposed that the QHP issuer's agreement with any delegated or downstream entity must specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts,

computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period.

Finally, we proposed in § 156.340(b)(5) that all existing agreements contain specifications described in paragraph (b) of this section by no later than January 1, 2015. For agreements that are newly entered into as of October 1, 2013, we proposed an effective date for the specifications described in paragraph (b) of this section to be no later than the effective date of the agreement.

Comment: One commenter suggested that health plans have the flexibility to ensure compliance with all *applicable* requirements, rather than requiring compliance with all existing Exchange regulatory requirements. Furthermore, the commenter recommended that health plans have the ability to tailor their agreements to the scope of the entity's work for the issuer.

Response: In § 156.340(a), we proposed that a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, as applicable, with all applicable standards. We believe that the proposed inclusion of “as applicable, with all applicable standards” in this section of the regulation addresses the commenter's suggestion. In addition, we believe that the regulation allows a health plan to tailor its agreement with a delegated or downstream entity to the scope of the entity's work for the issuer.

Comment: One commenter expressed concern that the proposed effective date of October 1, 2013, is too soon for compliance with specifications described in paragraph (b) of this section, for the reason that issuers may not know by that time which downstream and delegated entities with which they will enter into contracts to meet QHP requirements.

Response: In § 156.340(b)(5), we proposed that all existing agreements contain specifications described in paragraph (b) of this section by no later than January 1, 2015 for existing agreements, and no later than the effective date of the agreement for agreements that are newly entered into as of October 1, 2013. We believe that the proposed inclusion of “no later than the effective date of the agreement for agreements that are newly entered into as of October 1, 2013,” addresses the commenter's concern, in that the effective date of compliance with specifications described in paragraph (b)

becomes the effective date of the agreement for agreements newly entered into after October 1, 2013.

Comment: Two commenters urged CMS to rescind the proposed regulations under § 156.340(b), expressing concern that such requirements would unduly burden physician and medical group practices and negatively affect access to care.

Response: In § 156.340(b), we proposed that all agreements among a QHP issuer's delegated and downstream entities, including entities that provide health care services, be required to specify: 1) Delegated activities, reporting responsibilities; 2) and remedies for noncompliance; 3) mandatory compliance with all applicable laws and regulations related to the QHP issuer's obligations under 156.340(a); and 4) permission for the Secretary, OIG, or their designees to audit or inspect the entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations under 45 CFR 156.340(a) for 10 years from the final date of the agreement period. In § 156.340(a), we proposed that a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, as applicable, with all applicable standards. We believe that the proposed inclusion of “as applicable, with all applicable standards” in this section of the regulation means that health care providers that have entered into agreements with QHP issuers must comply with only those QHP standards that would be directly applicable to health care providers. We agree with the commenters that health care providers generally not be subject to many of the requirements for QHP issuers in the FFEs, unless the QHP issuer has delegated its responsibilities to the health care provider.

Comment: Many commenters strongly supported the proposed provisions of § 156.340, stating that the provisions provide greater support for the enforcement of Federal standards that protect consumers, including nondiscrimination protections that ensure equal access to care and coverage.

Response: We agree that the provisions will implement greater protections for consumers to receive equal access to care and coverage.

Summary of Regulatory Changes

We are finalizing the provision as proposed.

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

a. Available Remedies; Scope (§ 156.800)

In § 156.800, we proposed that HHS may impose civil money penalties (CMPs) on QHP issuers that are not in compliance with FFE standards and decertify QHPs offered by non-compliant QHP issuers. We sought comments on the use of these proposed compliance tools.

Comment: We received a comment requesting a moratorium on enforcement actions and a two year enforcement safe harbor for QHP issuers acting in good faith to comply with QHP requirements. The commenter explained that the safe harbor would give stakeholders additional time to come into compliance with FFE standards and the moratorium would allow HHS extra time to make sure that its technology and program infrastructure are working appropriately. Separately, we received another comment requesting a one year good faith enforcement safe harbor.

Response: QHP issuers are expected to be in compliance with standards applicable to QHP issuers at the time of certification and on an ongoing basis. As we stated in the preamble to the proposed rule, we expect QHP issuers in the FFEs to cooperate with HHS in resolving any issues of non-compliance that are identified during the plan benefit year. We also noted that HHS would take enforcement actions only in egregious circumstances and as such, we expect few, if any, decertifications, especially in the first year.

In response to the comments received, we now modify the regulation text to clarify that if CMS is able to determine that an issuer offering QHPs in an FFE is making good faith efforts to comply with Exchange standards applicable to issuers offering QHPs in the FFEs, we will not, under this subpart, seek to impose CMPs, or initiate decertifications during 2014. At the appropriate time we will consider extending this good-faith compliance through 2015.

We note that the determination of good faith may require issuers to allow CMS to conduct reviews of QHP materials and to make good faith efforts to comply with plans of correction. We will coordinate closely with States to avoid unnecessary duplication of monitoring and oversight efforts.

Summary of Regulatory Changes

We are adding a new paragraph (c) to § 156.800 to implement the good faith compliance policy described above.

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

In § 156.805, we proposed the bases and process for imposing a CMP in FFEs. We received general comments supporting our proposed enforcement of FFE standards through CMPs and decertifications but did not receive any comments regarding the specific bases for CMPs.

Summary of Regulatory Changes

We are making technical edits to §§ 156.805(d)(1)(v) and 156.805(e)(3) to reflect that the proposed administrative hearing process for enforcement actions under subpart I is not being finalized in this rule. We are finalizing the rest of this section as proposed.

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

In § 156.810, we proposed the bases for decertifying QHPs in the FFEs and standard and expedited processes for decertification. We proposed that when decertification is based on § 156.810(a)(7), (8) or (9), HHS may pursue the decertification on an expedited process. We sought comments on whether additional bases should be added.

Comment: We received comments in support of our proposed bases for decertification and the separate processes for standard and expedited decertification. One commenter recommended that we add § 156.810(a)(4) to the grounds for expedited decertification, citing the negative impacts that repeated, systematic, and willful violation of this standard would have on enrollees. We did not receive any comments opposing these two proposed processes.

Response: We proposed in § 156.810(a)(4) that a QHP may be decertified on the basis that the QHP issuer substantially fails to comply with the standards regarding advance payments of the premium tax credit and cost-sharing in Subpart E of Part 156. We agree with the commenter that violation of this standard may have negative impacts on enrollees; however, we envision expedited decertification to be reserved for the most serious instances of non-compliance that could present a risk to enrollees' ability to access needed health items or services and those that may substantially compromise the integrity of an FFE. After careful consideration, we will not add § 156.810(a)(4) to the bases for expedited decertification at this time;

however, we will continue to assess the appropriateness of adding this as a basis for expedited decertification.

Comment: One commenter recommended that rather than pursuing decertification when a QHP issuer substantially fails to meet the requirements under § 156.230 related to network adequacy standards, or § 156.235 related to the inclusion of essential community providers, HHS require QHP issuer networks to include a number of advanced practice registered nurses that is no less than 10 percent of the number of independently practicing advanced practice registered nurses enrolled as Medicare Part B providers who have provided one or more services to Medicare fee-for-service beneficiaries in the most recent year for which CMS provider data are available.

Response: We will continue assessing whether it is appropriate to require QHP issuers to contract with certain health care providers but not others as a certification requirement, but will be not make this change to the certification requirements at this time.

Summary of Regulatory Changes

We are making a change to § 156.810(e) to reflect that the proposed administrative hearing process for enforcement actions under subpart I is not being finalized in this rule. We are making a technical correction to a typographical error in subparagraph (b)(2) and a technical correction to add violation of privacy or security standards, proposed as a basis for decertification in the preamble to the proposed rule, to the list of bases in the regulation text.

5. Subpart K—Cases Forwarded to Qualified Health Plans and Qualified Health Plan Issuers in Federally-Facilitated Exchanges by HHS

a. Standards (§ 156.1010)

We proposed in § 156.1010 to set requirements for resolving cases forwarded by HHS to a QHP issuer operating in an FFE. We proposed the definition of a case as a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to State or Federal laws regulating insurance, concerning the person or entity's activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination as defined in 45 CFR 147.136(a)(2)(i). For a case forwarded by a State to a QHP issuer operating in an FFE, we proposed that the QHP issuer be required to comply with applicable State laws and

regulations. We proposed that cases received by a QHP issuer operating in an FFE directly from a complainant or the complainant's authorized representative be handled by the issuer through its internal customer service process. For cases received by a QHP issuer operating in an FFE from HHS, we proposed that the QHP issuer be required to investigate and resolve cases, as appropriate, pursuant to the proposed standards in § 156.1010.

In § 156.1010(a), we proposed the definition of a case. In § 156.1010(b), we proposed that QHP issuers operating in an FFE must investigate and resolve, as appropriate, cases brought by a complainant or the complainant's authorized representative and forwarded to the issuer by HHS. We proposed that this subsection would not apply to adverse benefit determinations as defined in 45 CFR 147.136(a)(2)(i), which are subject to the regulations governing internal claims appeals and external review in 45 CFR 147.136.

Section 156.1010(c) proposed that cases may be forwarded to a QHP issuer operating in an FFE through a casework tracking system developed by HHS, or through other means as determined by HHS. Section 156.1010(d) proposed that cases forwarded by HHS to a QHP issuer operating in an FFE must be resolved within fifteen calendar days of receipt of the case. We proposed that such cases involving an immediate need for health services, as defined in § 156.1010(e), must be resolved no later than 72 hours after receipt of the case, unless a State law or regulation established a stricter timeframe, which would then control.

In § 156.1010(e) we proposed that an urgent case is one in which there is an immediate need for health services because the non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, or health or ability to attain, maintain, or regain maximum function.

In § 156.1010(f), we proposed that, for cases forwarded by HHS, QHP issuers operating in an FFE are required to provide notice to complainants regarding the disposition of a case as soon as possible upon resolution of the case, but in no event later than seven business days after the case is resolved and that such notification may be by verbal or written means as determined most appropriate by the QHP issuer. In § 156.1010(g), we proposed that a QHP issuer operating in an FFE must document in a casework tracking system developed by HHS, or by other means as determined by HHS, that the case has been resolved, no later than seven business days after resolution of the case, and that the resolution record

must include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

In § 156.1010(h) we proposed that cases received by a QHP issuer operating in an FFE from a State in which the issuer offers QHPs must be investigated and resolved according to applicable State laws and regulations and that QHP issuers operating in an FFE must cooperate fully with the State, HHS, or any other appropriate regulatory authority that is handling a case.

Comment: Several commenters requested clarification regarding the definition of "case" and the types of cases that are subject to this subsection, and two commenters recommended that this subsection apply only to cases related to the advance payments of the premium tax credit and cost sharing reductions. Two commenters recommended that cases related to any health care services be excluded because they would necessarily be subject to the regulations governing internal claims appeals and external review in 45 CFR 147.136. Several commenters recommended that the definition of "urgent case" be expanded to include cases in which using the standard timeframe would jeopardize an individual's access to coverage.

Response: In response to comments received, we are adding language to § 156.1010(a) to provide that this subsection excludes cases related to eligibility determination processes, eligibility appeals, and other issues subject to Subpart F of this rule. We agree that some cases involving health care services should not be covered by this subsection, and explicitly exclude cases otherwise covered by 45 CFR 147.136. However, we do not agree that this subsection should explicitly exclude all cases related to health care services, and we also disagree that this subsection should apply only to cases related to the advance payments of the premium tax credit and cost-sharing reductions. Although complainants may bring some issues regarding advance payments of the premium tax credit and cost-sharing reductions to HHS' attention that will call for direct resolution or more intensive handling by HHS, we believe there are many areas in which HHS can act in the consumer's best interest by forwarding the consumer's case to the QHP issuer, as appropriate, including cases that may involve health care services but in which external review under 45 CFR 147.136 would not apply. For example, this would include a situation in which

the consumer contacts HHS because the QHP issuer has denied a service based on their assessment that the service is not a covered service. In this scenario, a consumer may disagree with a QHP issuer's determination that the matter is not eligible for external review. There are a number of issues—including deductibles, application of co-payments, and coverage of a specific service—that may not fall within the scope of 45 CFR 147.136 for external review purposes, but we believe that such cases should also be resolved in a timely fashion.

We agree with commenters who noted that some cases may qualify as urgent even where there is not necessarily an immediate need for health services, such as where a consumer encounters difficulties with enrollment near the end of an open enrollment period and is put at risk of not being able to enroll in coverage in a QHP offered through the Exchange. In such cases, it is important that the issuer respond quickly so as to not jeopardize consumers' ability to enroll in coverage. Accordingly, we are adding language that expands the definition of "urgent case" to include instances in which the standard timeframe for case resolution would jeopardize a consumer's ability to enroll in a QHP through the FFE.

Comment: Several commenters addressed the proposed timeframes and notification requirements for the resolution of cases forwarded by HHS to QHP issuers operating in an FFE, including two commenters who recommended that the timeframes either be removed or lengthened and several commenters who supported the proposed timeframes or suggested imposing more stringent requirements. One commenter recommended that issuers be required to notify a consumer of the resolution of a case in writing in order to ensure documentation of the resolution for the consumer, and another commenter requested clarification regarding the penalties that would apply to a QHP issuer operating in the FFE in the event that the issuer does not meet the regulatory timeframes. Several commenters requested clarification regarding the information that QHP issuers will be required to enter into the tracking system.

Response: Because we expect that consumer cases may often involve a consumer's ability to access to coverage—and, relatedly, health care services—on a timely basis, we believe it is important that cases be resolved in an expedient manner. We are therefore retaining the fifteen-day required response time for consumer cases forwarded by HHS to QHP issuers

operating in an FFE, with the exception of urgent cases as defined in this final rule, which require a resolution no later than 72 hours after the case is received. We expect QHP issuers operating in an FFE to resolve the urgent case as quickly as required by the severity of the case, but in no event later than the 72-hour timeframe provided. Additionally, we agree with commenters who indicated that a seven-day timeframe for notification to the complainant of the resolution of the case may create a significant burden on consumers while not meaningfully reducing burden on QHP issuers operating in an FFE as compared to a shorter timeframe; therefore, in response to these comments, we are shortening the case disposition notification requirement from seven business days to three business days. We also agree with commenters who noted that documentation of the case resolution is important for consumers to have, and we are modifying the final rule to require issuers to provide consumers with written notification of the case disposition. Written notification is not required to satisfy the three business day timeframe for case resolution notification; verbal notification can be used to meet this requirement so long as such notification is followed by written notification in a timely manner, pursuant to § 156.1010(f)(2).

Further, we are restructuring § 156.1010(g), including by adding three new paragraphs. We are adding § 156.1010(g)(1) to provide that for cases forwarded by HHS, a QHP issuer operating in an FFE must use the HHS-developed tracking system to document the date of resolution of a case. Section 156.1010(g)(2) contains the proposed requirement that a QHP issuer use the HHS-developed tracking system to document the case resolution summary no later than seven business days after resolution of the case, including a clean and concise narrative with specified content. We are also adding § 156.1010(g)(3) to provide that for cases forwarded by HHS and which have involved an investigation by a State agency, including but not limited to a State DOI, a QHP issuer operating in an FFE must use the HHS-developed tracking system to document "any compliance issues identified by the State agency implicating the QHP or QHP issuer."

We remind QHP issuers operating in an FFE that compliance with all applicable Federal standards, including those related to case resolution and notification, is a condition for QHP issuers to continue participating in an FFE. We expect QHP issuers will make

a good faith effort to comply with all applicable requirements. As such, as described below, during the 2014 plan year, we do not anticipate decertifying QHPs under 45 CFR 156.810(a)(1), nor pursuing civil money penalties under 45 CFR 156.805(a)(1) for non-compliance with these requirements except in the most egregious cases.

Comment: Several commenters suggested that HHS require States, issuers, and Exchanges to provide reports about consumer complaints and to make reports about consumer cases and complaints publicly available.

Response: HHS agrees that data regarding consumer complaints about an issuer is a critically important element of issuer oversight, and we intend to use the HHS tracking system to provide insight into such consumer complaints. HHS anticipates that we will be making reports and information publicly available that include analysis of the data we have collected in the HHS tracking system. However, we disagree with the recommendation that we require all States, issuers and Exchanges to provide such information. Many States already produce public reports regarding consumer complaints, and additional HHS requirements in this area would be duplicative in many instances. Additionally, we believe the enrollee satisfaction survey required by section 1311(c)(4) of the Affordable Care Act can provide HHS and consumers with the type of information that the commenters believe should be made publicly available by requiring Exchanges to publish information about enrollee satisfaction. HHS will also explore this issue as we receive cases to help us determine if requiring additional reporting in the future will help increase the effectiveness of issuer oversight.

Comment: Many commenters recommended changes related to the HHS tracking system and processes. Comments included requests for more specificity regarding issuer and State access to the system; requests for clarification regarding other methods that HHS may use to forward cases to QHP issuers operating in an FFE; and recommendations that issuers be required to track all consumer cases in the HHS tracking system, not simply those forwarded by HHS. We also received requests for clarification regarding the process that QHP issuers operating in an FFE are required to use to forward cases to the FFE.

Response: We anticipate that HHS will be using a tracking system for forwarding cases to QHP issuers operating in an FFE, and do not intend to routinely use alternate mechanisms to

do so. However, we retain the language about alternate mechanisms in order to allow HHS to use other methods if the need arises, such as where the tracking system is unavailable for an extended period of time. HHS intends to provide limited access to the tracking system to State DOIs in order to ensure that departments of insurance are able to access cases that fall under their jurisdiction. HHS also intends to provide limited access to the tracking system to QHP issuers operating in an FFE to ensure that QHP issuers can access cases that concern them on a timely basis so that they are able to identify and resolve such cases. We anticipate providing more information about access to this system in forthcoming guidance.

HHS acknowledges that issuers will receive cases directly from consumers and that such cases could be an important source of data, but we are not requiring QHP issuers to track all cases in the HHS tracking system. We believe that the enrollee satisfaction survey required by § 1311(c)(4) of the Affordable Care Act will be an appropriate way to track consumer cases received directly by QHP issuers. Additionally, we are not accepting the recommendation that HHS should operate a centralized tracking system for all consumer cases because State DOIs currently operate independent tracking systems and the creation of an additional, centralized system may be duplicative by necessarily including information about cases already existing in State tracking systems. Although the current model will undoubtedly result in some overlap with State systems, there will be a significant number of cases that are not accounted for in any State system. Rather than develop one centralized system operated by HHS, we will continue to explore ways to ensure that multiple systems can interact so that there is minimal duplication of cases across systems and that also meets appropriate security and privacy standards. Additionally, we will continue to monitor these issues to ensure that the HHS and State tracking systems as well as the information contained in enrollee satisfaction surveys provide HHS and consumers with adequate data about consumer cases to assess QHP issuer performance and conduct oversight of QHP issuers operating in an FFE.

For those cases best addressed by the FFE in which a consumer directly contacts the issuer, such as cases involving eligibility determinations or the amount of an advance premium tax credit, QHP issuers operating in the FFE should refer the consumer to the FFE

Call Center in order to allow the FFE to triage the case and resolve it appropriately.

Comment: Several commenters discussed the privacy and security standards related to the HHS tracking system, including an expression of opposition to the sharing of any personally identifiable information (PII) as well as requests for clarification about the consumer permission and consent necessary for the FFE to share case information with QHP issuers operating in an FFE and for those issuers to share case information with the FFE.

Response: QHP issuers operating in an FFE are required to meet the same privacy and security standards with respect to the HHS tracking system that they are required to meet as a condition of offering a QHP in an FFE. Additionally, FFEs will obtain consumer consent before sharing any information with QHP issuers operating in an FFE or with State DOIs in order to resolve the case. We understand concerns about the privacy and security of PII, including information about health; consumer consent represents a consumer's agreement to have such information shared with appropriate entities in order to help resolve the consumer's case. When such consent is obtained, the information will be shared in a manner that appropriately protects PII and, where applicable, personal health information (PHI), so that such information is not shared with other entities that should not have access to that information. We anticipate that the information shared with the appropriate QHP issuer will include the consumer name, contact information, and details about the case provided by the consumer to HHS.

Comment: One commenter expressed concern with the proposed approach to send consumers to issuers of the QHPs in which they are enrolled in cases where the consumer has already reached out to the issuer, and another commenter recommended that the proposed processes and timeframes apply to all consumer cases in all Exchanges.

Response: We understand the concern that, in this circumstance, this approach might not seem to offer the consumer additional assistance. However, our experience with Medicare Advantage and Part D complaints has demonstrated that we are often able to facilitate tangible results for beneficiaries when HHS sends a case directly to the applicable issuer, including in instances where the beneficiary has already reached out to the issuer. This approach also allows for a more streamlined

process in which the consumer's case may be dealt with more rapidly than an alternate process calling for intensive HHS involvement in every case in which a consumer has already reached out to the issuer.

Additionally, while we understand the argument for consistency across all casework systems and processes, and the compromises inherent in providing different resolution processes and timeframes for consumers depending on where they first report their case, we are not expanding this final rule to include Exchange- and QHP-related cases other than those which HHS forwards to QHP issuers operating in an FFE because we want to respect the State laws and regulations that currently apply to such cases. While in the absence of this final rule those laws and regulations would also apply to some of the cases that HHS forwards to QHP issuers operating in an FFE, we believe it is appropriate to establish additional timeframes and processes because there may be cases which are not subject to timeframes set forth by State laws and regulations, such as cases related to Exchange-specific requirements that apply to QHP issuers operating in an FFE.

Comment: One commenter recommended that the final rule require issuers to use processes and means of communication for resolving cases that are accessible to individuals with limited English proficiency and those with disabilities.

Response: We agree that it is important for consumers to receive assistance and information in a way that they can access and understand, including individuals with limited English proficiency and individuals with disabilities. However, we are not accepting the recommendation to include additional, specific language in this regulation because QHP issuers operating in an FFE are already required to provide accessible notices to enrollees pursuant to 45 CFR 156.250, which applies to communications regarding consumer cases. We will monitor this area carefully to assess whether additional guidance is necessary in order to ensure that all individuals have adequate and appropriate access to the information and tools needed to have cases resolved.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.1010 of the proposed rule, with the following modifications. We are amending § 156.1010(a) to provide that this section does not include cases otherwise addressed in Subpart F of this rule. In § 156.1010(e), we are expanding the definition of

“urgent case” to include instances in which application of the non-urgent standard would jeopardize a consumer's ability to enroll in a QHP through the Federally-facilitated Exchange. In § 156.1010(f) and new paragraph (f)(1), we are requiring issuers to provide notification to consumers about the disposition of a case within three business days of the resolution, by verbal or written means as determined most appropriate by the QHP issuer operating in an FFE. In new paragraph (f)(2), we are requiring that in instances when a QHP issuer operating in an FFE notifies the consumer about the disposition of a case using non-written means, the issuer must provide the consumer with written notification of the disposition in a timely manner following the verbal communication. In new paragraph (g)(1), we are requiring that a QHP issuer operating in an FFE provide the date of resolution of a case in the HHS-developed tracking system; § 156.1010(g)(2) contains the proposed requirement that a QHP issuer document the case resolution summary no later than seven business days after resolution of the case, including a clean and concise narrative with specified content; and in new paragraph (g)(3) we are requiring that a QHP issuer operating in an FFE provide information in the HHS-developed tracking system about any compliance issues found as part of an investigation of a case by a State agency, including but not limited to a State DOI.

6. Subpart M—Qualified Health Plan Issuer Responsibilities

a. Direct Enrollment With the QHP Issuer in a Manner Considered To Be Through the Exchange (§ 156.1230)

We proposed to add paragraph § 156.1230(a)(1)(i) that would allow, at the Exchange's option, a QHP issuer to enroll an applicant who initiates enrollment directly with the QHP issuer in a manner that is considered enrollment through the Exchange if the QHP issuer follows the enrollment process for qualified individuals set forth in § 156.265.

We proposed paragraph § 156.1230(a)(1)(ii) to ensure that QHP issuers that seek to directly enroll qualified individuals in a manner considered to be through the Exchange provide applicants the ability to view the QHPs offered by the issuer with data elements set forth at 45 CFR 155.205(b)(1).

We proposed in paragraph § 156.1230(a)(1)(iii) that QHP issuers that seek to directly enroll qualified individuals in a manner considered to

be through the Exchange using the issuer's Web site must clearly distinguish between QHPs for which the consumer is eligible and non-QHPs that the issuer may offer. We proposed that this distinction must also clearly articulate that advance payments of the premium tax credit and cost-sharing reductions apply only to QHPs offered through the Exchange.

In § 156.1230(a)(1)(iv), we proposed that QHP issuers that seek to directly enroll qualified individuals in a manner considered to be through the Exchange be required to notify applicants of the availability of other QHP products offered through the Exchange to consumers, regardless of whether they apply through a Web site, in-person or by phone. The QHP issuer would also be required to display the Web link to or describe how to access the Exchange Web site. We sought comment if HHS should require a universal disclaimer to be displayed by the issuer that informs applicants that other coverage options exist in the Exchange and that not all coverage options are displayed.

In § 156.1230(a)(1)(v), we proposed that a QHP issuer be required to ensure that, when an applicant initiates enrollment directly with the QHP issuer and the QHP issuer seeks to directly enroll the applicant in a manner considered to be through the Exchange, the applicant is allowed to select an advance payment of the premium tax credit amount, if applicable, in accordance with § 155.310(d)(2), provided that the applicant makes the attestations required by § 155.310(d)(2)(ii).

In § 156.1230(a)(2), we proposed that, if permitted by the Exchange pursuant to § 155.415, a QHP issuer seeking to directly enroll applicants in a manner considered to be through the Exchange enter into an agreement with the Exchange prior to allowing any of its customer service representatives to assist qualified individuals with certain application tasks whereby the QHP issuer would agree to require each of its customer service representatives to at a minimum: (i) Receive training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations; (ii) comply with the Exchange's privacy and security standards adopted consistent with § 155.260; and (iii) comply with applicable State law related to the sale, solicitation, and negotiation of health insurance products, including applicable State law related to agent, broker, and producer licensure; confidentiality; and conflicts of interest. We solicited comments on these proposals.

We also proposed to add § 156.1230(a)(3) to ensure that the premium that a QHP issuer charges to a qualified individual or enrollee is the same as was accepted by the Exchange in its certification of the QHP issuer after accounting for any advance payments of the premium tax credit. We proposed that if the QHP issuer identifies an error in the amount it has charged the qualified individual, the QHP issuer must retroactively correct the error no later than 30 calendar days after its discovery. We also proposed that for issuers of QHPs in the FFE, HHS may review the premiums charged to qualified individuals through the compliance reviews proposed in § 156.715(a).

Finally, in § 156.1230(b), we proposed that the individual market FFEs would permit the conduct set forth in this section, to the extent permitted by applicable State law. As stated earlier in the preamble, for purposes of clarity, we will refer to "issuer customer service representatives" as "issuer application assisters" for the rest of this section.

We received the following comments concerning the proposed enrollment process provisions.

Comment: Many commenters endorsed the use of a universal disclaimer to be displayed by issuers that informs applicants that other coverage options exist in the Exchange and that not all coverage options are displayed. Almost all the commenters echoed that they believed it was important that all applicants understand the coverage options available to them. One commenter recommended giving issuers the flexibility on how to inform applicants about the availability of other QHPs offered through the Exchange and expressed the operational difficulty in adding a universal disclaimer.

Response: In response to all the comments, we agree that a universal disclaimer would allow an applicant to make a more informed decision by informing applicants where to find information on all available QHPs including language that selecting multiple enrollment groups and catastrophic plans may only be supported through the FFM. Accordingly, we modified § 156.1230(a)(1)(iv) to clarify that issuers must use an HHS-approved universal disclaimer about the availability of other QHPs offered through the Exchange. We note that this disclaimer must be made available to applicants regardless of how consumers communicate with the issuer (Web site, phone, in-person, etc.). We expect that issuers will make this available at the beginning of the plan comparison

process and if an applicant is using an issuer's Web site, the issuer must prominently display this disclaimer when displaying plans to the applicant.

Comment: We received many comments supporting the proposed consumer protections requirements for direct enrollment. However, some commenters recommended adding additional disclosures such as informing applicants that other coverage options exist, requiring issuers to list all QHPs, and information on how to access available Navigators. One commenter wanted to eliminate direct enrollment altogether since the commenter believed the process would prevent applicants from receiving unbiased information from which to choose a health plan that best meets their needs.

Response: We recognize that direct enrollment may cause some confusion for the applicant, but believe the value of consumer choice outweighs potential confusion. Accordingly, in the final rule, we are finalizing § 156.1230(a)(1) to establish consumer protections. As explained previously, these protections will now include providing an HHS-approved universal disclaimer informing applicants of other coverage options. We note that the data elements displayed consistent with § 156.1230(a)(1)(ii) must provide the same information as that on the Exchange Web site and not all the data elements submitted to the Exchange on the issuer's QHP data templates. We do not believe that issuers should be required to give information about access to Navigators since applicants would have come to the issuer directly and direct enrollment would provide one of many ways in which an applicant can enroll in a QHP.

Comment: We received numerous comments on the training requirements and standards for issuer application assisters. A number of commenters were concerned that direct enrollment could lead to consumer confusion and suggested that application assisters go through the same training as certified application counselors (CACs). Some commenters recommended these individuals meet the same standards as the ones applicable to other assisters, such as Navigators, CACs, and agents/brokers, and be trained and certified by the Exchange. One commenter recommended that issuers be responsible for the requirements related to training.

Response: We intend for issuers to provide the training to their own customer service representatives. We also expect the Exchange to provide the agent/broker or other related assister training curriculum to issuers so they

can utilize those materials while conducting their training. We leave the decision on whether to establish a program for certifying these individuals up to the Exchange. The FFEs do not intend to permit issuers to allow their application assisters to perform the assistance functions set forth in this section in the first year of Exchange operations. We will evaluate whether to implement a certification requirement, which would be done through rulemaking, for future years.

Comment: Some commenters recommended that issuer application assisters ensure that individuals who are ineligible for QHPs receive the information necessary to follow up with programs that they may be eligible for such as Medicaid or CHIP.

Response: We expect that issuer application assisters who are approached by individuals and families looking for assistance with Exchange enrollment will work with all applicants, including individuals who are ultimately determined to be eligible for Medicaid or CHIP. Any applicant who is working with an issuer application assister and is determined by an Exchange to be eligible for Medicaid or CHIP will receive an appropriate notice of assessment or determination of Medicaid/CHIP eligibility from the Exchange. In such cases, we expect that the issuer application assister would refer the individual to the applicable State agency. We anticipate that issuer application assister training will provide information on where to direct Medicaid or CHIP-eligible individuals.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.1230 of the proposed rule, with a few modifications. We modified language in § 156.1230(a)(1)(iv) to clarify that issuers must use an HHS-approved universal disclaimer about the availability of other QHPs offered through the Exchange. We also made a technical correction in paragraph (a)(1)(iv) replacing “or” with “and.” As described in Part C(5) of this rule, we will use the term “issuer application assisters” in place of “issuer customer service representatives” to more clearly articulate the role of such individuals and for consistency, will refer to the definition of “issuer application assisters” being finalized at § 155.20. We also modified § 156.1230(a)(2) to remove the express requirement for an agreement between an issuer and the Exchange for its issuer application assisters, but still require that issuers ensure their application assisters

comply with § 156.1230(a)(2)(i) through (a)(2)(iii). Lastly, we are not finalizing subparagraph § 155.1230(a)(3) regarding premium accuracy requirements at this time because we intend to address that provision in future rulemaking.

b. Enrollment Process for Qualified Individuals (§ 156.1240)

We proposed to require that QHP issuers, at a minimum, accept a variety of payment formats so that individuals without a bank account or a credit card will have readily available options for making monthly premium payments. We gave examples of methods including, but not limited to, paper checks, cashier's checks, money orders, replenishable pre-paid debit cards, electronic funds transfer from a bank account, and an automatic deduction from a credit or debit card. We sought comment on this proposal and whether other payment methods should be included.

We received the following comments concerning the proposed enrollment process provisions.

Comment: A majority of commenters were in favor of requiring QHP issuers to accept methods of payment customarily used by people without bank accounts or credit cards. Furthermore, commenters recommended codifying in the regulation text the specific payment methods options yielding an illustrative list of payment methods. This would ensure that issuers accept a range of payment methods instead of just one in addition to a bank account or credit card depending on an issuer's operations. Other commenters recommended that the rule not require an exhaustive list of payment methods, but rather establish a baseline for payment methods and allow issuers to include other forms of payment based on their market needs.

Response: We are finalizing a revised § 156.1240(a)(2), which lists the payment methods that QHP issuers must accept at a minimum. This will provide a range of options for those individual with and without banking accounts and/or credit cards. Most issuers already have the capability to accept these payment options.

Comment: We received several comments suggesting that we should clarify that QHP issuers must accept the proposed payment methods for all premium payments, including the initial premium payment. Commenters stated that applicants would not be able to enroll and maintain health coverage if their principal payment option is not available for all payments. Other commenters recommended using electronic payments for initial payments

due to longer processing times needed, higher transaction fees, and a delay in effectuate coverage for certain payment methods.

Response: The requirement to accept the stated payment methods must apply to all payments including initial premium. Interpreting this rule any other way would defeat the purpose of this section as explained in the proposed rule, because individuals who would benefit from the protections in this section would likely not be able to effectuate coverage to make monthly premiums thereafter. Issuers should work with individuals to make them aware that certain payment methods take longer to process and plan accordingly. In this final rule, we are finalizing a revised § 156.1240(a)(2), which clarifies that this provision applies to all payments.

Comment: We received a comment to clarify whether this is a requirement in all Exchanges and whether this is specific to the individual market.

Response: This provision applies only in the individual market and we have indicated this in § 155.1240(a)(2) of the final rule. We also note that this applies to all Exchanges, including State Exchanges.

Comment: One commenter recommended that we avoid partnering with payment service companies that will profit from payment fees since some pre-paid debit cards and money transfer programs require additional fees to consumers. That commenter also recommended that we partner with reputable non-profit organizations that will provide safe and affordable services such as non-profit enrollment assisters. Another commenter suggested that we limit which pre-paid debit cards may be used in order to limit the transaction fee for both the consumer and issuer.

Response: We will leave it up to each Exchange on whether or not to partner with particular payment service companies. FFEs will not partner with any payment service companies for the first year. We will subsequently evaluate the value of having a relationship with such partner.

Comment: We received some comments suggesting that we maximize the range of payment options offered to applicants. Commenters noted that issuers should offer electronic funds transfer (EFT) for individuals with bank accounts using Automated Clearing House payments including direct deposits. Other commenters recommended that applicants be made aware of all their payment options by mail and information displayed to the applicant on the Web site. In particular, issuers should ensure that consumers

are aware of all alternative payment methods.

Response: In this final rule, we are including EFT as a payment method that issuers must accept. While we believe many individuals with bank accounts will select this option, the requirement to accept a variety of payment methods, as proposed in the proposed rule and as being finalized here, necessitates that issuers inform the consumer of all payment options when a consumer needs to make a payment, whether in the mail or on the issuer's Web site. We are therefore making explicit in this final rule that, when collecting payment, all payment method options must be equally presented to the consumer.

Comment: We received numerous comments on what payment methods QHP issuers should be required to accept. Many commenters supported the methods provided in the preamble of the proposed rule. Some commenters suggested the use of all general-purpose pre-paid debit cards instead of just reloadable or replenishable pre-paid debit cards to be more inclusive and since it doesn't make a difference operationally. Other commenters recommended money transfer platforms, the ability to deduct from an enrollee's paycheck, and automatic deductions from credit or debit cards. However, other commenters expressed concern on whether all issuers would be able to support credit or debit card payments as well as ongoing automatic deductions from credit or debit cards. We received some comments that issuers should mimic CHIP programs and accept multiple methods of payment from multiple locations, most importantly accepting cash by establishing payment providers throughout communities. Lastly, many commenters were concerned about additional administrative and transactional fees depending on which payment methods would be required, whether the fees be assessed on the issuer, Exchange, or consumer.

Response: Due to the overwhelming support for pre-paid debit cards, we have included all general-purpose pre-paid debit cards as a payment method that issuers are required to accept. Because many issuers accept debit cards, this requirement should not cause administrative or operational issues. At this time, we will allow issuers to decide whether or not to accept automatic deductions from credit or debit cards. We also think that requiring issuers to accept cash would not be operationally possible given the resource and time restraint to establish the necessary relationship with payment

providers. However, we are still requiring issuers to accept other paper payment methods described in the preamble of the proposed rule including paper checks, money orders, and cashier's checks.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 156.1240 of the proposed rule, with a few modifications. We revised paragraph (a)(2) to include the minimum payment methods that issuers must accept. Additionally, we clarified that these methods must be accepted for all payments. We also clarified that this applies to the individual market only. Lastly, we added language to reflect that all payment method options must be presented equally for a consumer to select their preferred payment method.

III. 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 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 (PRA) 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.

The following sections of this document contain estimates of burden imposed by the associated information collection requirements (ICRs); however, not all of these estimates are subject to the ICRs under the PRA for the reasons noted. Estimated salaries for the positions cited were mainly taken from the Bureau of Labor Statistics (BLS) Web site (http://www.bls.gov/oco/ooh_index.htm).

The estimated salaries for the health policy analyst and the senior manager were taken from the Office of Personnel Management Web site. Fringe Benefits estimates were taken from the BLS

March 2013 Employer Costs for Employee Compensation Report.¹¹

A. ICRs Related to the Risk Corridors Program (§ 153.500)

In this final rule, we amend the definition of a QHP in § 153.500 for the purposes of the risk corridors program. We provide that a plan will be subject to the risk corridors program if it is (a) A QHP, as defined in 45 CFR 155.20; (b) a plan offered outside the Exchange that is the same plan as a QHP, as defined in 45 CFR 155.20, offered through the Exchange by the same issuer, pursuant to the criteria finalized in Part C(1)(a) of this rule; or (c) a plan offered outside the Exchange that is substantially the same as a QHP, as defined in 45 CFR 155.20, offered through the Exchange by the same issuer, pursuant to the criteria finalized in Part B(1)(a) of this rule.

In this final rule, we note that we intend to issue guidance on the operational aspects of this standard, including with respect to how HHS and issuers will identify plans submissions (including those submitted for the 2014 benefit year) that are "substantially the same" as a QHP offered through an Exchange for the purposes of determining whether the plan will participate in the risk corridors program. QHP issuers may be required to submit plan identification information to HHS as part of HHS's determination of which plans offered outside of the Exchange will participate in the risk corridors program. We intend to account for this information collection requirement in a PRA package that we will publish for public comment and advance for OMB approval in the future. Information related to the requirement will not be effective until comment is sought and the collection is approved by OMB.

B. ICRs Related to Ability of States To Permit Agents and Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in Qualified Health Plans in the Federally-Facilitated Exchange (§ 155.220)

In § 155.220(c)(3)(i), we amend the provision to require Web-brokers to display all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of § 155.205(b)(1) and § 155.205(c), and to the extent that not all information required under § 155.205(b)(1) is displayed on the agent or broker's Internet Web site for a QHP,

¹¹ BLS March 2013 Employer Costs for Employee Compensation Report (March 12, 2013). Available at <http://www.bls.gov/news.release/eccec.toc.htm>.

prominently display a standardized disclaimer provided by HHS stating that information required under § 155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site. To comply with this requirement, each Web-broker will have to program its Web site to display the standardized disclaimer language in the event that it cannot display plan information required under § 155.205(b)(1) for a particular QHP. The Web-broker will also have to include a Web link to the Exchange Web site. We estimate that it will take up to 12 hours at an hourly cost of \$52.50 for a computer programmer to perform the necessary programming, and 4 hours at an hourly cost of \$79.08 for a senior manager to review the Web site display, for a total cost of approximately \$950 per Web-broker. Assuming that approximately 50 Web-brokers elect to access the FFE's application programming interface and that each Web-broker will have to display the standardized disclaimer language and Web link, we estimate that this provision would increase the overall burden estimate by approximately \$47,300.

Section 155.220(c)(3)(vii) requires each Web-broker in FFE states to display on its Web site a standardized disclaimer provided by HHS and a link to the FFE Web site. To comply with this requirement, each Web-broker will have to program its Web site to display the standardized disclaimer and a Web link to the Exchange Web site. We estimate that it will take up to 12 hours at an hourly cost of \$52.50 for a computer programmer to perform the necessary programming, and 4 hours at an hourly cost of \$79.08 for a senior manager to review the Web site display, for a total cost of approximately \$950 per Web-broker. At this time, we anticipate that all Web-brokers will be participating in FFE states. Assuming that approximately 50 Web-brokers elect to access the FFE's application programming interface and that each Web-broker will have to display the standardized disclaimer language and Web link, we estimate that this provision would increase the burden estimate by approximately \$47,300.

Section 155.220(c)(4) requires a Web-broker to comply with several standards when the Web-broker permits other agents and brokers to use its Web site to enroll a consumer through the FFE, pursuant to a contractual or other arrangement between the Web-broker and the other agent or broker. One of the standards requires the Web-broker to provide to the FFE a list of agents or brokers who enter into such an

arrangement, if requested by HHS. We understand that Web-brokers who work with other agents and brokers typically obtain and manage information on each of its agents or brokers as part of an agent onboarding process. As a result, Web-brokers already have the necessary data to list each of their agents or brokers that it contracts with under such arrangements. We estimate that it will take up to 48 hours at an hourly cost of \$52.50 for a computer programmer to perform the necessary programming, and 4 hours at an hourly cost of \$79.08 for a senior manager to develop a listing of affiliated third-party agents and brokers, \$3,150 per Web-broker. Assuming that approximately 50 Web-brokers elect to access the FFE's application programming interface and that each has allows third-party agents to access their Web sites, we estimate that this provision would increase the burden estimate by approximately \$157,600. Section 155.220(g) authorizes HHS to terminate an agent's or broker's agreement with an FFE if HHS determines that the agent or broker is out of compliance with the standards outlined in 45 CFR 155.220. Section 155.220(h) sets forth the process whereby an agent or broker can request reconsideration of HHS's termination. Specifically, the agent or broker must submit the request for reconsideration within 30 calendar days of receipt of the date of the notice of termination. Because we are finalizing this provision as proposed, and did not receive comments on our estimates, we continue to use our estimates from the proposed rule.

C. ICRs Related to the Eligibility Process (§ 155.310)

Section 155.310(k) provides that if an Exchange does not have enough information to conduct an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions, the Exchange must provide notice to the applicant regarding the incomplete application. We anticipate that this notice requirement is not a separate notice to an individual but text within the eligibility determination notice described in § 155.310(g) and discussed in a separate information collection request that is associated with the notice of proposed rulemaking (January 22, 2013 (78 FR 4594)). We therefore do not include a separate burden estimate to develop this notice but the time and cost associated with this notice is included within the estimate in § 155.310(g).

Section 155.310(k)(2) provides that the Exchange must provide the applicant with a period of no less than

10 days and no more than 90 days from the date on which the notice is sent to the applicant to provide the information needed to complete the application to the Exchange. Because we are finalizing these provisions with only a minor modification to the lower limit of time that the Exchange must provide to the applicant to complete an application, and did not receive comments on our estimates, we continue to use our estimates from the proposed rule. For a detailed explanation of burden hour and cost please refer to the associated supporting statement at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS%E2%80%939310490.html>.

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

It is important to note that these regulations involve several information collections that will occur through the single, streamlined application for enrollment in a QHP and for insurance affordability programs described in 45 CFR 155.405. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (OMB control number 0938–1191/CMS–10440).

D. ICRs Regarding Appeals (§§ 155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740)

The eligibility appeals provisions in subparts F and H include requirements for the collection of information that will support processing and adjudicating appeals for individuals, employers facing potential tax liability, and SHOP employers and employees. The information collection will be largely the same for each type of appeal and includes the appeal request, expedited appeal request, appeal withdrawal, request to vacate, request for additional information, special considerations form, and appointment and removal of authorized representative. Because we are finalizing these provisions as proposed, and did not receive comments on our estimates, we continue to use our estimates from the proposed rule. For a detailed explanation of burden hour and cost please refer to the associated supporting statement at <http://>

www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS%E2%80%939310490.html.

E. ICRs Regarding Consumer Cases Related to Qualified Health Plans and Qualified Health Plan Issuers (§ 156.1010)

In subpart K of part 156, we describe the information collection requirements that pertain to the resolution of consumer cases related to QHPs and QHP issuers. Section 156.1010(g)(1) states that QHP issuers must include the date of case resolution, § 156.1010(g)(2) states that QHP issuers must record a clear and concise narrative documenting the resolution of a consumer case in the HHS-developed casework tracking system, and § 156.1010(g)(3) states that QHP issuers must provide information about compliance issues found by a State during the investigation of a case. The additional information required by § 156.1010(g)(1) and § 156.1010(g)(3) are clarifications of the original proposed requirements and do not represent an additional burden. Because we are finalizing these provisions as proposed, and did not receive comments on our estimates, we continue to use our estimates from the proposed rule.

For a detailed explanation of burden hour and cost please refer to the associated supporting statement at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS%E2%80%939310490.html>.

F. ICRs Related to Enrollment Process for Qualified Individuals (§ 156.1230)

Section § 156.1230(a)(1)(ii), issuers would be required provide information on available QHPs when they choose to use their Web site to directly enroll qualified individuals into QHPs in a manner considered to be through the Exchange. The QHP information required to be posted on the Web site would include premium and cost-sharing information, the summary of benefits and coverage, levels of coverage (“metal levels”) for each QHP, results of the enrollee satisfaction survey, quality ratings, medical loss ratio information, transparency of coverage measures, and a provider directory. Section § 156.1230(a)(1)(i) requires an issuer to direct an individual to complete an application with the Exchange and receive eligibility determinations from the Exchange to allow for an accurate plan selection process. Additionally, section § 156.1230(a)(1)(iv) would require the issuer Web site to inform

applicants about the availability of other QHP products available through an Exchange and to display a Web site link to the appropriate Exchange Web site. An issuer would also submit enrollment information back to the Exchange including the APTC amount and attestation from an individual as required by § 156.1230(a)(1)(v).

Section 156.1230(a)(2) would allow qualified individuals to apply for an eligibility determination or redetermination for coverage through the Exchange and insurance affordability programs with the assistance of an issuer application assister if the issuer ensures its application assisters’ compliance with requirements, including training and privacy and security standards.

We are finalizing these provisions with a few modifications. Since we are no longer requiring an additional requirement for the issuer agreement, the burden associated with amending the agreement between the issuer and the Exchange if the Exchange implements this provision is no longer applicable. The burden associated with the rest of these provisions remains the same as the proposed rule. For a detailed explanation of burden hour and cost please refer to the associated supporting statement at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS%E2%80%939310490.html>. We clarified that the burden in § 156.1230(a)(1) took into account an issuer needing to distinguish between QHPs for which a consumer is eligible and other non-QHPs that an issuer may offer as required by § 156.1230(a)(1)(iii).

We have submitted an information collection request to OMB for review and approval of the ICRs contained in this final rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

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

Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [CMS–9957–F], Fax: (202) 395–6974; or Email: OIRA_submission@omb.eop.gov.

IV. Regulatory Impact Analysis

In accordance with the provisions of Executive Order 12866, this rule was reviewed by OMB.

A. Summary

This final rule outlines Exchange standards with respect to eligibility

appeals, agents and brokers, direct enrollment, the handling of consumer cases, imposing CMPs in FFEs; and decertification of a QHP offered by an issuer through a FFE. It also sets forth standards with respect to a State’s operation of an Exchange and SHOP.

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

B. Executive Orders 13563 and 12866

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

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

A regulatory impact analysis (RIA) must be prepared for major rules with

economically significant effects (\$100 million or more in any 1 year), and a "significant" regulatory action is subject to review by the OMB. HHS has concluded that this final rule is not likely to have economic impacts of \$100 million or more in any one year, and therefore does not meet the definition of "economically significant rule" under Executive Order 12866. HHS has, however, provided an assessment of the potential costs and benefits associated with this final regulation.

1. Need for Regulatory Action

Starting in 2014, qualified individuals and qualified employers will be able to use coverage provided by QHPs—private health insurance that has been certified as meeting certain standards—through Exchanges. This final rule sets

forth standards related to eligibility, including standards for eligibility appeals, verification of eligibility for minimum essential coverage, and treatment of incomplete applications. It also establishes consumer protections regarding privacy and security, clarifies the role of agents, brokers, and issuer application assisters; consumer cases; methods of premium payment; enforcement actions such as CMPs and decertification of a QHP in a FFE. Finally, it sets forth provisions regarding a State's operation of a SHOP.

2. Summary of Impacts

In accordance with OMB Circular A-4, Table IV.1 below depicts an accounting statement summarizing HHS's assessment of the benefits and costs associated with this regulatory

action. The period covered by the RIA is 2014–2017.

HHS anticipates that the provisions of this final rule will ensure smooth operation of Exchanges and provide consumer protections. The eligibility appeals process and the notice standards included in this final rule will support the development and implementation of a streamlined eligibility process, and in doing so, will increase enrollment in health insurance. Affected entities such as States, QHP issuers, agents, and brokers will incur costs to submit reports to HHS and Exchanges, to comply with privacy and security standards for PII, and to comply with enforcement actions. In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

TABLE IV.1: ACCOUNTING TABLE

Benefits:

Qualitative:

- * Ensure smooth functioning of State Exchanges and FFEs
- * Increased access to fair and unbiased customer assistance and information about coverage options for consumers, enabling consumers to make informed decisions
- * Ensure privacy and data security protections
- * Improve access to health insurance, by ensuring accurate and fair appeals of eligibility determinations
- * Improve program performance, reduce non-compliance by QHPs and agents and brokers, and decrease the likelihood of errors and adverse outcomes for consumers

Costs	Estimate	Year	Discount Rate	Period
Annualized	\$17.64 million	2013	7	2014–2017
Monetized (\$/year)	\$17.64 million	2013	3	2014–2017

Annual costs related to eligibility appeals; enrollment process for Qualified Individuals; documentation of resolution of consumer cases; costs to agents and brokers and QHPs related to enforcement actions.¹

Qualitative:

- * Costs to Exchanges and non-Exchange entities subject to FFE privacy and data security standards to comply with privacy and data security standards
- * Possible reduction in costs for SHOPS due to elimination of the requirement to accept paper applications and applications by telephone
- * Cost incurred by SHOPS to develop uniform standards for the termination of a group's coverage in a QHP and to keep sufficient records of terminations and reasonable accommodations
- * Eligibility appeals process may reduce administrative costs, by providing resolution options that enable the vast majority of issues to be resolved by lower-level staff

Note: 1. The bases for these costs are discussed in the Paperwork Reduction Act sections of the proposed rules associated with this final rule.

3. Anticipated Benefits and Costs

Starting in 2014, qualified individuals and qualified employers will be able to use health coverage obtained through Exchanges. The Congressional Budget Office estimated that the number of people enrolled in coverage through Exchanges will increase from 7 million in 2014 to 24 million in 2017.¹² Exchanges will create competitive marketplaces where qualified

individuals and qualified employers can shop for insurance coverage, and are expected to reduce the unit price of quality insurance for the average consumer by pooling risk and promoting competition.

The final rule specifies the standards and processes for the oversight and accountability of entities responsible for certain operations of the Exchanges. Affected entities include States, in their roles of establishing and operating Exchanges and SHOPS; FFEs and FF-SHOPS; issuers of QHPs; Exchange appeals entities; and insurance agents and brokers.

a. Benefits

This final rule implements provisions that will ensure smooth functioning of State Exchanges and FFEs, improve access to health insurance and customer service, and establish consumer protection measures.

The final rule provides that, for individual eligibility determinations, applicants and enrollees may appeal eligibility determinations made through the eligibility process at the State level, if the State opts to establish an appeals process, or at the Federal level, if the State opts not to establish an appeals process or upon exhaustion of a State

¹² "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," Congressional Budget Office, May 14, 2013.

based appeals process. An effective eligibility appeals process improves access to health insurance, by providing recourse for issues that arise in the eligibility process that can disrupt coverage. The appeals process is based on best practices to provide flexible, transparent, and consumer-centric appeals review and resolution. By providing an efficient, but comprehensive appeals process, the provisions of this final rule will ensure accurate and fair appeals of eligibility determinations. In addition, by providing a separate appeals process for small businesses, the provisions of this final rule will help ensure that accurate and satisfactory determinations are made for small businesses.

The final rule also allows a State to operate only a State-based SHOP while the individual market Exchange is operated as an FFE. This will enable the State to focus on effective implementation of the SHOP. Each SHOP is also required to develop uniform standards for the termination of coverage in a QHP, starting in 2015, unless the SHOP offers employers the opportunity to give their employees a choice of plans at one actuarial value level ("employee choice") before then. Standardizing the timing, form, and manner of a group's termination in the SHOP ensures that an employer offering coverage through multiple health insurance issuers (under the SHOP "employee choice" model) will be subject to uniform, predictable termination policies.

The final rule implements consumer protections designed to ensure privacy and security of PII, increased access to customer assistance, greater information about coverage options, and more informed coverage decisions by consumers. Permitting issuer application assisters to assist individuals with applying for eligibility determinations or redeterminations for coverage through the Exchange will increase assistance available to consumers, while the training and compliance standards will ensure that such assistance is fair and unbiased. The final rule establishes requirements for issuer application assisters and agents and brokers who assist consumers, requiring them to comply with registration and training requirements. The final rule also establishes standards under which HHS can terminate its relationship with agents and brokers in the FFE, to help ensure that agents and brokers continue to meet Exchange standards. The final rule also amends and establishes additional standards for Web-brokers. In addition, the requirement for QHP

issuers conducting direct enrollment, in a manner considered to be through an Exchange, to provide standardized comparative information on their Web sites ensures that consumers can readily differentiate and compare plan choices leading to informed decisions. Consumers without bank accounts will also have a variety of payment options.

Oversight and enforcement actions such as CMPs and decertification of a QHP, termination of an agent and broker agreement for participation in the individual market of an FFE, will improve program performance, reduce non-compliance by QHPs and agents and brokers, and decrease the likelihood of errors and adverse outcomes for consumers.

b. Costs

Affected entities will incur costs to comply with the provisions of this final rule. Costs related to information collection requirements subject to PRA are discussed in detail in section III and include administrative costs incurred by States, issuers and agents and brokers related to notice and reporting requirements; enforcement actions; enrollment process for qualified individuals; and training requirements. In this section we discuss other costs related to the provisions in this final rule.

A State that establishes an eligibility appeals process, an employer appeals process, or a SHOP eligibility appeals process will incur related administrative costs. However, HHS will provide such processes if States fail to do so. In addition, an effective eligibility process will reduce administrative costs, by providing resolution options that enable the vast majority of issues to be resolved by lower-level staff.

Exchanges and agents and brokers permitted by States to assist consumers will incur costs to comply with additional standards for display of QHPs when using their Web sites as Web-brokers to assist consumers select a QHP, comply with the Exchange's privacy and security standards as required in an agreement with HHS, and to submit a request for reconsideration if HHS terminates its agreement with the agent or broker. Issuers will also incur expenses to provide privacy and security training to their customer service representatives. It is anticipated that Exchanges and issuers' IT systems will need minimal changes to comply with these provisions, particularly because they must already comply with similar standards regarding protected health information.

The final rule also amends existing requirements so that SHOPs are no

longer be required to accept paper applications and applications by telephone. This may reduce the cost of operating a SHOP. A SHOP will also incur costs to develop uniform standards for the termination of a group's coverage in a QHP and to keep sufficient records of terminations and reasonable accommodations.

C. Regulatory Alternatives

Under the Executive Order, HHS is required to consider alternatives to issuing rules and alternative regulatory approaches.

One alternative considered was to establish only a Federal eligibility appeals process and not to offer State Exchanges the option to establish their own appeals processes. This alternative, however, was not selected because it would limit State flexibility and negate the administrative efficiencies available through the use of existing appeals processes. HHS believes that the option adopted for this final rule strikes the best balance of ensuring efficient operation and integrity of Exchanges while providing flexibility to the States and minimizing the burden on States.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a "small entity" as— (1) A proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (States and individuals are not included in the definition of "small entity"). HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent to 5 percent. HHS anticipates that the final rule would not have a significant economic impact on a substantial number of small entities.

As discussed in the Web Portal final rule published on May 5, 2010 (75 FR 24481), HHS examined the health insurance industry in depth in the RIA we prepared for the final rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the

size thresholds for “small” business established by the SBA (currently \$7 million in annual receipts for health issuers).¹³ In addition, HHS used the data from Medical Loss Ratio (MLR) annual report submissions for the 2011 MLR reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates may overstate the actual number of small health insurance issuers that would be affected, since they do not include receipts from these companies’ other lines of business. It is estimated that out of 466 issuers nationwide, there are 22 small entities each with less than \$7 million in earned premiums that offer individual or group health insurance coverage and would therefore be subject to the requirements of this final regulation. Thirty six percent of these small issuers belong to larger holding groups, and many if not all of these small issuers are likely to have other lines of business that would result in their revenues exceeding \$7 million. It is uncertain how many of these 466 issuers will offer QHPs and be subject to the provisions of this final rule. Based on this analysis, however, HHS expects that this final rule will not affect small issuers.

Some of the agents and brokers affected by the provisions of this final rule may be small entities and will incur costs to comply with the provisions of this final rule. The size threshold for “small” business established by the SBA is currently \$7 million in annual receipts for insurance agencies and brokerages. We anticipate that agents and brokers will continue to be an important source of assistance for many consumers seeking access to health insurance coverage through an Exchange, including those who own and/or are employed by small businesses. Due to lack of data, HHS is unable to estimate how many agents and brokers permitted by States to assist consumers would be small entities.

This final rule establishes an appeals process through which an employer may appeal a determination that the employer does not provide qualifying coverage in an eligible employer-sponsored plan with respect to the employee referenced in the notice pursuant to section 1411(f)(2) of the Affordable Care Act, or an eligibility determination for SHOP. This rule establishes standards for employers that choose to participate in a SHOP. 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 eligible to participate in the SHOP would meet the SBA standard for small entities. However, since participation in the SHOP is voluntary, this final rule does not place any requirements on small employers.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately \$141 million.

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

The final rule directs States to undertake activities for State Exchanges. There are no mandates on local or tribal governments. The private sector, for example, QHP issuers and agents and brokers, will incur costs to comply with the requirements set forth in this final rule. The related costs are estimated to be approximately \$17.5 million in 2014. However, consistent with policy embodied in UMRA, this final rule has been designed to be a low-burden alternative for State, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

F. Federalism

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

States are the primary regulators of health insurance coverage. States will continue to apply State laws regarding health insurance coverage. If any State law or requirement prevents the application of a Federal standard, then that particular State law or requirement would be preempted. State requirements

that are more stringent than the Federal requirements would be not be preempted by this final rule. Accordingly, States have significant latitude to impose requirements with respect to health insurance coverage that are more restrictive than the Federal law.

States will continue to license, monitor and regulate all agents and brokers, both inside and outside of Exchanges. All State laws related to agents and brokers, including State laws related to appointments, contractual relationships with issuers, and licensing and marketing requirements, will continue to apply. Under the final rule, States have the option to establish and operate only a State-based SHOP while the individual market Exchange is operated as an FFE. The final rule also provides additional flexibility to States with respect to the operation of a SHOP-specific Navigator program when the State establishes and operates only a SHOP Exchange. HHS would coordinate enforcement actions for QHP issuers with State efforts in order to streamline the oversight of QHP issuers by States and to avoid inappropriate duplication of enforcement actions. Because QHPs are one of several commercial market insurance products operating in State markets, HHS would not seek to inappropriately duplicate or interfere with the traditional regulatory roles played by the State departments of insurance. HHS would generally confine its QHP oversight to Exchange-specific requirements and attributes. HHS would also seek to work collaboratively with State DOIs on topics of mutual concern, in the interest of efficiently deploying oversight resources and avoiding needlessly duplicative regulatory roles. HHS may consider the regulatory action taken by a State against a QHP issuer as a factor in determining whether to decertify a QHP. HHS recognizes that States play an important role in handling consumer cases related to health insurance and HHS anticipates that States will continue to assist consumers with these grievances and complaints. QHP issuers are expected to comply with standards established by State law and regulation for cases forwarded to an issuer by a State in which it offers QHPs. States may opt to establish an eligibility appeals process and an employer appeals process or HHS will provide such a process if a State fails to do so.

The requirements specified in this final rule will impose direct costs on State and local governments and HHS has made every effort to minimize those costs. In compliance with the requirement of Executive Order 13132

¹³ “Table of Size Standards Matched To North American Industry Classification System Codes,” effective January 7, 2013, U.S. Small Business Administration, available at <http://www.sba.gov>.

that agencies examine closely any policies that may have Federalism implications or limit the policymaking discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States. Throughout the process of developing this final rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congressional intent to provide uniform protections to consumers in every State. By doing so, it is HHS's view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached final rule in a meaningful and timely manner.

G. Congressional Review Act

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

List of Subjects

45 CFR Part 147

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

45 CFR Part 153

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

45 CFR Part 155

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

tax credit, Plan variations, Actuarial value.

45 CFR Part 156

Administrative 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, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, 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 parts 147, 153, 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.

■ 2. Section 147.102 is amended by revising paragraph (a) introductory text and adding two sentences at the end of paragraph (a)(1)(ii) to read as follows:

§ 147.102 Fair health insurance premiums.

(a) *In general.* With respect to the premium rate charged by a health insurance issuer in accordance with § 156.80 of this subchapter for health insurance coverage offered in the individual or small group market—

(1) * * *

(ii) * * * For purposes of this paragraph, rating area is determined in the small group market using the group policyholder's principal business address and in the individual market using the primary policyholder's address. For plans (other than qualified health plans offered through the Federally-facilitated Small Business Health Options Program) for which an issuer can demonstrate that it relied in good faith on guidance from an applicable State authority issued before August 28, 2013, that differs from this paragraph (a)(1)(ii), the preceding sentence will not apply until the first plan year beginning on or after January

1, 2015 with respect to coverage in the small group market.

* * * * *

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

■ 3. Authority citation for part 153 is revised to read as follows:

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

§ 153.20 [Amended]

■ 4. Section 153.20 is amended by removing the definition of “Qualified health plan or QHP”.

■ 5. Section 153.500 is amended by adding a definition of “Qualified health plan or QHP” to read as follows:

§ 153.500 Definitions.

* * * * *

Qualified health plan or QHP means, with respect to the risk corridors program only —

(1) A qualified health plan, as defined at § 155.20 of this subchapter;

(2) A health plan offered outside the Exchange by an issuer that is the same plan as a qualified health plan, as defined at § 155.20 of this subchapter, offered through the Exchange by the issuer. To be the same plan as a qualified health plan (as defined at § 155.20 of this subchapter) means that the health plan offered outside the Exchange has identical benefits, premium, cost-sharing structure, provider network, and service area as the qualified health plan (as defined at § 155.20 of this subchapter); or

(3) A health plan offered outside the Exchange that is substantially the same as a qualified health plan, as defined at § 155.20 of this subchapter, offered through the Exchange by the issuer. To be substantially the same as a qualified health plan (as defined at § 155.20 of this subchapter) means that the health plan meets the criteria set forth in paragraph (2) of this definition with respect to the qualified health plan, except that its benefits, premium, cost-sharing structure, and provider network may differ from those of the qualified health plan (as defined at § 155.20 of this subchapter) provided that such differences are tied directly and exclusively to Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside an Exchange.

* * * * *

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

■ 6. 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, 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).

■ 7. Section 155.20 is amended by revising the definition for “Exchange” and by adding a definition for “Issuer application assister” to read as follows:

§ 155.20 Definitions.

* * * * *

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/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

* * * * *

Issuer application assister means an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

* * * * *

■ 8. Section 155.100 is amended by revising paragraph (a), by redesignating paragraph (b) as paragraph (c) and by adding a new paragraph (b) to read as follows:

§ 155.100 Establishment of a State Exchange.

(a) *General requirements.* Each State may elect to establish:

(1) An Exchange that facilitates the purchase of health insurance coverage in QHPs in the individual market and that provides for the establishment of a SHOP; or

(2) An Exchange that provides only for the establishment of a SHOP.

(b) *Timing.* For plan years beginning before January 1, 2015, only States that provide reasonable assurances to CMS that they will be in a position to

establish and operate only a SHOP for 2014 may elect to establish an Exchange that provides only for the establishment of a SHOP, pursuant to the process in § 155.105(c), (d), and/or (e), whichever is applicable. For plan years beginning on or after January 1, 2015, any State may elect to establish an Exchange that provides only for the establishment of a SHOP, pursuant to the process in § 155.106(a).

* * * * *

■ 9. Section 155.105 is amended by revising paragraphs (b)(1) and (2) and (f) to read as follows:

§ 155.105 Approval of a State Exchange.

* * * * *

(b) * * *

(1) The Exchange is able to carry out the required functions of an Exchange consistent with subparts C, D, E, F, G, H, and K of this part unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2), in which case the Exchange must perform the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein;

(2) The Exchange is capable of carrying out the information reporting requirements in accordance with section 36B of the Code, unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2); and

* * * * *

(f) *HHS operation of an Exchange.* (1) If a State does not elect to operate an Exchange under § 155.100(a)(1) or an electing State does not have an approved or conditionally approved Exchange pursuant to § 155.100(a)(1) 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 this case, the requirements in § 155.120(c), § 155.130 and subparts C, D, E, F, G, H, and K of this part will apply.

(2) If an electing State has an approved or conditionally approved Exchange pursuant to § 155.100(a)(2) by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate an Exchange that facilitates the purchase of health insurance coverage in QHPs in the individual market and operate such Exchange within the State. In this case, the requirements in § 155.120(c), § 155.130 and subparts C, D, E, F, G, and K of this part will apply to the Exchange operated by HHS.

■ 10. Section 155.140 is amended by revising paragraph (c)(2)(ii) to read as follows:

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.

* * * * *

(c) * * *

(2) * * *

(ii) Encompass the same geographic area for its regional or subsidiary SHOP and its regional or subsidiary Exchange except:

(A) In the case of a regional Exchange established pursuant to § 155.100(a)(2), the regional SHOP must encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of States establishing the regional SHOP; and

(B) In the case of a subsidiary Exchange established pursuant to § 155.100(a)(2), the combined geographic area of all subsidiary SHOPs established in the State must encompass the geographic area of the individual market Exchange established to serve the State.

■ 11. Section 155.200 is amended by revising paragraph (a) to read as follows:

§ 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, F, G, H, and K of this part unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2), in which case the Exchange operated by the State must perform the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein while the Exchange operated by HHS must perform the minimum functions described in this subpart and in subparts D, E, F, G, and K of this part.

* * * * *

■ 12. Section 155.220 is amended by:

■ a. Revising paragraph (c)(3)(i);

■ b. Removing the word “and” from the end of paragraph (c)(3)(v) and removing the period at the end of paragraph (c)(3)(vi) and adding “; and” in its place;

■ c. Adding paragraphs (c)(3)(vii) and (c)(4);

■ d. Revising paragraph (d)(3); and

■ e. Adding paragraphs (f), (g), and (h).

The revisions and additions read as follows:

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(c) * * *

(3) * * *

(i) Disclose and display all QHP information provided by the Exchange

or directly by QHP issuers consistent with the requirements of § 155.205(b)(1) and § 155.205(c), and to the extent that not all information required under § 155.205(b)(1) is displayed on the agent or broker's Internet Web site for a QHP, prominently display a standardized disclaimer provided by HHS stating that information required under § 155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site;

* * * * *

(vii) For the Federally-facilitated Exchange, prominently display a standardized disclaimer provided by HHS, and provide a Web link to the Exchange Web site.

(4) When an agent or broker, through a contract or other arrangement, uses the Internet Web site of another agent or broker to help an applicant or enrollee complete a QHP selection in the Federally-facilitated Exchange, and the agent or broker accessing the Web site pursuant to the arrangement is listed as the agent of record on the enrollment:

(i) The agent or broker who makes the Web site available must:

(A) Provide HHS with a list of agents and brokers who enter into such an arrangement to the Federally-facilitated Exchange, if requested by HHS;

(B) Verify that any agent or broker accessing or using the Web site pursuant to the arrangement is licensed in the State in which the consumer is selecting the QHP; and has completed training and registration and has signed all required agreements with the Federally-facilitated Exchange pursuant to paragraph (d) of this section and § 155.260(b);

(C) Ensure that its name and any identifier required by HHS prominently appears on the Internet Web site and on written materials containing QHP information that can be printed from the Web site, even if the agent or broker that is accessing the Internet Web site is able to customize the appearance of the Web site;

(D) Terminate the agent or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker;

(E) Report to HHS and applicable State departments of insurance any potential material breach of the standards in paragraphs (c) and (d) of this section, or the agreement entered into pursuant to § 155.260(b), by the agent or broker accessing the Internet Web site, should it become aware of any such potential breach.

(ii) HHS retains the right to temporarily suspend the ability of the

agent or broker making its Web site available to transact information with HHS, if HHS discovers a security and privacy incident or breach, for the period in which HHS begins to conduct an investigation and until the incident or breach is remedied to HHS' satisfaction.

* * * * *

(f) *Termination notice to HHS.* (1) An agent or broker may terminate its agreement with HHS by sending to HHS a written notice at least 30 days in advance of the date of intended termination.

(2) The notice must include the intended date of termination, but if it does not specify a date of termination, or the date provided is not acceptable to HHS, HHS may set a different termination date that will be no less than 30 days from the date on the agent's or broker's notice of termination.

(3) Prior to the date of termination, an agent or broker should—

(i) Notify applicants, qualified individuals, or enrollees that the agent or broker is assisting, of the agent's or broker's intended date of termination;

(ii) Continue to assist such individuals with Exchange-related eligibility and enrollment services up until the date of termination; and

(iii) Provide such individuals with information about alternatives available for obtaining additional assistance, including but not limited to the Federally-facilitated Exchange Web site.

(4) When termination becomes effective under paragraph this paragraph (f) or paragraph (g) of this section, the agent or broker will not be able to assist any individual through the Federally-facilitated Exchange, and the agent's or broker's agreement with the Exchange pursuant to § 155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchange.

(g) *Standards for termination for cause from the Federally-facilitated Exchange.* (1) If, in HHS's determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's or broker's agreement with the Federally-facilitated Exchange for cause.

(2) An agent or broker may be determined noncompliant if HHS finds that the agent or broker violated—

(i) Any standard specified under this section;

(ii) Any term or condition of its agreement with the Federally-facilitated

Exchange required under paragraph (d) of this section, or if the agreement with the Federally-facilitated Exchange under § 155.260(b) is terminated;

(iii) Any State law applicable to agents or brokers, as required under paragraph (e) of this section, including but not limited to State laws related to confidentiality and conflicts of interest; or

(iv) Any Federal law applicable to agents or brokers.

(3) HHS will notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(4) After the period in paragraph (g)(3) of this section has elapsed, the agent or broker will no longer be registered with the Federally-facilitated Exchange or able to transact information with HHS

(h) *Request for reconsideration of termination for cause from the Federally-facilitated Exchange.* (1) *Request for reconsideration.* An agent or broker whose agreement with the Federally-facilitated Exchange has been terminated may request reconsideration of such action in the manner and form established by HHS.

(2) *Timeframe for request.* The agent or broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written notice from HHS.

(3) *Notice of reconsideration decision.* The HHS reconsideration entity will provide the agent or broker with a written notice of the reconsideration decision within 30 calendar days of the date it receives the request for reconsideration. This decision will constitute HHS's final determination.

■ 13. Section 155.270 is amended by revising paragraph (a) to read as follows:

§ 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 that are adopted by the Secretary in 45 CFR parts 160 and 162 or that are otherwise approved by HHS.

* * * * *

■ 14. Section 155.280 is added to subpart C to read as follows:

§ 155.280 Oversight and monitoring of privacy and security requirements.

(a) *General.* HHS will oversee and monitor the Federally-facilitated Exchanges and non-Exchange entities required to comply with the privacy and security standards established and implemented by a Federally-facilitated Exchange pursuant to § 155.260 for compliance with those standards. HHS will oversee and monitor State Exchanges for compliance with the standards State Exchanges establish and implement pursuant to § 155.260. State Exchanges will oversee and monitor non-Exchange entities required to comply with the privacy and security standards established and implemented by a State Exchange pursuant to § 155.260.

(b) *Audits and investigations.* HHS may conduct oversight activities that include but are not limited to the following: audits, investigations, inspections, and any reasonable activities necessary for appropriate oversight of compliance with the Exchange privacy and security standards. HHS may also pursue civil, criminal or administrative proceedings or actions as determined necessary.

■ 15. Section 155.310 is amended by adding paragraph (k) to read as follows:

§ 155.310 Eligibility process.

* * * * *

(k) *Incomplete application.* If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must—

(1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and

(2) Provide the applicant with a period of no less than 10 days and no more than 90 days from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange.

(3) During the period described in paragraph (k)(2) of this section, the Exchange must not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost-sharing reductions, unless an application filer has provided sufficient information to determine his or her eligibility for

enrollment in a QHP through the Exchange, in which case the Exchange must make such a determination for enrollment in a QHP.

■ 16. Section 155.320 is amended by revising the section heading and paragraph (b) to read as follows:

§ 155.320 Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.

* * * * *

(b) *Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.* (1)(i) 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 for verification purposes.

(ii) 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.

(2) Consistent with § 164.512(k)(6)(i) of this subchapter, the disclosure to HHS of information regarding eligibility for and enrollment in a health plan, which may be considered protected health information, as that term is defined in § 160.103 of this subchapter, is expressly authorized, for the purposes of verification of applicant eligibility for minimum essential coverage as part of the eligibility determination process for advance payments of the premium tax credit or cost-sharing reductions.

* * * * *

■ 17. Section 155.345 is amended by revising paragraphs (i) and (j) to read as follows:

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

* * * * *

(i) *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)(1)(ii), 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.

(j) *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.

■ 18. Section 155.415 is added to read as follows:

§ 155.415 Allowing issuer application assisters to assist with eligibility applications.

(a) *Exchange option.* An Exchange, to the extent permitted by State law, may permit issuer application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and insurance affordability programs, provided that such issuer application assisters meet the requirements set forth in § 156.1230(a)(2) of this subchapter.

(b) [Reserved]

■ 19. Add Subpart F to read as follows:

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

Sec.

155.500	Definitions.
155.505	General eligibility appeals requirements.
155.510	Appeals coordination.
155.515	Notice of appeal procedures.
155.520	Appeal requests.
155.525	Eligibility pending appeal.
155.530	Dismissals.
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Subpart F—Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

§ 155.500 Definitions.

In addition to those definitions in §§ 155.20 and 155.300, for purposes of this subpart and § 155.740 of subpart H, the following terms have the following meanings:

Appeal record means the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

Appeal request means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued in accordance with §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) or (f), reviewed by an appeals entity.

Appeals entity means a body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) and (f).

Appellant means the applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

De novo review means a review of an appeal without deference to prior decisions in the case.

Evidentiary hearing means a hearing conducted where evidence may be presented.

Vacate means to set aside a previous action.

§ 155.505 General eligibility appeals requirements.

(a) *General requirements.* Unless otherwise specified, the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a State Exchange appeals entity or by the HHS appeals entity.

(b) *Right to appeal.* An applicant or enrollee must have the right to appeal—

(1) An eligibility determination made in accordance with subpart D, including—

(i) An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with the standards specified in § 155.305(a) through (h); and

(ii) A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with §§ 155.330 and 155.335;

(2) An eligibility determination for an exemption made in accordance § 155.605;

(3) A failure by the Exchange to provide timely notice of an eligibility determination in accordance with §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), or 155.610(i); and

(4) A denial of a request to vacate dismissal made by a State Exchange appeals entity in accordance with § 155.530(d)(2), made pursuant to paragraph (c)(2)(i) or this section; and

(c) *Options for Exchange appeals.* Exchange eligibility appeals may be conducted by—

(1) A State Exchange appeals entity, or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart; or

(2) The HHS appeals entity—

(i) Upon exhaustion of the State Exchange appeals process;

(ii) If the Exchange has not established an appeals process in accordance with the requirements of this subpart; or

(iii) If the Exchange has delegated appeals of exemption determinations made by HHS pursuant to § 155.625(b) to the HHS appeals entity, and the appeal is limited to a determination of eligibility for an exemption.

(d) *Eligible entities.* An appeals process established under this subpart must comply with § 155.110(a).

(e) *Representatives.* An appellant may represent himself or herself, or be represented by an authorized representative under § 155.227, or by legal counsel, a relative, a friend, or another spokesperson, during the appeal.

(f) *Accessibility requirements.* Appeals processes established under this subpart must comply with the accessibility requirements in § 155.205(c).

(g) *Judicial review.* An appellant may seek judicial review to the extent it is available by law.

§ 155.510 Appeals coordination.

(a) *Agreements.* The appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Such agreements must include a clear delineation of the responsibilities of each entity to support the eligibility appeals process, and must—

(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process;

(2) Ensure prompt issuance of appeal decisions consistent with timeliness standards established under this subpart; and

(3) Comply with the requirements set forth in—

(i) 42 CFR 431.10(d), if the state Medicaid agency delegates authority to

hear fair hearings under 42 CFR 431.10(c)(ii) to the Exchange appeals entity; or

(ii) 42 CFR 457.348(b), if the state CHIP agency delegates authority to review appeals under § 457.1120 to the Exchange appeals entity.

(b) *Coordination for Medicaid and CHIP appeals.* (1) Where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR 431.10(c)(1)(ii) or 457.1120, and the Exchange appeals entity has accepted such delegation—

(i) The Exchange appeals entity will conduct the appeal in accordance with—

(A) Medicaid and CHIP MAGI-based income standards and standards for citizenship and immigration status, in accordance with the eligibility and verification rules and procedures, consistent with 42 CFR parts 435 and 457.

(B) Notice standards identified in this subpart, subpart D, and by the State Medicaid or CHIP agency, consistent with applicable law.

(ii) Consistent with 42 CFR 431.10(c)(1)(ii), an appellant who has been determined ineligible for Medicaid must be informed of the option to opt into pursuing his or her appeal of the adverse Medicaid eligibility determination with the Medicaid agency, and if the appellant elects to do so, the appeals entity transmits the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid agency.

(2) Where the Medicaid or CHIP agency has not delegated appeals authority to the appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, the appeals entity must transmit the eligibility determination and all relevant information provided as part of the initial application or appeal, if applicable, via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

(3) The Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(c) *Data exchange.* The appeals entity must—

(1) Ensure that all data exchanges that are part of the appeals process, comply

with the data exchange requirements in §§ 155.260, 155.270, and 155.345(i); and

(2) Comply with all data sharing requests made by HHS.

§ 155.515 Notice of appeal procedures.

(a) *Requirement to provide notice of appeal procedures.* The Exchange must provide notice of appeal procedures at the time that the—

(1) Applicant submits an application; and

(2) Notice of eligibility determination is sent under §§ 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), and 155.610(i).

(b) *General content on right to appeal and appeal procedures.* Notices described in paragraph (a) of this section must contain—

(1) An explanation of the applicant or enrollee's appeal rights under this subpart;

(2) A description of the procedures by which the applicant or enrollee may request an appeal;

(3) Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or another representative;

(4) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as described in § 155.525; and

(5) An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change will be handled as a redetermination of eligibility for all household members in accordance with the standards specified in § 155.305.

§ 155.520 Appeal requests.

(a) *General standards for appeal requests.* The Exchange and the appeals entity—

(1) Must accept appeal requests submitted—

(i) By telephone;

(ii) By mail;

(iii) In person, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeal requests; and

(iv) Via the Internet.

(2) Must assist the applicant or enrollee in making the appeal request, if requested;

(3) Must not limit or interfere with the applicant or enrollee's right to make an appeal request; and

(4) Must consider an appeal request to be valid for the purpose of this subpart, if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and § 155.505(b).

(b) *Appeal request.* The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within—

(1) 90 days of the date of the notice of eligibility determination; or

(2) A timeframe consistent with the state Medicaid agency's requirement for submitting fair hearing requests, provided that timeframe is no less than 30 days, measured from the date of the notice of eligibility determination.

(c) *Appeal of a State Exchange appeals entity decision to HHS.* If the appellant disagrees with the appeal decision of a State Exchange appeals entity, he or she may make an appeal request to the HHS appeals entity within 30 days of the date of the State Exchange appeals entity's notice of appeal decision or notice of denial of a request to vacate a dismissal.

(d) *Acknowledgement of appeal request.* (1) Upon receipt of a valid appeal request pursuant to paragraph (b), (c), or (d)(3)(i) of this section, the appeals entity must—

(i) Send timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including—

(A) Information regarding the appellant's eligibility pending appeal pursuant to § 155.525; and

(B) An explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR 1.36B-4.

(ii) Send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to § 155.525, to the Exchange and to the agencies administering Medicaid or CHIP, where applicable.

(iii) If the appeal request is made pursuant to paragraph (c) of this section, send timely notice via secure electronic interface of the appeal request to the State Exchange appeals entity.

(iv) Promptly confirm receipt of the records transferred pursuant to paragraph (d)(3) or (4) of this section to the Exchange or the State Exchange appeals entity, as applicable.

(2) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section or § 155.505(b), the appeals entity must—

(i) Promptly and without undue delay, send written notice to the applicant or enrollee informing the appellant:

(A) That the appeal request has not been accepted;

(B) About the nature of the defect in the appeal request; and

(C) That the applicant or enrollee may cure the defect and resubmit the appeal

request by the date determined under paragraph (b) or (c) of this section, as applicable, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section and § 155.505(b).

(3) Upon receipt of a valid appeal request pursuant to paragraph (b) of this section, or upon receipt of the notice under paragraph (d)(1)(ii) of this section, the Exchange must transmit via secure electronic interface to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the Exchange; and

(ii) The appellant's eligibility record.

(4) Upon receipt of the notice pursuant to paragraph (d)(1)(iii) of this section, the State Exchange appeals entity must transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to the HHS appeals entity.

§ 155.525 Eligibility pending appeal.

(a) *General standards.* After receipt of a valid appeal request or notice under § 155.520(d)(1)(ii) that concerns an appeal of a redetermination under § 155.330(e) or § 155.335(h), the Exchange or the Medicaid or CHIP agency, as applicable, must continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in paragraph (b) of this section or as determined by the Medicaid or CHIP agency consistent with 42 CFR parts 435 and 457, as applicable.

(b) *Implementation.* If the tax filer or appellant, as applicable, accepts eligibility pending an appeal, the Exchange must continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

§ 155.530 Dismissals.

(a) *Dismissal of appeal.* The appeals entity must dismiss an appeal if the appellant—

(1) Withdraws the appeal request in writing;

(2) Fails to appear at a scheduled hearing without good cause;

(3) Fails to submit a valid appeal request as specified in § 155.520(a)(4); or

(4) Dies while the appeal is pending.

(b) *Notice of dismissal to the appellant.* If an appeal is dismissed under paragraph (a) of this section, the

appeals entity must provide timely written notice to the appellant, including—

- (1) The reason for dismissal;
- (2) An explanation of the dismissal's effect on the appellant's eligibility; and
- (3) An explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with paragraph (d) of this section.

(c) *Notice of the dismissal to the Exchange, Medicaid, and CHIP.* If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely notice to the Exchange, and to the agency administering Medicaid or CHIP, as applicable, including instruction regarding—

- (1) The eligibility determination to implement; and
- (2) Discontinuing eligibility provided under § 155.525, if applicable.

(d) *Vacating a dismissal.* The appeals entity must—

- (1) Vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated; and
- (2) Provide timely written notice of the denial of a request to vacate a dismissal to the appellant, if the request is denied.

§ 155.535 Informal resolution and hearing requirements.

(a) *Informal resolution.* The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A State Exchange appeals entity may also provide an informal resolution process prior to a hearing, provided that—

- (1) The process complies with the scope of review specified in paragraph (e) of this section;
- (2) The appellant's right to a hearing is preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process;
- (3) If the appeal advances to hearing, the appellant is not asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and
- (4) If the appeal does not advance to hearing, the informal resolution decision is final and binding.

(b) *Notice of hearing.* When a hearing is scheduled, the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.

(c) *Conducting the hearing.* All hearings under this subpart must be conducted—

- (1) At a reasonable date, time, and location or format;
- (2) After notice of the hearing, pursuant to paragraph (b) of this section;
- (3) As an evidentiary hearing, consistent with paragraph (e) of this section; and
- (4) By one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter.

(d) *Procedural rights of an appellant.* The appeals entity must provide the appellant with the opportunity to—

- (1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing;
- (2) Bring witnesses to testify;
- (3) Establish all relevant facts and circumstances;
- (4) Present an argument without undue interference; and
- (5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

(e) *Information and evidence to be considered.* The appeals entity must consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeals process, including at the hearing.

(f) *Standard of review.* The appeals entity will review the appeal *de novo* and will consider all relevant facts and evidence adduced during the appeals process.

§ 155.540 Expedited appeals.

(a) *Expedited appeals.* The appeals entity must establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

(b) *Denial of a request for expedited appeal.* If the appeals entity denies a request for an expedited appeal, it must—

- (1) Handle the appeal request under the standard process and issue the appeal decision in accordance with § 155.545(b)(1); and
- (2) Inform the appellant, promptly and without undue delay, through electronic or oral notification, if

possible, of the denial and, if notification is oral, follow up with the appellant by written notice, within the timeframe established by the Secretary. Written notice of the denial must include—

- (i) The reason for the denial;
- (ii) An explanation that the appeal request will be transferred to the standard process; and
- (iii) An explanation of the appellant's rights under the standard process.

§ 155.545 Appeal decisions.

(a) *Appeal decisions.* Appeal decisions must—

- (1) Be based exclusively on the information and evidence specified in § 155.535(e) and the eligibility requirements under subpart D or G of this part, as applicable, and if the Medicaid or CHIP agencies delegate authority to conduct the Medicaid fair hearing or CHIP review to the appeals entity in accordance with 42 CFR 431.10(c)(1)(ii) or 457.1120, the eligibility requirements under 42 CFR parts 435 and 457, as applicable;

(2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;

(3) Summarize the facts relevant to the appeal;

(4) Identify the legal basis, including the regulations that support the decision;

(5) State the effective date of the decision; and

(6) If the appeals entity is a State Exchange appeals entity—

(i) Provide an explanation of the appellant's right to pursue the appeal before the HHS appeals entity, including the applicable timeframe, if the appellant remains dissatisfied with the eligibility determination; and

(ii) Indicate that the decision of the State Exchange appeals entity is final, unless the appellant pursues the appeal before the HHS appeals entity.

(b) *Notice of appeal decision.* The appeals entity—

(1) Must issue written notice of the appeal decision to the appellant within 90 days of the date of an appeal request under § 155.520(b) or (c) is received, as administratively feasible.

(2) In the case of an appeal request submitted under § 155.540 that the appeals entity determines meets the criteria for an expedited appeal, must issue the notice as expeditiously as reasonably possible, consistent with the timeframe established by the Secretary.

(3) Must provide notice of the appeal decision and instructions to cease pending eligibility to the appellant, if applicable, via secure electronic

interface, to the Exchange or the Medicaid or CHIP agency, as applicable.

(c) *Implementation of appeal decisions.* The Exchange, upon receiving the notice described in paragraph (b), must promptly—

(1) Implement the appeal decision effective—

(i) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with § 155.330(f)(2) or (3), if applicable; or

(ii) Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant.

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in § 155.305.

§ 155.550 Appeal record.

(a) *Appellant access to the appeal record.* Subject to the requirements of all applicable Federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity must make the appeal record accessible to the appellant at a convenient place and time.

(b) *Public access to the appeal decision.* The appeals entity must provide public access to all appeal decisions, subject to all applicable Federal and State laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

§ 155.555 Employer appeals process.

(a) *General requirements.* The provisions of this section apply to employer appeals processes through which an employer may, in response to a notice under § 155.310(h), appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

(b) *Exchange employer appeals process.* An Exchange may establish an employer appeals process in accordance with the requirements of this section, § 155.505(f) through (g), and § 155.510(a)(1), (a)(2), and (c). Where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process that meets the requirements of this section, §§ 155.505(f) through (g), and 155.510(a)(1), (a)(2), and (c).

(c) *Appeal request.* The Exchange and appeals entity, as applicable, must—

(1) Allow an employer to request an appeal within 90 days from the date the notice described under § 155.310(h) is sent;

(2) Allow an employer to submit relevant evidence to support the appeal;

(3) Allow an employer to submit an appeal request to—

(i) The Exchange or the Exchange appeals entity, if the Exchange establishes an employer appeals process; or

(ii) The HHS appeals entity, if the Exchange has not established an employer appeals process;

(4) Comply with the requirements of § 155.520(a)(1) through (3); and

(5) Consider an appeal request valid if it is submitted in accordance with paragraph (c)(1) of this section and with the purpose of appealing the determination identified in the notice specified in § 155.310(h).

(d) *Notice of appeal request.* Upon receipt of a valid appeal request, the appeals entity must—

(1) Send timely acknowledgement of the receipt of the appeal request to the employer, including an explanation of the appeals process;

(2) Send timely notice to the employee of the receipt of the appeal request, including—

(i) An explanation of the appeals process;

(ii) Instructions for submitting additional evidence for consideration by the appeals entity; and

(iii) An explanation of the potential effect of the employer's appeal on the employee's eligibility.

(3) Promptly notify the Exchange of the appeal, if the employer did not initially make the appeal request to the Exchange.

(4) Promptly and without undue delay send written notice to the employer of an appeal request that is not valid because it fails to meet the requirements of this section. The written notice must inform the employer—

(i) That the appeal request has not been accepted;

(ii) About the nature of the defect in the appeal request; and

(iii) That the employer may cure the defect and resubmit the appeal request by the date determined under paragraph (c) of this section, or within a reasonable timeframe established by the appeals entity.

(iv) Treat as valid an amended appeal request that meets the requirements of this section, including standards for timeliness.

(e) *Transmittal and receipt of records.*

(1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph

(d)(3) of this section, the Exchange must promptly transmit via secure electronic interface to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the Exchange; and

(ii) The employee's eligibility record.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (e)(1) of this section to the entity that transmitted the records.

(f) *Dismissal of appeal.* The appeals entity—

(1) Must dismiss an appeal under the circumstances specified in § 155.530(a)(1) or if the request fails to comply with the standards in paragraph (c)(4) of this section.

(2) Must provide timely notice of the dismissal to the employer, employee, and Exchange including the reason for dismissal; and

(3) May vacate a dismissal if the employer makes a written request within 30 days of the date of the notice of dismissal showing good cause as to why the dismissal should be vacated.

(g) *Procedural rights of the employer.* The appeals entity must provide the employer the opportunity to—

(1) Provide relevant evidence for review of the determination of an employee's eligibility for advance payments of the premium tax credit or cost-sharing reductions;

(2) Review—

(i) The information described in § 155.310(h)(1);

(ii) Information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored minimum essential coverage is measured, as set forth by standards described in 26 CFR 1.36B; and

(iii) Other data used to make the determination described in § 155.305(f) or (g), to the extent allowable by law, except the information described in paragraph (h) of this section.

(h) *Confidentiality of employee information.* Neither the Exchange nor the appeals entity may make available to an employer any tax return information of an employee as prohibited by section 6103 of the Code.

(i) *Adjudication of employer appeals.* Employer appeals must—

(1) Be reviewed by one or more impartial officials who have not been directly involved in the employee eligibility determination implicated in the appeal;

(2) Consider the information used to determine the employee's eligibility as well as any additional relevant evidence provided by the employer or the employee during the course of the appeal; and

(3) Be reviewed *de novo*.

(j) *Appeal decisions*. Employer appeal decisions must—

(1) Be based exclusively on the information and evidence described in paragraph (i)(2) of this section and the eligibility standards in 45 CFR part 155, subpart D;

(2) State the decision, including a plain language description of the effect of the decision on the employee's eligibility; and

(3) Comply with the requirements set forth in § 155.545(a)(3) through (5).

(k) *Notice of appeal decision*. The appeals entity must provide written notice of the appeal decision within 90 days of the date the appeal request is received, as administratively feasible, to—

(1) The employer. Such notice must include—

(i) The appeal decision; and

(ii) An explanation that the appeal decision does not foreclose any appeal rights the employer may have under subtitle F of the Code.

(2) The employee. Such notice must include—

(i) The appeal decision; and

(ii) An explanation that the employee and his or her household members, if applicable, may appeal a redetermination of eligibility that occurs as a result of the appeal decision.

(3) The Exchange.

(l) *Implementation of the appeal decision*. After receipt of the notice under paragraph (k)(3) of this section, if the appeal decision affects the employee's eligibility, the Exchange must promptly redetermine the employee's eligibility and the eligibility of the employee's household members, if applicable, in accordance with the standards specified in § 155.305.

(m) *Appeal record*. Subject to the requirements of § 155.550 and paragraph (h) of this section, the appeal record must be accessible to the employer and to the employee in a convenient format and at a convenient time.

■ 14. In § 155.700, paragraph (b) is amended by adding the definition of "SHOP application filer" in alphabetical order to read as follows:

§ 155.700 Standards for the establishment of a SHOP.

* * * * *

(b) * * *

SHOP application filer means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by other law.

■ 15. Section 155.705 is amended by adding paragraphs (c) and (d) to read as follows:

§ 155.705 Functions of a SHOP.

* * * * *

(c) *Coordination with individual market Exchange for eligibility determinations*. A SHOP must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to § 155.100(a)(2).

(d) *Duties of Navigators in the SHOP*. In States that have elected to operate only a SHOP pursuant to § 155.100(a)(2), at State option and if State law permits the Navigator duties described in § 155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

■ 16. Section 155.730 is amended by revising paragraph (f) to read as follows:

§ 155.730 Application standards for SHOP.

* * * * *

(f) *Filing*. The SHOP must:

(1) Accept applications from SHOP application filers; and

(2) Provide the tools to file an application via an Internet Web site.

* * * * *

■ 17. Section 155.735 is added to subpart H to read as follows:

§ 155.735 Termination of coverage.

(a) *General requirements*. The SHOP must determine the timing, form, and manner in which coverage in a QHP may be terminated.

(b) *Termination of employer group health coverage at the request of the employer*. (1) The SHOP must establish policies for advance notice of termination required from the employer and effective dates of termination.

(2) In the FF-SHOP, an employer may terminate coverage for all enrollees covered by the employer group health plan effective on the last day of any month, provided that the employer has given notice to the FF-SHOP on or before the 15th day of any month. If notice is given after the 15th of the month, the FF-SHOP may terminate the coverage on the last day of the following month.

(c) *Termination of employer group health coverage for non-payment of premiums*. (1) The SHOP must establish policies for termination for non-payment of premiums, including but not limited to policies regarding due dates for payment of premiums to the SHOP, grace periods, employer and employee notices, and reinstatement provisions.

(2) In an FF-SHOP—

(i) For a given month of coverage, premium payment is due by the first day of the coverage month.

(ii) If premium payment is not received 31 days from the first of the coverage month, the FF-SHOP may terminate the qualified employer for lack of payment.

(iii) If a qualified employer is terminated due to lack of premium payment, but within 30 days following its termination the qualified employer requests reinstatement, pays all premiums owed including any prior premiums owed for coverage during the grace period, and pays the premium for the next month's coverage, the FF-SHOP must reinstate the qualified employer in its previous coverage.

(d) *Termination of employee or dependent coverage*. (1) The SHOP must establish consistent policies regarding the process for and effective dates of termination of employee or dependent coverage in the following circumstances:

(i) The employee or dependent is no longer eligible for coverage under the employer's group health plan;

(ii) The employee requests that the SHOP terminate the coverage of the employee or a dependent of the employee under the employer's group health plan;

(iii) The QHP in which the employee is enrolled terminates or is decertified as described in § 155.1080;

(iv) The enrollee changes from one QHP to another during the employer's annual open enrollment period or during a special enrollment period in accordance with § 155.725(j); or

(v) The enrollee's coverage is rescinded in accordance with § 147.128 of this subtitle.

(2) In the FF-SHOP, termination is effective on the last day of the month in which the FF-SHOP receives notice of an event described in paragraph (d)(1) of this section, and notice must have been received by the FF-SHOP prior to the proposed date of termination.

(e) *Termination of coverage tracking and approval*. The SHOP must comply with the standards described in § 155.430(c).

(f) *Applicability date*. The provisions of this section apply to coverage—

(1) Beginning on or after January 1, 2015; and

(2) In any SHOP providing qualified employers with the option described in § 155.705(b)(2) or the option described in § 155.705(b)(4) before January 1, 2015, beginning with the date that option is offered.

■ 20. Section 155.740 is added to Subpart H to read as follows:

§ 155.740 SHOP employer and employee eligibility appeals requirements.

(a) *Definitions.* The definitions in §§ 155.20, 155.300, and 155.500 apply to this section.

(b) *General requirements.* (1) A State, establishing an Exchange that provides for the establishment of a SHOP pursuant to § 155.100 must provide an eligibility appeals process for the SHOP. Where a State has not established an Exchange that provides for the establishment of a SHOP pursuant to § 155.100, HHS will provide an eligibility appeals process for the SHOP that meets the requirements of this section and the requirements in paragraph (b)(2) of this section.

(2) The appeals entity must conduct appeals in accordance with the requirements established in this section, §§ 155.505(e) through (g), and 155.510(a)(1), (a)(2), and (c).

(c) *Employer right to appeal.* An employer may appeal—

(1) A notice of denial of eligibility under § 155.715(e); or

(2) A failure of the SHOP to make an eligibility determination in a timely manner.

(d) *Employee right to appeal.* An employee may appeal—

(1) A notice of denial of eligibility under § 155.715(f); or

(2) A failure of the SHOP to make an eligibility determination in a timely manner.

(e) *Appeals notice requirement.*

Notices of the right to appeal a denial of eligibility under § 155.715(e) or (f) must be written and include—

(1) The reason for the denial of eligibility, including a citation to the applicable regulations; and

(2) The procedure by which the employer or employee may request an appeal of the denial of eligibility.

(f) *Appeal request.* The SHOP and appeals entity must—

(1) Allow an employer or employee to request an appeal within 90 days from the date of the notice of denial of eligibility to—

(i) The SHOP or the appeals entity; or

(ii) HHS, if no State Exchange that provides for establishment of a SHOP has been established;

(2) Accept appeal requests submitted through any of the methods described in § 155.520(a)(1);

(3) Comply with the requirements of § 155.520(a)(2) and (3); and

(4) Consider an appeal request valid if it is submitted in accordance with paragraph (f)(1) of this section.

(g) *Notice of appeal request.* Upon receipt of a valid appeal request, the appeals entity must—

(1) Send timely acknowledgement to the employer, or employer and

employee if an employee is appealing, of the receipt of the appeal request, including—

(i) An explanation of the appeals process; and

(ii) Instructions for submitting additional evidence for consideration by the appeals entity.

(2) Promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP.

(3) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer or employee that is appealing that—

(A) The appeal request has not been accepted,

(B) The nature of the defect in the appeal request; and

(C) An explanation that the employer or employee may cure the defect and resubmit the appeal request if it meets the timeliness requirements of paragraph (f) of this section, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section.

(h) *Transmittal and receipt of records.*

(1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (g)(2) of this section, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the SHOP; and

(ii) The eligibility record of the employer or employee that is appealing.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (h)(1) of this section to the SHOP that transmitted the records.

(i) *Dismissal of appeal.* The appeals entity—

(1) Must dismiss an appeal if the employer or employee that is appealing—

(i) Withdraws the request in writing; or

(ii) Fails to submit an appeal request meeting the standards specified in paragraph (f) of this section.

(2) Must provide timely notice to the employer or employee that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal.

(3) May vacate a dismissal if the employer or employee makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(j) *Procedural rights of the employer or employee.* The appeals entity must provide the employer, or the employer and employee if an employee is appealing, the opportunity to submit relevant evidence for review of the eligibility determination.

(k) *Adjudication of SHOP appeals.* SHOP appeals must—

(1) Comply with the standards set forth in § 155.555(i)(1) and (3); and

(2) Consider the information used to determine the employer or employee's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.

(l) *Appeal decisions.* Appeal decisions must—

(1) Be based solely on—

(i) The evidence referenced in paragraph (k)(2) of this section;

(ii) The eligibility requirements for the SHOP under § 155.710(b) or (e), as applicable.

(2) Comply with the standards set forth in § 155.545(a)(2) through (5); and

(3) Be effective retroactive to the date the incorrect eligibility determination was made, if the decision finds the employer or employee eligible, or effective as of the date of the notice of the appeal decision, if eligibility is denied.

(m) *Notice of appeal decision.* The appeals entity must issue written notice of the appeal decision to the employer, or to the employer and employee if an employee is appealing, and to the SHOP within 90 days of the date the appeal request is received.

(n) *Implementation of SHOP appeal decisions.* The SHOP must promptly implement the appeal decision upon receiving the notice under paragraph (m) of this section.

(o) *Appeal record.* Subject to the requirements of § 155.550, the appeal record must be accessible to the employer, or employer and employee if an employee is appealing, in a convenient format and at a convenient time.

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

■ 21. 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, and 1401–1402, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18042).

■ 22. Section 156.20 is amended by adding definitions for “*Delegated*

entity” and “Downstream entity” to read as follows:

§ 156.20 Definitions.

* * * * *

Delegated entity means any party, including an agent or broker, that enters into an agreement with a QHP issuer to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Downstream entity means any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term “downstream entity” is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

* * * * *

■ 23. Section 156.270 is amended by revising paragraph (b) introductory text to read as follows:

§ 156.270 Termination of coverage for qualified individuals.

* * * * *

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

* * * * *

■ 24. Section 156.285 is amended by revising paragraphs (d)(1)(i) and (iii) to read as follows:

§ 156.285 Additional standards specific to SHOP.

* * * * *

(d) * * *

(1) * * *

(i)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage established in § 155.735 of this subchapter, if applicable to the coverage being terminated; otherwise

(B) General requirements regarding termination of coverage established in § 156.270(a) of this subchapter.

* * * * *

(iii)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage effective dates as set forth in § 155.735 of this subchapter, if applicable to the coverage being terminated; otherwise

(B) Requirements regarding termination of coverage effective dates as set forth in § 156.270(i).

* * * * *

■ 25. Subpart D is added to read as follows:

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

§ 156.340 Standards for downstream and delegated entities.

(a) *General requirement.* Effective October 1, 2013, notwithstanding any relationship(s) that a QHP issuer may have with delegated and downstream entities, a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, as applicable, with all applicable standards, including—

(1) Standards of subpart C of part 156 with respect to each of its QHPs on an ongoing basis;

(2) Exchange processes, procedures, and standards in accordance with subparts H and K of part 155 and, in the small group market, § 155.705 of this subchapter;

(3) Standards of § 155.220 of this subchapter with respect to assisting with enrollment in QHPs; and

(4) Standards of §§ 156.705 and 156.715 for maintenance of records and compliance reviews for QHP issuers operating in a Federally-facilitated Exchange or FF-SHOP.

(b) *Delegation agreement specifications.* If any of the QHP issuer's activities or obligations, in accordance with paragraph (a) of this section, are delegated to other parties, the QHP issuer's agreement with any delegated or downstream entity must—

(1) Specify the delegated activities and reporting responsibilities;

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

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

(4) Specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with

Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period; and

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

■ 26. Subpart I is added to read as follows:

Subpart I—Enforcement Remedies in Federally-Facilitated Exchanges

Sec.

156.800 Available remedies; Scope.

156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

Subpart I—Enforcement Remedies in Federally-Facilitated Exchanges

§ 156.800 Available remedies; Scope.

(a) *Kinds of sanctions.* HHS may impose the following types of sanctions on QHP issuers in a Federally-facilitated Exchange that are not in compliance with Exchange standards applicable to issuers offering QHPs in the Federally-facilitated Exchange:

(1) Civil money penalties as specified in § 156.805; and

(2) Decertification of a QHP offered by the non-compliant QHP issuer in a Federally-facilitated Exchange as described in § 156.810.

(b) *Scope.* Sanctions under subpart I are applicable only for non-compliance with QHP issuer participation standards and other standards applicable to issuers offering QHPs in a Federally-facilitated Exchange.

(c) *Compliance standard.* For 2014, sanctions under this subpart will not be imposed if the QHP issuer has made good faith efforts to comply with applicable requirements.

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

(a) *Grounds for imposing civil money penalties.* Civil money penalties may be imposed on an issuer in a Federally-facilitated Exchange by HHS if, based on credible evidence, HHS has reasonably determined that the issuer has engaged in one or more of the following actions:

(1) Misconduct in the Federally-facilitated Exchange or substantial non-compliance with the Exchange standards applicable to issuers offering QHPs in the Federally-facilitated Exchange under subparts C through G of part 153 of this subchapter;

(2) Limiting the QHP's enrollees' access to medically necessary items and services that are required to be covered as a condition of the QHP issuer's ongoing participation in the Federally-facilitated Exchange, if the limitation has adversely affected or has a substantial likelihood of adversely affecting one or more enrollees in the QHP offered by the QHP issuer;

(3) Imposing on enrollees premiums in excess of the monthly beneficiary premiums permitted by Federal standards applicable to QHP issuers participating in the Federally-facilitated Exchange;

(4) Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment into a QHP offered by the issuer (except as permitted by this part) by qualified individuals whose medical condition or history indicates the potential for a future need for significant medical services or items;

(5) Intentionally or recklessly misrepresenting or falsifying information that it furnishes—

(i) To HHS; or

(ii) To an individual or entity upon which HHS relies to make its certifications or evaluations of the QHP issuer's ongoing compliance with Exchange standards applicable to issuers offering QHPs in the Federally-facilitated Exchange;

(6) Failure to remit user fees assessed under § 156.50(c); or

(7) Failure to comply with the cost-sharing reductions and advance payments of the premium tax credit standards of subpart E of this Part.

(b) *Factors in determining the amount of civil money penalties assessed.* In determining the amount of civil money penalties, HHS may take into account the following:

(1) The QHP issuer's previous or ongoing record of compliance;

(2) The level of the violation, as determined in part by—

(i) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread; and

(ii) The magnitude of financial and other impacts on enrollees and qualified individuals; and

(3) Aggravating or mitigating circumstances, or other such factors as justice may require, including complaints about the issuer with regard to the issuer's compliance with the medical loss ratio standards required by the Affordable Care Act and as codified by applicable regulations.

(c) *Maximum penalty.* The maximum amount of penalty imposed for each

violation is \$100 for each day for each QHP issuer for each individual adversely affected by the QHP issuer's non-compliance; and where the number of individuals cannot be determined, HHS may estimate the number of individuals adversely affected by the violation.

(d) *Notice of intent to issue civil money penalty.* If HHS proposes to assess a civil money penalty in accordance with this part, HHS will send a written notice of this decision to—

(1) The QHP issuer against whom the civil money penalty is being imposed, whose notice must include the following:

(i) A description of the basis for the determination;

(ii) The basis for the penalty;

(iii) The amount of the penalty;

(iv) The date the penalty is due;

(v) An explanation of the issuer's right to a hearing under an applicable administrative hearing process; and

(vi) Information about where to file the request for hearing.

(2) [Reserved]

(e) *Failure to request a hearing.* (1) If the QHP issuer does not request a hearing within 30 days of the issuance of the notice described in paragraph (d)(1) of this section, HHS may assess the proposed civil money penalty.

(2) HHS will notify the QHP issuer in writing of any penalty that has been assessed and of the means by which the responsible entity may satisfy the judgment.

(3) The QHP issuer has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with the requirements of the applicable administrative hearing process unless the QHP issuer can show good cause, as determined under § 156.905(b), for failing to timely exercise its right to a hearing.

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) *Bases for decertification.* A QHP may be decertified on one or more of the following grounds:

(1) The QHP issuer substantially fails to comply with the Federal laws and regulations applicable to QHP issuers participating in the Federally-facilitated Exchange;

(2) The QHP issuer substantially fails to comply with the standards related to the risk adjustment, reinsurance, or risk corridors programs under 45 CFR part 153, including providing HHS with valid risk adjustment, reinsurance or risk corridors data;

(3) The QHP issuer substantially fails to comply with the transparency and marketing standards in §§ 156.220 and 156.225;

(4) The QHP issuer substantially fails to comply with the standards regarding advance payments of the premium tax credit and cost-sharing in subpart E of this part;

(5) The QHP issuer is operating in the Federally-facilitated Exchange in a manner that hinders the efficient and effective administration of the Exchange;

(6) The QHP no longer meets the conditions of the applicable certification criteria;

(7) Based on credible evidence, the QHP issuer has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data;

(8) The QHP issuer substantially fails to meet the requirements under § 156.230 related to network adequacy standards or, § 156.235 related to inclusion of essential community providers;

(9) The QHP issuer substantially fails to comply with the law and regulations related to internal claims and appeals and external review processes; or

(10) The State recommends to HHS that the QHP should no longer be available in a Federally-facilitated Exchange.

(11) The QHP issuer substantially fails to comply with the privacy or security standards set forth in § 156.260.

(b) *State sanctions and determinations.* (1) *State sanctions.* HHS may consider regulatory or enforcement actions taken by a State against a QHP issuer as a factor in determining whether to decertify a QHP offered by that issuer.

(2) *State determinations.* HHS may decertify a QHP offered by an issuer in a Federally-facilitated Exchange based on a determination or action by a State as it relates to the issuer offering QHPs in a Federally-facilitated Exchange, including when a State places an issuer or its parent organization into receivership or when the State recommends to HHS that the QHP no longer be available in a Federally-facilitated Exchange.

(c) *Standard decertification process.* For decertification actions on grounds other than those described in paragraphs (a)(7), (8), or (9) of this section, HHS will provide written notices to the QHP issuer, enrollees in that QHP, and the State department of insurance in the State in which the QHP is being decertified. The written notice must include the following:

(1) The effective date of the decertification, which will be a date specified by HHS that is no earlier than 30 days after the date of issuance of the notice;

(2) The reason for the decertification, including the regulation or regulations that are the basis for the decertification;

(3) For the written notice to the QHP issuer, information about the effect of the decertification on the ability of the issuer to offer the QHP in the Federally-facilitated Exchange and must include information about the procedure for appealing the decertification by making a hearing request; and

(4) The written notice to the QHP enrollees must include information about the effect of the decertification on enrollment in the QHP and about the availability of a special enrollment period, as described in § 155.420 of this subchapter.

(d) *Expedited decertification process.* For decertification actions on grounds described in paragraphs (a)(7), (8), or (9) of this section, HHS will provide written notice to the QHP issuer, enrollees, and the State department of insurance in the State in which the QHP is being decertified. The written notice must include the following:

(1) The effective date of the decertification, which will be a date specified by HHS; and

(2) The information required by paragraphs (c)(2) through (4) of this section.

(e) *Appeals.* An issuer may appeal the decertification of a QHP offered by that issuer under paragraph (c) or (d) of this section by filing a request for hearing under an applicable administrative hearing process.

(1) *Effect of request for hearing.* If an issuer files a request for hearing under this paragraph,

(i) If the decertification is under paragraph (c) of this section, the decertification will not take effect prior to the issuance of the final administrative decision in the appeal, notwithstanding the effective date specified in the notice under paragraph (c)(1) of this section.

(ii) If the decertification is under paragraph (d) of this section, the decertification will be effective on the date specified in the notice of decertification, but the certification of the QHP may be reinstated immediately upon issuance of a final administrative decision that the QHP should not be decertified.

(2) [Reserved]

■ 27. Subpart K is added to read as follows:

Subpart K—Cases Forwarded to Qualified Health Plans and Qualified Health Plan Issuers in Federally-facilitated Exchanges

§ 156.1010 Standards.

(a) A case is a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to State or Federal laws regulating insurance, concerning the person or entity's activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination as defined in § 147.136(a)(2)(i) of this subchapter. Issues related to adverse benefit determinations are not addressed in this section and are subject to the provisions in § 147.136 of this subchapter governing internal claims appeals and external review. Issues related to eligibility determination processes and appeals are not addressed in this section and are subject to the provisions in Subpart F of Part 155.

(b) QHP issuers operating in a Federally-facilitated Exchange must investigate and resolve, as appropriate, cases from the complainant forwarded to the issuer by HHS. Cases received by a QHP issuer operating in a Federally-facilitated Exchange directly from a complainant or the complainant's authorized representative will be handled by the issuer through its internal customer service process.

(c) Cases may be forwarded to a QHP issuer operating in a Federally-facilitated Exchange through a casework tracking system developed by HHS or other means as determined by HHS.

(d) Cases received by a QHP issuer operating in a Federally-facilitated Exchange from HHS must be resolved within 15 calendar days of receipt of the case. Urgent cases as defined in paragraph (e) of this section that do not otherwise fall within the scope of § 147.136 of this subchapter must be resolved no later than 72 hours after receipt of the case. Where applicable State laws and regulations establish timeframes for case resolution that are stricter than the standards contained in this paragraph, QHP issuers operating in a Federally-facilitated Exchange must comply with such stricter laws and regulations.

(e) For cases received from HHS by a QHP issuer operating in a Federally-facilitated Exchange, an urgent case is one in which there is an immediate need for health services because the non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, or health or ability to attain, maintain, or regain maximum function; or one in which the process

for non-urgent cases would jeopardize the enrollee's or potential enrollee's ability enroll in a QHP through the Federally-facilitated Exchange.

(f) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange are required to notify complainants regarding the disposition of the case as soon as possible upon resolution of the case, but in no event later than three (3) business days after the case is resolved.

(1) For the purposes of meeting the requirement in this paragraph (f), notification may be by verbal or written means as determined most appropriate by the QHP issuer.

(2) In instances when the initial notification of a case's disposition is not written, written notification must be provided to the consumer in a timely manner.

(g) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange must use the casework tracking system developed by HHS, or other means as determined by HHS, to document the following:

(1) The date of resolution of a case received from HHS;

(2) A resolution summary of the case no later than seven (7) business days after resolution of the case. The record must include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution; and

(3) For a case in which a State agency, including but not limited to a State department of insurance, conducts an investigation related to that case, any compliance issues identified by the State agency implicating the QHP or QHP issuer.

(h) Cases received by a QHP issuer operating in a Federally-facilitated Exchange from a State in which the issuer offers QHPs must be investigated and resolved according to applicable State laws and regulations. With respect to cases directly handled by the State, HHS or any other appropriate regulatory authority, QHP issuers operating in a Federally-facilitated Exchange must cooperate fully with the efforts of the State, HHS, or other regulatory authority to resolve the case.

■ 28. Subpart M is added to read as follows:

Subpart M—Qualified Health Plan Issuer Responsibilities

Sec.

156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

156.1240 Enrollment process for qualified individuals.

Subpart M—Qualified Health Plan Issuer Responsibilities

§ 156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

(a) A QHP issuer that is directly contacted by a potential applicant may, at the Exchange's option, enroll such applicant in a QHP in a manner that is considered through the Exchange. In order for the enrollment to be made directly with the issuer in a manner that is considered to be through the Exchange, the QHP issuer needs to comply with at least the following requirements:

(1) *QHP issuer general requirements.*

(i) The QHP issuer follows the enrollment process for qualified individuals consistent with § 156.265.

(ii) The QHP issuer's Web site provides applicants the ability to view QHPs offered by the issuer with the data elements listed in § 155.205(b)(1)(i) through (viii) of this subchapter.

(iii) The QHP issuer's Web site clearly distinguishes between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(iv) The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to and describes how to access the Exchange Web site.

(v) The QHP issuer's Web site allows applicants to select and attest to an advance payment of the premium tax credit amount, if applicable, in accordance with § 155.310(d)(2) of this subchapter.

(2) *QHP issuer application assister eligibility application assistance requirements.* If permitted by the Exchange pursuant to § 155.415 of this subchapter, and to the extent permitted by State law, a QHP issuer may permit its issuer application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, provided that such issuer ensures that each of its application assisters at least—

(i) Receives training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations;

(ii) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260 of this subchapter; and

(iii) Complies with applicable State law related to the sale, solicitation, and negotiation of health insurance products, including applicable State law related to agent, broker, and producer licensure; confidentiality; and conflicts of interest.

(b) *Direct enrollment in a Federally-facilitated Exchange.* The individual market Federally-facilitated Exchanges will permit issuers of QHPs in each Federally-facilitated Exchange to

directly enroll applicants in a manner that is considered to be through the Exchange, pursuant to paragraph (a) of this section, to the extent permitted by applicable State law.

§ 156.1240 Enrollment process for qualified individuals.

(a) *Premium payment.* A QHP issuer must—

(1) Follow the premium payment process established by the Exchange in accordance with § 155.240.

(2) At a minimum, for all payments in the individual market, accept paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method.

(b) [Reserved]

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 13, 2013.

Marilyn Tavenner,
Administrator, Centers for Medicare & Medicaid Services.

Approved: August 15, 2013.

Kathleen Sebelius,
Secretary, Department of Health and Human Services.

[FR Doc. 2013-21338 Filed 8-28-13; 4:15 pm]

BILLING CODE 4120-01-P

**STATE OF MINNESOTA
INTERAGENCY AGREEMENT
MNsire Appeals First Amendment**

Contract Start Date: May 23, 2013
Original Contract Expiration Date: June 30, 2014
Current Contract Expiration Date: June 30, 2014
Requested Contract Expiration Date: June 30, 2014

Total Contract Amount: \$240,000*
Original Contract Amount: \$240,000†
Previous Amendment(s) Total: n/a
First Amendment Amount: \$0.00

This amendment is by and between the State of Minnesota, through its Commissioner of Human Services ("DHS"), Chief Judge of Office of Administrative Hearings, and MNsure Board of Directors, identified as Interagency Agreement MNsure Appeals.

WHEREAS, the Minnesota Department of Human Services (hereinafter "DHS"); the Minnesota Health Insurance Marketplace (hereinafter "MNsire"); and the Minnesota Office of Administrative Hearings (hereinafter "OAH") are empowered to enter into interagency agreements pursuant to Minnesota Statutes, section 471.59, subdivision 10; and

WHEREAS, the regulations at Code of Federal Regulations, title 45, part 155 empower MNsure to conduct Exchange eligibility appeals; the Laws of Minnesota 2013, Chapter 9, Section 7, subdivision 1 empowers MNsure to exercise all powers reasonably necessary to implement and administer the requirements of Minnesota Statutes, Chapter 62V and the Affordable Care Act, Public Law 111-148; and the Laws of Minnesota 2013, Chapter 9, Section 7, subdivision 6, allow MNsure to conduct eligibility hearings, appoint hearing officers, and recommend final orders related to appeals of any MNsure determinations, except for those determinations where a state agency hearing is available under Minnesota Statutes, section 256.045; and

WHEREAS, the regulations at Code of Federal Regulations, title 45, part 155.110(a)(1)-(2) empower MNsure to enter into agreements with eligible entities to carry out Exchange functions, including the State Medicaid agency, and other State agencies that have demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage, and that is not a health insurance issuer; and

WHEREAS, Laws of Minnesota 2013, Chapter 9, Section 7, subdivision 6(b) allow MNsure to establish service level agreements with other state agencies to conduct hearings for appeals; and

WHEREAS, the regulations at Code of Federal Regulations, title 42, part 435.1200(b)(3) require an agreement between the State Medicaid agency and the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs; and

WHEREAS, the [proposed] regulations at Code of Federal Regulations, title 45, part 155.510 require an agreement between the appeals entity and the agency administering insurance affordability programs regarding the appeals processes for such programs; and

* This total amount also includes direct charging for salaries to meet initial staffing recruit and hire until September 30, 2013.

† This total amount also includes direct charging for salaries to meet initial staffing recruit and hire until September 30, 2013.

WHEREAS, DHS is the designated state Medicaid agency and currently conducts administrative hearings related to Medicaid eligibility determinations; and

WHEREAS, OAH is an appeals tribunal within the Minnesota Executive branch that conducts administrative hearings throughout the State, and resolves cases involving claims to workers' compensation and disability benefits, regulation of Minnesota's insurance industry, the practice of licensed health care providers and the operation of nursing care facilities; and

WHEREAS, MNsure requires adjudication, design and consultation services for MNsure eligibility appeals; and

WHEREAS, the intent of this Agreement does not alter the authority of DHS or the consideration and payment for costs pertaining to appeals of Medical Assistance (MA), MinnesotaCare, a Basic Health Plan (BHP), including MA eligibility determined by Modified Adjusted Gross Income (MAGI); and

WHEREAS, DHS, MNsure, and OAH have a mutual interest in the design, development, and efficient operation of the MNsure appeals system that is uniform, easily accessible to Minnesota consumers, efficient, and cost effective.

NOW, THEREFORE, it is agreed:

I. DHS Duties: DHS shall,

- a. Ensure proper initial staffing levels by immediately recruiting and hiring 6 human services judges, 1 paralegal, 2 support staff and a supervisor human services judge no later than July 30, 2013;
- b. Submit to OAH and MNsure bi-weekly project plan updates until June 1, 2014, or a later agreed upon date;
- c. Coordinate with MNsure on direct charging for salaries for the following staff to meet initial staffing recruit and hire: 6 human services judges, 1 paralegal, 2 support staff and a supervisor human services judge. The direct charging for these staff will follow an agreed upon process for direct charging of staff through SEMA4 and will cover the time period from hire through September 30, 2013;

Revision 1. Clause I, "DHS duties" is amended to add, in accordance with Exhibit A:

- d. Adjudicate, including issuing final orders of eligibility determinations, all MNsure eligibility appeals, provided, DHS under its discretion may subcontract with OAH;
- e. Manage the intake of all MNsure eligibility appeals;
- f. Provide redaction of a representative sample of final decisions to be publically posted, provided, DHS may subcontract with OAH;
- g. Send all correspondence regarding MNsure eligibility appeals to the parties, including, but not limited to, an acknowledgement of receipt of appeal requests, hearing notices, and decisions, provided, DHS may subcontract with OAH;
- h. Submit measurable reports, as agreed upon, to MNsure;
- i. Investigate and respond to all complaints received pertaining to DHS's handling of

MNsure appeals and respond to complainant, copying MNsure's Authorized Representative;

II. OAH Duties: OAH shall:

- a. Provide consultation services to MNsure and DHS, as agreed upon and subject to MNsure and DHS approval, including:
 - i. Drafting policies and procedures related to MNsure eligibility appeals;
 - ii. Drafting templates for appellant correspondence (notices), recommended decisions, and MNsure Orders of eligibility determinations;
 - iii. Drafting training materials and plans for MNsure eligibility appeals judges based upon DHS appeals judge manual;
 - iv. Drafting public education materials;
 - v. Documenting MNsure eligibility appeals process flow and business requirements, provided, advice and consultation from MNsure and DHS;
 - vi. Consultation regarding the development and use of an internal decisions database to ensure decision consistency;
- b. Submit to DHS and MNsure bi-weekly project plan updates until June 1, 2014, or a later agreed upon date;
- c. Submit measurable reports, as agreed upon, to MNsure;
- d. Provide information, reports and testimony, upon request and as agreed, to the Minnesota Legislature and other entities; and
- e. Invoice MNsure for the costs of consultation services provided under Section II, paragraphs (a), (b), (c) and (d) at the following rates:
 - i. Technical/Business consulting at a rate of \$85.00 per hour;
 - ii. Judges at a rate of \$75.00 per hour;
 - iii. Managers at a rate of \$60.00 per hour;
 - iv. Attorneys at a rate of \$47.00 per hour;
 - v. Professional staff at a rate of \$35.00 per hour; and
 - vi. Support staff at a rate of \$27.00 per hour.

The total costs of these consultation services shall not exceed \$240,000.00. The rates and total costs established in this section shall remain in place for the initial six (6) months of the Agreement. OAH may seek to amend the rates and total costs after the initial six (6) months of this Agreement, based on the evolving needs of the parties and the project.

Revision 2. Clause II, "OAH duties" is amended to add, in accordance with Exhibit A:

- f. Investigate and respond to all complaints received pertaining to OAH's handling of MNsure appeals, if any, and respond to complainant, copying MNsure's Authorized Representative;

III. MNsure Duties: MNsure shall:

- a. Provide the consultation, coordination, and directive services of a full time MNsure Appeals Manager;

- b. Provide the design for public interfacing for MNsure eligibility appeals;
- c. Pay DHS and OAH in accordance with clauses I and II above; and
- d. Coordinate with DHS on direct charging for salaries utilizing for the following staff to meet initial staffing recruit and hire: 6 human services judges, 1 paralegal, 2 support staff and a supervisor human services judge. The direct charging for these staff will follow an agreed upon process for direct charging of staff through SEMA4 and will cover the time period from hire until a mutually agreed upon date to be determined prior to September 30, 2013. If no date for which direct charge will cease is amended into this agreement prior to September 30, 2013, direct charge will only cover the time period through September 30, 2013.

Revision 3. Clause III, "MNsure duties" is amended, in accordance with Exhibit A, as follows:

- c. Pay DHS and OAH in accordance with clauses I, II, and IV and ~~II~~ above; and

IV. Consideration and Payment

- a. Consideration for all services performed by DHS pursuant to this agreement shall be paid by the MNsure as follows: MNsure shall pay DHS for its costs as provided in clause I of this agreement. Further consideration and payment terms shall be agreed upon by all parties and incorporated into this agreement as part of an amendment duly agreed upon and executed under the requirements of Section VIII. Amendments. Such consideration and payment terms are anticipated to be incorporated into this agreement no later than July 31, 2013.
- b. Terms of Payment. Payment shall be made by MNsure within 30 days after DHS has presented to MNsure's Authorized Representative invoices for services performed to MNsure.
- c. Consideration for all services performed by OAH pursuant to this agreement shall be paid by the MNsure as follows: MNsure shall pay OAH for its costs as provided in clause II of this agreement. Further consideration and payment terms shall be agreed upon by all parties and incorporated into this agreement as part of an amendment duly agreed upon and executed under the requirements of Section VIII. Amendments. Such consideration and payment terms are anticipated to be incorporated into this agreement no later than July 31, 2013.
- d. Terms of Payment. Payment shall be made by MNsure within 30 days after OAH has presented to MNsure's Authorized Representative invoices for services performed to MNsure.

Revision 4. Clause IV, "Consideration and Payment" is amended to add:

- e. Upon October 1, 2013, consideration for all services performed by DHS pursuant to this agreement shall be paid in accordance with DHS's cost allocation procedures, incorporated in a separate agreement between MNsure and DHS.

V. Conditions of Payment

All services provided by DHS and OAH under this Agreement must be performed to the satisfaction of MNsure, as determined at the reasonable discretion of its Authorized Representative.

VI. Term of Agreement:

Effective date: May 17, 2013, or the date the State obtains all required signatures.

Expiration date: June 30, 2014, or until all obligations have been satisfactorily fulfilled, whichever is later.

VII. Authorized Representative

DHS's Authorized Representative is Darwin Lookingbill, Director of DHS Appeals Division, or his successor.

OAH's Authorized Representative is Honorable Tammy L. Pust, Chief Administrative Law Judge, or her successor.

MNsured's Authorized Representative is Jessica Kennedy, MNsure Appeals Manager & Legal Counsel, 85 7th Place East, Suite 120, St. Paul, MN 55101-2198, 612-279-8955, Jessica.M.Kennedy@state.mn.us or her successor.

Revision 5. Clause VII, "Authorized Representative" is amended as follows:

MNsured's Authorized Representative is Jessica Kennedy, MNsure Appeals Manager & Legal Counsel, 85 7th Place East, Suite 120, St. Paul, MN 55101-2198, 81 Seventh Street East, Suite 300, St. Paul, MN 55101-2211, 612-279-8955, Jessica.M.Kennedy@state.mn.us or her successor.

VIII. Amendments

Any amendment to this Agreement must be in writing and will not be effective until it has been approved and executed by the parties.

IX. Audits

DHS and OAH shall surrender its books, records, documents, and accounting procedures and practices relevant to MNsure eligibility appeals for examination by any state or federal authorized auditor, as required or as appropriate as a contractor carrying out Exchange functions, for the duration of this Agreement and a minimum of six years from the end of this Agreement.

X. Reporting

DHS and OAH shall create reports relevant to this agreement required by state or federal law.

XI. Liability

Each party will be responsible for its own acts and behavior and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other parties and the results thereof. The liability of each party shall be governed by the provisions of the Minnesota Tort Claims Act, Minnesota Statutes, Section 3.736, and other applicable law.

XII. Cancellation.

This agreement may be canceled by any party at any time, with or without cause, upon one hundred eighty (180) days written notice to the other party. In the event of such a cancellation, parties providing services shall be entitled to payment, determined on a pro rata basis, for work or services

satisfactorily performed.

XIV. Assignment

No party to this agreement shall assign or transfer any rights or obligations under this agreement without the prior written consent of the other parties.

XV. Information Privacy Protection

For purposes of executing its responsibilities and to the extent set forth in this Agreement, all parties will be considered part of the "welfare system," as defined in Minnesota Statutes, section 13.46, subdivision 1. The employees and agents of each agency will have access to private or confidential data maintained by the other agencies to the extent necessary to carry out the parties respective responsibilities under this Agreement. Each party agrees to comply with all relevant requirements of the Minnesota Government Data Practices Act (hereinafter "Data Practices Act," Minnesota Statutes, Chapter 13) in providing services under this Agreement. Darwin Lookingbill, Director of DHS Appeals Division (DHS's employee or agent) or his successor, Michael Lewis (OAH's employee or agent) or his successor, and Jessica Kennedy, MNsure Appeals Manager (MNsure's employee or agent) or her successor are the responsible authorities in charge of all data collected, used, or disseminated by their respective agencies in connection with the performance of this Agreement. See Minn. Stat. § 13.46, subd. 10.

Duty to ensure proper handling of data: Each party shall be responsible for training their respective employees who are authorized to access and use the data collected under the terms and for the purposes specified in this Agreement. This responsibility includes ensuring that staff are properly trained regarding:

- The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, and in particular, §13.46 ("welfare data");
- The Minnesota Health Records Act; Minn. Stat. §§144.291-144.298;
- Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 USCS § 290dd-2 and 42 CFR § 2.1 to § 2.67;
- The Health Insurance Portability Accountability Act ("HIPAA"), 45 CFR Parts 160 and 164 (if applicable);
- Electronic Health Records (as governed by Health Information Technology for Economic and Clinical Health Act (HITECH); 42 USC 201 note, 42 USC 17931); and
- Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

Minimum necessary access to data:

Each party shall comply with the "minimum necessary" access and disclosure standards set forth in the Data Practices Act. The dissemination of "private" and/or "confidential" data on individuals is limited to "that necessary for the administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." See Minnesota Statutes, § 13.05, subd. 3.

Each Party shall:

- (1) Not use or further disclose the information other than as permitted or required by this Agreement or

as required by law;

(2) Use appropriate safeguards to prevent use or disclosure of the information by its employees other than as provided for by this Agreement;

(3) Report any use or disclosure of the information not provided for by this Agreement of which it becomes aware;

(4) Consistent with this Agreement, ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides private or confidential data, agree to be bound by the same restrictions and conditions that apply to them with respect to such information;

(5) Upon completion, expiration or termination of this Agreement, return or destroy all protected information received from the other agency, unless return or destruction is not feasible. If return or destruction is not feasible, each agency will extend the protections of this agreement to the information collected during the course of this Agreement.

Release of data:

No private or confidential data created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement will be disseminated except as authorized by statute, either during the period of this Agreement or hereafter. Each party shall be independently responsible for compliance with any requirements of the Health Insurance Portability Accountability Act ("HIPAA," 45 CFR §§160 and 164), and neither party will be liable for any violation of any provision of HIPAA indirectly or directly arising out of, resulting from, or in any manner attributable to actions of the other party or its employees or agents.

Each party agrees that each is independently responsible for complying with the Minnesota Data Practices Act, Minnesota Statutes Chapter 13, and that each party will be responsible for its own acts and those of its employees and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other party or its employees, or the results thereof.

This Amendment is effective September 30, 2014, or the date the State obtains all required signatures.

Except as amended herein, the terms and conditions of the Original Contract and all previous amendments remain in full force and effect.

1. Minnesota Department of Human Services

By: [Signature]

(with delegated authority)

Title: Director of Appeals

Date: 9/19/2013

2. Minnesota Office of Administrative Hearings

By: [Signature]

(with delegated authority)

Title: Chief Administrative Law Judge

Date: September 26, 2013

3. MNsure

By: [Signature]

(with delegated authority)

Title: MNsure CFO

Date: 9/27/13

Exhibit A
STATE OF MINNESOTA
INTERAGENCY AGREEMENT
Statement of Work
MNsured Appeals

I. Contractor Department of Human Services (DHS) will perform the following tasks.

1. Staffing and Training

No later than July 31, 2013, DHS will devise an initial staffing plan that will provide sufficient staffing levels necessary for adjudicating eligibility appeals and all other functions incorporated through this Agreement, in accordance with state and federal law and MNsure policies and procedures, provided, DHS may subcontract with OAH. DHS will train its MNsure appeals staff according to the training plan developed by OAH. DHS will monitor staffing levels on an ongoing basis and will preemptively identify options for filling staffing vacancies on short notice. DHS will monitor on an ongoing basis all staffing and training weakness and report the same upon identification to MNsure and OAH, which will actively identify potential solutions for DHS to explore.

2. Project Plan

DHS will submit bi-weekly project plans to MNsure and OAH until June 1, 2014, or a later agreed upon date. MNsure will provide DHS with a template project plan to be populated, beginning one week after the final execution of this Agreement or upon a later date, if determined by MNsure's Authorized Representative. DHS will send its updated project plan to the Authorized Representative for MNsure and OAH, respectively, no later than 5pm on the date due. MNsure's Authorized Representative will be made available for assistance in developing and updating said project plan, upon request.

3. Adjudication

DHS will adjudicate all MNsure eligibility appeals, provided, DHS may subcontract with the Office of Administrative Hearings (OAH) on:

- 3.1 Any MNsure determination of eligibility to enroll in a Qualified Health Plan (QHP) through MNsure, including redeterminations in accordance with 45 C.F.R. § 155.305 (a)-(b) (2013); 45 C.F.R. § 155.330 (2013); and 45 C.F.R. § 155.335 (2013);
- 3.2 Any MNsure determination of eligibility for and level of Advanced Payment Tax Credit (APTC), and eligibility for and level of Cost Sharing Reductions (CSR), including redeterminations in accordance with 45 C.F.R. § 155.305 (f)-(g) (2013); 45 C.F.R. § 155.330 (2013); and 45 C.F.R. § 155.335 (2013);
- 3.3 Any MNsure determination or redetermination of eligibility for employee and/or employer in a Small Business Health Option Program (SHOP) in accordance with 45 C.F.R. § 155.7105 (ae) (2013) and 45 C.F.R. § 155.7105 (ef) (2013);
- 3.4 Any MNsure determination or redetermination of a grant of certification attesting that, for the purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Service Code of 1986, an individual is exempt from the individual requirement imposed, in accordance with 45 C.F.R. § 155.605 (2013);

- 3.5 Any MNSure determination to deny a request to vacate an appeal dismissal made pursuant to these rules by MNSure in accordance with 45 C.F.R. § 155.530(d)(2) (2013);
- 3.6 Any failure by MNSure to provide timely notice of an eligibility determination in accordance with 45 C.F.R. § 155.310 (g) (2013), 45 C.F.R. § 155.330 (e)(1)(ii) (2013), 45 C.F.R. § 155.335 (h)(ii) (2013), 45 C.F.R. § 155.610 (i) (2013) or 45 C.F.R. § 155.715 (e)-(f) (2013); and
- 3.7 In response to a notice sent by MNSure under 45 C.F.R. § 155.310 (h) (2013), a determination that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but is not affordable coverage with respect to an employee.

The adjudication of MNSure appeals will offer all procedural due process required by federal and state law; offer all accessibility rights under state and federal law; and will adhere to all final and proposed state and federal regulations governing the adjudication of MNSure appeals. The adjudication will honor the timelines specified in state and federal law. The adjudication includes "expedited appeals," in accordance with 45 Code of Federal Regulations, part 155.540, and MNSure policies and procedures. The adjudication will include, but not be limited to, the following components:

- A written recommended decision;
- A telephone hearing, a videoconference hearing, or an in-person hearing, when required;
- A prehearing conference, if deemed necessary by the presiding judge;
- A scheduling order;
- A MNSure Order issued on behalf of the MNSure Board;
- Digital recording of the hearing;
- Language interpretation and translation services, where requested, provided, assistance from MNSure in exploring options for providing in-person interpretation when requested; and
- Compliance with all MNSure policies and procedures.

4. Intake and Finalization

DHS will provide, at minimum, daily monitoring of the designated EDMS folder to check for new appeals forms and eligibility records to transfer from MNSure to DHS. DHS will input all received MNSure appeals forms into the case management system (CMS), categorize and assign the appeal. If DHS subcontracts the appeal to OAH, it should transfer the appeal request form and eligibility records to OAH in a manner agreed upon in the subcontract. MNSure reserves the right to review appeal requests and informally resolve them internally.

If an appeal request arrives at DHS directly, DHS will record the date of arrival and contact MNSure's Authorized Representative for automated filing. If DHS receives an appeal request directly, it will enter the appeal request into the electronic appeal form available via the internet.

DHS will input the eligibility records received from MNSure and/or the appellant into the CMS or records management system. DHS is responsible for ensuring accumulation of the appeal record and its comprehensive retention, including the digital recording of the hearing.

Upon final order, DHS will input the entire Appeal record into the designated EDMS folder for MNSure to

maintain.

5. Redaction

DHS will redact for public viewing a sizeable representative sample of MNsure Orders in accordance with state and federal data privacy laws. The size of the representative sample and the methodology for the sampling will be agreed upon by the parties and specified in the Project Plan.

DHS will carefully review each Order chosen for redaction so as to redact all identifying information on a case-by-case basis, in addition to redacting all standard identifiers. DHS will upload each redacted order to the decisions database designated by MNsure.

6. Sending and Maintaining Correspondence

DHS will send all correspondence regarding filed MNsure appeals, including, but not limited to, an acknowledgement of receipt of appeal requests, hearing notices, decisions and MNsure Orders, and reconsideration requests, provided, DHS may subcontract with OAH. All correspondence related to MNsure appeals will use letterhead approved by MNsure's Authorized Representative, and will use the appropriate MNsure appeals correspondence template. Correspondence that must be mailed in a "timely" manner will be sent on or before 10(ten) business days. Final Orders will be mailed within 1 (one) business day of finalization and always within 90 (ninety) days of receipt of request, as administratively feasible. Dismissals of expedited appeals and final Orders of expedited appeals will be sent within the timeframes as determined by the Secretary of the United States Department of Health and Human Services. A copy of all MNsure appeals correspondence will be retained in the case management system, as part of the appeal record. All correspondence related to MNsure appeals will be post-marked no later than one calendar day following the date listed on the MNsure appeals correspondence (i.e., all MNsure appeals correspondence post-marked on Monday will reflect Monday's date on the letter). DHS will investigate all returned MNsure appeals correspondence, and notify MNsure's Authorized Representative of all returned MNsure appeals and their respective resolutions within three business days of return. To the extent that DHS subcontracts the adjudication of certain appeals to OAH, OAH will be responsible for complying with the foregoing terms.

7. Reporting

DHS will submit to MNsure's Authorized Representative, biweekly reports to measure various metrics pertaining to MNsure appeals, including, but not limited to, number of appeals; number of hearings; timeliness or pending appeals; timeliness of finalized appeals; caseloads; requests for reconsideration, and any metrics measured by state and/or federal reporting needs or audits. By October 1, 2013, DHS and MNsure will determine the nature of the reports. By October 1, 2013, DHS and MNsure will determine the process and frequency of the reporting.

8. Investigation and Response to complaints

DHS will investigate and respond to all complaints received pertaining to DHS's handling of MNsure appeals and respond to complainant, copying MNsure's Authorized Representative, within 30 days of receiving complaint, per the policy and procedure developed according to this Statement.

9. Task: Invoicing

DHS will submit to MNSure's Authorized Representative, quarterly itemized invoices according to the terms in the interagency agreement.

II. Contractor Office of Administrative Hearings (OAH) will perform the following work.

1. Task: Consultation

OAH will provide consultation to MNSure regarding MNSure eligibility appeals, including the following:

A. Policies and procedures related to MNSure eligibility appeals:

OAH will draft all policies and procedures for MNSure eligibility appeals, provided the consultation and direction of MNSure's Authorized Representative and DHS. The drafts will offer all procedural due process required by federal and state law; offer all accessibility rights under state and federal law; and will adhere to all final and proposed state and federal regulations governing the adjudication of MNSure appeals. The procedures will include processes for redacting and posting decisions and sending correspondence. The policies and procedures drafted should include, but not be limited to, the following topics:

- A.1 Individual eligibility appeals, including MA-MAGI appeals;
- A.2 SHOP eligibility appeals;
- A.3 Employer penalty appeals;
- A.4 Investigations of complaints related to MNSure appeals; and
- A.5 All other policies and procedures recommended by DHS or OAH and approved by MNSure's Authorized Representative.

Policies due for review and approval by MNSure's and DHS's Authorized Representative on June 24, 2013. Procedures due for review and approval by MNSure's and DHS's Authorized Representative on July 1, 2013.

B. Templates for appellant correspondence (notices), recommended decisions and MNSure Orders of eligibility determinations:

OAH will draft all templates to be used for correspondence regarding filed MNSure appeals, including acknowledgements of receipt of appeals requests; hearing notices; decisions; and all other correspondence related to MNSure appeals, as approved by MNSure's Authorized Representative. OAH will draft all decision templates to be used for MNSure appeal recommended decisions and Orders. OAH will draft a decision template for each type of MNSure eligibility appeal, or more, if OAH and DHS recommend that templates with more specificity will enhance the timeliness and effectiveness of MNSure Appeals. Decision templates will be used by MNSure appeals judges to ensure consistency in decisions. The extent of text included into decision templates will be determined by OAH with input from DHS. Templates for appellant correspondence (notices) due for review and approval by MNSure's and DHS's Authorized Representative on June 12, 2013. Templates for recommended decisions and MNSure Orders of eligibility determinations due for review by MNSure's and DHS's Authorized Representative on July 31, 2013.

C. Training materials and plans for MNsure appeals judges and staff based upon DHS appeals judge manual;

OAH will draft training materials and plans for MNsure appeals judges and staff based upon the existing DHS appeals judge manual, and aforementioned policies and procedures being developed by OAH. OAH will incorporate methodologies and materials determined by its discretion, subject to input and consultation with DHS. OAH will submit its proposal(s) for training materials and plans to MNsure's and DHS's Authorized Representative for review and approval before implementing the same. **Due for review and approval by MNsure's and DHS's Authorized Representative on July 15.**

D. Public education materials;

OAH will draft public education materials to be used on MNsure's website informing the general public about MNsure Appeals, including, but not limited to the following materials:

- D.1 Instructions/process page (e.g., how do I appeal?)
- D.2 MNsure Appeals Glossary;
- D.3 MNsure Appeals Frequently Asked Questions;
- D.4 MNsure Appeals Appellant Flow chart; and
- D.5 All other public education materials recommended by DHS and/or OAH and approved by MNsure's Authorized Representative.

OAH will work with MNsure's Marketing and Outreach staff, as appropriate. These materials must be simple and clear, a good example of which is found here:

<http://www.uimn.org/uimn/applicants/howappeal/>. Due to recent deadlines promulgated by MNsure's Marketing and Outreach staff, MNsure will provide the framework and baseline materials for such materials to OAH by July 5, 2013. **Due for review and approval by MNsure's and DHS's Authorized Representative on August 12, 2013.**

E. MNsure eligibility appeals process flow and business requirements, provided, advice and consultation from MNsure and DHS;

OAH will draft MNsure Appeals process flow and business requirements materials, provided advice and consultation from MNsure and DHS. At a minimum, this will consist of two documents: a flow chart (process flow) and an excel sheet (business requirements) MNsure will provide the form for the process flow and business requirements. MNsure has begun this work. OAH will refine the existing work product based upon its consultation with DHS, MNsure, and existing knowledge of administrative appeals process flow and business requirements. **Due for review and approval by MNsure's and DHS's Authorized Representative on June 10, 2013. These documents will be reviewed by MNsure and DHS by June 12, 2013.** As policies and procedures are subsequently developed, the process flow and business requirements may be modified. For the purpose of modifications, OAH will maintain updated copies. An updated copy will be provided by OAH to MNsure or DHS upon request.

F. Consultation regarding the development and use of an internal decisions database to ensure decision consistency;

OAH will present to MNSure and DHS options for development and use of an internal decisions database to ensure decision consistency, provided consultation with MNSure's and DHS's Authorized Representatives in identifying and developing options. Due date is flexible and open to discussion among the parties.

1. Project Plan

OAH will submit bi-weekly project plans to MNSure and DHS until June 1, 2014, or a later agreed upon date. MNSure will provide OAH with a template project plan to be populated, beginning one week after the final execution of this Agreement or upon a later date, if determined by MNSure's Authorized Representative. OAH will send its updated project plan to the Authorized Representative for MNSure and DHS, respectively, no later than 5pm on the date due. MNSure's Authorized Representative will be made available for assistance in developing and updating said project plan, upon request.

2. Reporting

OAH will submit to MNSure's Authorized Representative, biweekly reports to measure various metrics pertaining to MNSure appeals, including, but not limited to, number of appeals; number of hearings; timeliness or pending appeals; timeliness of finalized appeals; caseloads; requests for reconsideration, and any metrics measured by state and/or federal reporting needs or audits. By October 1, 2013, OAH and MNSure will determine the nature of the reports. By October 1, 2013, OAH and MNSure will determine the process and frequency of the reporting.

3. Information, Reports, Testimony

OAH will provide information, reports and testimony pertaining to MNSure appeals, upon request and as agreed by MNSure and DHS, to the Minnesota Legislature and other entities.

4. Investigation and Response to complaints

OAH will investigate and respond to all complaints received pertaining to OAH's handling of MNSure appeals, if any, and respond to complainant, copying MNSure's Authorized Representative, within 30 days of receiving complaint, per the policy and procedure developed according to this Statement.

5. Invoicing

OAH will submit to MNSure's Authorized Representative, monthly itemized invoices, according to the terms in the interagency agreement.

III. Contractor MNSure will perform the following tasks.

1. Consultation, Coordination, and Direction

MNSure will provide to DHS and OAH the consultation, coordination, and directive services of a full-time MNSure Appeals Manager. The MNSure Appeals Manager will coordinate the efforts of the three entities under Agreement; organize weekly meetings; serve as a subject matter expert for MNSure appeals; and generally be available to consult and provide direction on a need-be basis for DHS and OAH. In the

absence of the MNSure Appeals Manager (e.g., vacation), an interim replacement will be identified.

2. Public Interfacing for MNSure appeals

MNSure will provide the sole public interfacing for MNSure appeals by making appeal information and materials available on its website and through outreach plans developed by MNSure.

3. Payment

MNSure will pay DHS and OAH upon acceptance by MNSure that the tasks and deliverables have been completed, and in accordance with the invoices of each respective agency and the costs as detailed above. **Payment will generally occur within 30 days of receipt of invoice, with rare exceptions for invoices submitted around July 1.**



Appeal Request Form

Important: Please make sure you complete pages 1 & 2 of this form.

Information about Person Requesting to Appeal

First Name:

Middle Name:

Last Name:

MNSure Username of the person
requesting this appeal:

Street Address:

Phone Number:

City:

State:

Zip Code:

Date of Birth:

Email:

Do you need an interpreter for the hearing?

☐ Yes ☐ No

If you do need an interpreter, what
is your preferred language?

☐ Spanish

☐ Hmong

☐ Somali

☐ Other (explain): _____

Representative

A representative is a person whom you have named to act on your behalf in this appeal. If you are being assisted by a representative, you should identify that person in this section.

First Name:

Middle Name:

Last Name:

Street Address:

Phone Number:

City:

State:

Zip Code:

Email:



Programs (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Advance Premium Tax Credits (APTC) | <input type="checkbox"/> MinnesotaCare | <input type="checkbox"/> Other; Please list: _____ |
| <input type="checkbox"/> Medical Assistance (MA)/Children's Health Insurance Program (CHIP) | <input type="checkbox"/> Small Business Health Options Program (SHOP):Employer | _____ |
| <input type="checkbox"/> Qualified Health Plan (QHP) | <input type="checkbox"/> Small Business Health Options Program (SHOP):Employee | _____ |
| <input type="checkbox"/> Cost Sharing Reductions (CSR) | | |

Reason for Appeal (check all that apply):

I disagree with the eligibility determination recently made by MNSure. I want to appeal because:

- ☐ I was notified that I am not eligible to use MNSure.
- ☐ I was notified that I don't qualify for the program(s) checked above.
- ☐ You took too long to determine my eligibility.
- ☐ I'm enrolled in MA/CHIP/MinnesotaCare and I disagree with the level of benefits, services, initial premiums or claims.
- ☐ I qualify for premium tax credits and/or cost sharing reductions, but I disagree with the amount or prepayment you calculated.
- ☐ I'm enrolled in MA/CHIP/MinnesotaCare and you took too long to process my claim.
- ☐ I was notified by MNSure that I don't qualify for the Individual Responsibility Exemption.
- ☐ I'm an employer and I was notified that I am being penalized for not providing affordable health coverage.
- ☐ I was notified that my request to vacate a dismissed MNSure appeal was denied.
- ☐ Other; please explain: _____

Does this appeal involve a Medical Emergency?

Please refer to the instructions for Requesting an Appeal on page 3 before you complete this section.

☐ Yes* ☐ No

*If yes, please explain the medical emergency:

Status of Continued Eligibility and Benefits During Appeal

Please refer to the Instructions for Requesting an Appeal on page 3 before you complete this section.

If my benefits are being cut or stopped, my decision for continuing benefits is:

- ☐ I want to keep getting benefits at the same rate as before until the appeal decision.
- ☐ I want to reduce my benefits to the level in my notice until the appeal decision.

Client Signature: _____

Date: _____



Instructions for Requesting an Appeal

To request an appeal, please complete, sign and date pages 1 & 2 of the appeal request form. You can submit this form in the following ways:

- Online: MNSure.org
- Phone: MNSure Customer service at 1-855-366-7873
- Mail: MNSure, 81 Seventh Street East, Suite 300, St. Paul, MN 55101-2211
- In person: Minnesota Department of Human Services, Information Desk, 444 Lafayette Rd. N., St. Paul, MN 55101

Time Limit

You must file an appeal within ninety (90) days of the date of your Health Care Notice. If your appeal involves Medical Assistance or MinnesotaCare, you must file an appeal within thirty (30) days of receiving the Health Care Notice, or ninety (90) days, if you can show good cause for filing the appeal late. If you are receiving Medical Assistance or MinnesotaCare benefits and wish to continue benefits at the same rate as before, you must appeal within ten (10) days of the date on the Health Care Notice or before the date when the action takes place.

What if it is an Emergency?

You have a right to request an emergency expedited appeal if there is an immediate need for health services because a standard appeal could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. If you have a medical emergency, check 'yes' when asked if the appeal involves a medical emergency on the appeal request form or call MNSure at 1-855-366-7873.

Information about Continued Benefits

In appeals where your eligibility is redetermined, your benefits will only continue at the same rate as before the determination you are appealing if you select the 'I want to keep getting benefits at the same rate as before' checkbox.

If you lose your appeal, you will likely have to pay back the extra benefits.

If you lose your appeal, you will likely have to pay back the benefits you got while your appeal was pending.

The meaning of the term 'benefits' based on the type of appeal you file. If you appeal a decision made regarding Medical Assistance or MinnesotaCare, the term 'benefits' means eligibility and program benefits. If you appeal the advanced payment of premium tax credits (APTC) and or cost-sharing reductions (CSR), the term 'benefits' means the amount of tax credits and/or reductions. If you appeal the eligibility to purchase a QHP through MNSure, 'benefits' means the eligibility to purchase a QHP through MNSure.

Data Practices

Data on individuals will be collected throughout the appeals process. During this process, evidence and testimony will be collected for the purpose of deciding an individual's rights under Minnesota and federal law. A party to an appeal is not required to supply data for an appeal; yet, deciding which evidence and testimony to submit may have an impact on the outcome of the appeal decision. Certain other government officials may have access to information provided throughout the appeals process if this is allowed by statute or pursuant to a valid court order. When the appeal proceeds outside of the MNSure appeals process to district court, the appeal record will be public unless a protective order is issued. When the appeal proceeds outside of the MNSure appeals process to the United States Department of Health and Human Services, the record will be classified pursuant to federal law governing the collection of data on individuals.

1.1 **MNsure**1.2 **Adopted Exempt Permanent Rules Relating to MNsure Appeals**1.3 **7700.0100 ADMINISTRATIVE REVIEW OF MNSURE ELIGIBILITY**
1.4 **DETERMINATIONS.**

1.5 Subpart 1. **Applicability.** Parts 7700.0100 to 7700.0105 govern the administration of
1.6 MNsure eligibility appeals. Parts 7700.0100 to 7700.0105 must be read in conjunction with
1.7 the federal Affordable Care Act, Public Law 111-148; Code of Federal Regulations, title
1.8 45, part 155; and Minnesota Statutes, chapter 62V; and sections 256.045 and 256.0451.

1.9 Subp. 2. **Applicability to medical assistance and MinnesotaCare.** Although
1.10 MNsure offers a unique single marketplace for consumers to compare several
1.11 health insurance coverage options, including coverage under medical assistance and
1.12 MinnesotaCare, appeals rights and processes for medical assistance and MinnesotaCare
1.13 are found in applicable federal or state statute or rule, including, but not limited to, parts
1.14 9505.0130, 9505.5105, 9505.0545, and 9506.0070, and Minnesota Statutes, sections
1.15 256.045, 256.0451, and 256L.10. Nothing in these rules should be construed to supersede,
1.16 abridge, or in any way limit the appeal rights of appellants contesting issues covered or not
1.17 covered under these rules that are available under applicable federal or state statute or rule,
1.18 including, but not limited to, parts 9505.0130, 9505.5105, 9505.0545, and 9506.0070, and
1.19 Minnesota Statutes, sections 256.045, 256.0451, and 256L.10. However, nothing in these
1.20 rules prevent any MNsure consumer from filing appeals through MNsure.

1.21 Subp. 3. **Regulatory investigations.** Nothing in these rules limits or supersedes the
1.22 ability of the commissioners of commerce and health to conduct investigations or facilitate
1.23 appeals as authorized by laws administered by the Departments of Commerce and Health.

1.24 **7700.0101 DEFINITIONS.**

1.25 Subpart 1. **Scope.** As used in parts 7700.0100 to 7700.0105, the terms defined in
26 this part have the meanings given them.

2.1 Subp. 2. **Agency.** "Agency" means the entity that made the eligibility determination
2.2 being contested. Agency includes MNsure and, where applicable, any entity involved
2.3 under a contract, subcontract, grant, or subgrant with MNsure that provides or operates
2.4 programs or services for which appeals are available. Agency does not include the
2.5 Minnesota Department of Commerce or the Minnesota Department of Health.

2.6 Subp. 3. **Appeal.** "Appeal" means a challenge to or dispute of an initial determination
2.7 or redetermination made by MNsure enumerated under part 7700.0105, subpart 1, item A.

2.8 Subp. 4. **Appeal record.** "Appeal record" means all relevant records pertaining
2.9 to the contested issues, including eligibility records filed in the proceeding, the appeal
2.10 decision, all papers and requests filed in the proceeding, and if a hearing is held, the
2.11 recording of the hearing testimony or an official report containing the substance of what
2.12 happened at the hearing and any exhibits introduced at the hearing.

2.13 Subp. 5. **Appeals examiner.** "Appeals examiner" means a person appointed to
2.14 conduct hearings under this part by the MNsure board and includes human services judges
2.15 of the Department of Human Services and administrative law judges of the Office of
2.16 Administrative Hearings, when acting under a delegation of authority from the MNsure
2.17 board.

2.18 Subp. 6. **Appellant.** "Appellant" means the applicant or enrollee, the employer,
2.19 or small business employer or employee submitting an appeal. Appellant includes the
2.20 appellant's attorney or representative. An appellant who is not a business owner may file
2.21 and appeal on his or her own behalf or on behalf of the appellant's household.

2.22 Subp. 7. **Business day.** "Business day" means any day other than a Saturday,
2.23 Sunday, or legal holiday as defined in Minnesota Statutes, section 645.44.

2.24 Subp. 8. **Business hours.** "Business hours" means the hours between 8:30 a.m. and
2.25 4:30 p.m., Central Standard Time, on business days.

3.1 Subp. 9. **Chief appeals examiner.** "Chief appeals examiner" means the chief
3.2 human services judge of the Department of Human Services and the chief administrative
3.3 law judge of the Office of Administrative Hearings, when acting under a delegation of
3.4 authority from the MNsure board.

3.5 Subp. 10. **De novo review.** "De novo review" means a review of an appeal without
3.6 deference to prior decisions in the case and can include making new findings of fact
3.7 based on the appeal record.

3.8 Subp. 11. **Eligibility.** "Eligibility" means meeting the stipulated requirements for
3.9 participation in a program or access to a service or product.

3.10 Subp. 12. **MNsure board or board.** "MNsure board" or "board" means the entity
3.11 established in Minnesota Statutes, chapter 62V, as a board under Minnesota Statutes,
3.12 section 15.012, and should be understood to include any individual or entity to whom the
3.13 board has delegated a specific power or authority either directly or through an interagency
3.14 agreement when that individual or entity is exercising the delegation.

3.15 Subp. 13. **Party or parties.** "Party" or "parties" means the appellants and agencies
3.16 that are involved in an appeal and who have the legal right to make claims and defenses,
3.17 offer proof, and examine and cross-examine witnesses during the appeal.

3.18 Subp. 14. **Person.** "Person" means a natural person.

3.19 Subp. 15. **Preponderance of the evidence.** "Preponderance of the evidence" means,
3.20 in light of the record as a whole, the evidence leads the appeals examiner to believe that
3.21 the finding of fact is more likely to be true than not true.

3.22 Subp. 16. **Representative.** "Representative" means a person who is empowered by
3.23 the party to support, speak for, or act on behalf of the party. Representative includes legal
3.24 counsel, relative, friend, or other spokesperson or authorized representative under Code of
25 Federal Regulations, title 45, section 155.227.

4.1 Subp. 17. **Vacate.** "Vacate" means to set aside a previous action.

4.2 **7700.0105 MNSURE ELIGIBILITY APPEALS.**

4.3 Subpart 1. **Eligibility.**

4.4 A. MNSure appeals are available for the following actions:

4.5 (1) initial determinations and redeterminations made by MNSure of
4.6 individual eligibility to purchase a qualified health plan through MNSure, made in
4.7 accordance with Code of Federal Regulations, title 45, sections 155.305, (a) and (b);
4.8 155.330; and 155.335;

4.9 (2) initial determinations and redeterminations made by MNSure of
4.10 eligibility for and level of advance payment of premium tax credit, and eligibility for and
4.11 level of cost sharing reductions, made in accordance with Code of Federal Regulations,
4.12 title 45, sections 155.305 (f) to (g); 155.330; and 155.335;

4.13 (3) initial determinations and redeterminations made by MNSure of
4.14 employer eligibility to purchase coverage for qualified employees through the Small
4.15 Business Health Options Program under Code of Federal Regulations, title 45, section
4.16 155.710 (a);

4.17 (4) initial determinations and redeterminations made by MNSure of
4.18 employee eligibility to purchase coverage through the Small Business Health Options
4.19 Program under Code of Federal Regulations, title 45, section 155.710 (e);

4.20 (5) initial determinations and redeterminations made by MNSure of
4.21 individual eligibility for an exemption from the individual responsibility requirement
4.22 made in accordance with Code of Federal Regulations, title 45, section 155.605;

4.23 (6) a failure by MNSure to provide timely notice of an eligibility
4.24 determination in accordance with Code of Federal Regulations, title 45, sections 155.310
4.25 (g); 155.330 (e)(1)(ii); 155.335 (h)(ii); 155.610 (i); and 155.715 (e) and (f);

(7) in response to a notice from MNsure under Code of Federal Regulations, title 45, section 155.310 (h), a determination by MNsure that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but is not affordable coverage with respect to an employee; and

(8) in response to a denial of a request to vacate a dismissal made according to this chapter and in accordance with Code of Federal Regulations, title 45, section 155.530 (d)(2).

B. If an individual has been denied eligibility for medical assistance under Code of Federal Regulations, title 45, section 155.302 (b), an appeal of a determination of eligibility for advanced payments of the premium tax credit or cost-sharing reduction must also be treated as an appeal of medical assistance determination of eligibility.

Subp. 2. Filing an appeal.

A. To initiate an appeal, an appellant must file the appeal with MNsure as follows:

(1) by mail;

(2) by telephone;

(3) by Internet; and

(4) in person.

B. MNsure must provide the necessary contact information for each method of filing an appeal with each eligibility determination and also through the MNsure Web site.

C. The agency must assist any potential appellant in filing an appeal when assistance is requested.

D. An appeal must be received by MNsure within 90 days from the date of the notice of eligibility determination. There is a rebuttable presumption that the date of the notice of eligibility determination is five business days later than the date printed on the

notice. The person may rebut this presumption by presenting evidence or testimony that they received the notice five business days after the date printed on the notice. An appeal received more than 90 days after the date of the eligibility notice will be dismissed. If the deadline for filing an appeal falls on a day that is not a business day, the filing deadline is the next business day.

E. Appeal request forms will be available to persons through the Internet, by in-person request, by mail, and by telephone. The following information is requested, but not required, in an appeal:

- (1) name;
- (2) MNsure username;
- (3) date of birth;
- (4) address, including either an e-mail address, if available, or a mailing or physical address;
- (5) MNsure programs involved in the appeal, for which a list must be provided on the appeal request form;
- (6) reason for the appeal; and
- (7) in appeals of redeterminations of eligibility, whether the appellant intends to continue at the level of eligibility and benefits before the redetermination being appealed until the appeal decision.

F. Appeals shall be accepted regardless of whether the requested information is provided on the form or the information is incomplete. However, failure by an appellant to provide all of the requested information may prevent resolution of the appeal or delivery of effective notice.

G. The date of official receipt of appeals submitted after business hours, whether filed through the Internet or by telephone, is the next business day.

7.1 Subp. 3. **Notices and communications.**

7.2 A. The parties to an appeal have the right to the following timely notices and
7.3 communications:

7.4 (1) acknowledgement of receipt of the appeal and a scheduling order,
7.5 including information regarding the appellant's eligibility pending appeal and an
7.6 explanation that any advance payments of the premium tax credit paid on behalf of the
7.7 tax filer pending appeal are subject to reconciliation; and

7.8 (2) the decision and order of the MNsure board.

7.9 B. Any notice sent to the appellant must also be sent to the appellant's attorney
7.10 or representative.

7.11 C. An appeals examiner shall not have ex parte contact on substantive issues
7.12 with the agency, the appellant, or any person involved in an appeal. No agency employee
7.13 shall review, interfere with, change, or attempt to influence the recommended decision
7.14 of the appeals examiner in any appeal, except through the procedures allowed herein.
7.15 The limitations in this subpart do not affect the board's authority to review or make final
7.16 decisions.

7.17 Subp. 4. **Rescheduling.**

7.18 A. Requests to reschedule a hearing must be made in person, by telephone,
7.19 through the Internet, or mailed and postmarked to the appeals examiner at least five days
7.20 in advance of the regularly scheduled hearing date. The rescheduling request may be made
7.21 orally or in writing. The requesting party must provide the other party a copy of a written
7.22 request or must otherwise notify the other party of the request.

7.23 B. Any rescheduling of a hearing with less than five days' advance notice will
7.24 be at the discretion of the appeals examiner and granted only when the rescheduling does
25 not prejudice any party to the rescheduling.

8.1 C. Unless a determination is made by the appeals examiner that a request to
8.2 reschedule a hearing is made for the purpose of delay, a hearing must be rescheduled
8.3 by the appeals examiner for good cause as determined by the appeals examiner. Good
8.4 cause includes the following:

- 8.5 (1) to accommodate a witness;
- 8.6 (2) to obtain necessary evidence, preparation, or representation;
- 8.7 (3) to review, evaluate, and respond to new evidence;
- 8.8 (4) to permit negotiations of resolution between the parties;
- 8.9 (5) to permit the agency to reconsider;
- 8.10 (6) to permit actions not previously taken;
- 8.11 (7) to accommodate a conflict of previously scheduled appointments;
- 8.12 (8) to accommodate a physical or mental illness;
- 8.13 (9) where an interpreter, translator, or other service necessary to
8.14 accommodate a person with a disability is needed but not available; or
- 8.15 (10) any other compelling reasons beyond the control of the party that
8.16 prevents attendance at the originally scheduled time.

8.17 D. If requested by the appeals examiner, a written statement confirming the
8.18 reasons for the rescheduling request must be provided to the appeals examiner by the
8.19 requesting party.

8.20 Subp. 5. **Telephone, videoconference, or in-person hearing.**

8.21 A. A hearing may be conducted by telephone, videoconference, or in person.
8.22 An in-person appeals hearing will only be held at the discretion of the appeals examiner, or
8.23 if the person asserts that either the person or a witness has a physical or mental disability
8.24 that would impair the person's ability to fully participate in a hearing held by interactive

9.1 video technology. To have the hearing conducted by videoconference or in person, a
9.2 person must make a specific request for that type of hearing.

9.3 B. When an in-person hearing is granted, the appeals examiner shall conduct
9.4 the hearing in the county where the person involved resides, unless an alternate location is
9.5 mutually agreed upon before the hearing.

9.6 C. Where federal law or regulation does not require a telephone,
9.7 videoconference, or in-person hearing and allows for a review of documentary evidence
9.8 through a desk review, a telephone, videoconference, or in-person hearing will only be
9.9 provided when the appeals examiner determines that such a hearing would materially
9.10 assist in resolving the issues presented by the appeal.

9.11 Subp. 6. **Emergency expedited appeals.**

9.12 A. An appellant has a right to request an emergency expedited appeal when
13 there is an immediate need for health services because a standard appeal could seriously
9.14 jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum
9.15 function. An appellant must specify that an emergency expedited appeal is being requested
9.16 when submitting the initial appeal.

9.17 B. If an emergency develops during a pending appeal such that there has
9.18 developed an immediate need for health services because a standard appeal could seriously
9.19 jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum
9.20 function, an appellant may request an expedited appeal.

9.21 C. If a request for an expedited appeal is denied, the appellant will be notified
9.22 according to the process and time period required under the applicable federal law.

9.23 D. If a request for an expedited appeal is accepted, the appeals examiner will
9.24 issue a decision according to the process and time period required under the applicable
25 federal law.

10.1 **Subp. 7. Interpreter and translation services.**

10.2 A. Appeals must be accessible to appellants who have limited English
10.3 proficiency, appellants who require interpreter and translation services, and appellants with
10.4 disabilities. An appeals examiner has a duty to inquire whether any person involved in the
10.5 hearing needs the services of an interpreter, translator, or reasonable accommodations to
10.6 accommodate a disability in order to participate in or to understand the appeal process.

10.7 B. Necessary interpreter services, translation services, or reasonable
10.8 accommodations must be provided at no cost to the person involved in the appeal.

10.9 C. If an appellant requests interpreter services, translation services, or reasonable
10.10 accommodations or it appears to the appeals examiner that necessary interpreter or
10.11 translation services are needed but not available for the scheduled hearing, the hearing shall
10.12 be rescheduled to the next available date when the appropriate services can be provided.

10.13 **Subp. 8. Access to data.**

10.14 A. Subject to the requirements of all applicable state and federal laws regarding
10.15 privacy, confidentiality, and disclosure of personally identifiable information, the
10.16 appellants and agencies involved in an appeals hearing must be allowed to access the
10.17 appeal record upon request at a convenient place and time before and during the appeals
10.18 hearing. Copies of the appeal record, including an electronic copy of the recorded hearing,
10.19 must be provided at no cost and, upon request, must be mailed or sent by electronic
10.20 transmission to the party or the party's representative.

10.21 B. An appellant involved in an appeals hearing may enforce the right of access
10.22 to data and copies of the case file by making a request to the appeals examiner. The
10.23 appeals examiner shall make an appropriate order enforcing the appellant's right of access,
10.24 including but not limited to ordering access to files, data, and documents possessed by the
10.25 agency; continuing or rescheduling an appeal hearing to allow adequate time for access to
10.26 data; or prohibiting use by the agency of files, data, or documents that have been generated,

collected, stored, or disseminated in violation of the requirements of state or federal law, or when the documents have not been provided to the appellant involved in the appeal.

Subp. 9. Data practices.

A. Data on individuals, as defined in Minnesota Statutes, section 13.02, subdivision 5, will be collected about persons and appellants throughout the appeals process. The purpose of this data collection is to conduct an appeal. A party to an appeal is not required to supply data for an appeal. However, deciding which evidence and testimony to submit may have an impact on the outcome of the appeal decision. Certain other government officials may have access to information provided throughout the appeals process if this is allowed by law or pursuant to a valid court order.

B. When an appeal proceeds beyond the MNsure appeals process to judicial review, the appeal record will be public unless the court with jurisdiction over the appeal issues a protective order. When the appeal proceeds outside of the MNsure appeals process to the United States Department of Health and Human Services, the record will be classified according to federal law governing the collection of data on individuals.

Subp. 10. Appeal summary. The agency must prepare an appeal summary for each appeal hearing. The appeal summary shall be delivered to each party and the MNsure appeals examiner at least three business days before the date of the appeal hearing. The appeals examiner shall confirm that the appeal summary is delivered to the party involved in the appeal as required under this subpart. Each party shall be provided, through the appeal summary or other reasonable methods, appropriate information about the procedures for the appeal hearing and an adequate opportunity to prepare. The contents of the appeal summary must be adequate to inform each party of the evidence on which the agency relies and the legal basis for the agency's action or determination.

Subp. 11. Representation during appeal. An appellant may personally appear in any appeal hearing and may be represented by an attorney or representative. A

12.1 partnership may be represented by any of its members, an attorney, or other representative.
12.2 A corporation or association may be represented by an officer, an attorney, or other
12.3 representative. In a case involving an unrepresented appellant, the appeals examiner shall
12.4 examine witnesses and receive exhibits for the purpose of identifying and developing in
12.5 the appeal record relevant facts necessary for making an informed and fair decision. An
12.6 unrepresented appellant shall be provided an adequate opportunity to respond to testimony
12.7 or other evidence presented by the agency at the appeal hearing. The appeals examiner shall
12.8 ensure that an unrepresented appellant has a full and reasonable opportunity at the appeal
12.9 hearing to establish a record for appeal. An agency may be represented by an employee or
12.10 an attorney, including an attorney employed by the agency as authorized by law.

12.11 **Subp. 12. Dismissals.**

12.12 A. The appeals examiner must dismiss an appeal if the appellant:

12.13 (1) withdraws the appeal orally or in writing;

12.14 (2) fails to appear at a scheduled appeal hearing or prehearing conference
12.15 and good cause is not shown;

12.16 (3) fails to submit a valid appeal; or

12.17 (4) dies while the appeal is pending.

12.18 B. If an appeal is dismissed, the appeals examiner must provide timely notice to
12.19 the parties, which must include the reason for dismissal, an explanation of the dismissal's
12.20 effect on the appellant's eligibility, and an explanation of how the appellant may show
12.21 good cause why the dismissal should be vacated.

12.22 C. The appeals examiner must vacate a dismissal if the appellant makes a
12.23 written request within 30 days of the date of the notice of dismissal showing good cause
12.24 why the dismissal should be vacated. There is a rebuttable presumption that the date of
12.25 the notice of dismissal is five business days later than the date printed on the notice. The

13.1 person may rebut this presumption by presenting evidence or testimony that they received
13.2 the notice later than five business days after the date printed on the notice. Good cause can
13.3 be shown when there is:

13.4 (1) a death or serious illness in the person's family;

13.5 (2) a personal injury or physical or mental illness that reasonably prevents
13.6 an appellant or witness from attending the hearing;

13.7 (3) an emergency, crisis, including a mental health crisis, or unforeseen
13.8 event that reasonably prevents an appellant or witness from attending the hearing;

13.9 (4) an obligation or responsibility of an appellant or witness which a
13.10 reasonable person, in the conduct of one's affairs, could reasonably determine takes
13.11 precedence over attending the hearing;

13.12 (5) lack of or failure to receive timely notice of the hearing in the preferred
13.13 language of an appellant involved in the hearing;

13.14 (6) excusable neglect, excusable inadvertence, or excusable mistake as
13.15 determined by the appeals examiner; or

13.16 (7) any other compelling reason beyond the control of the party as
13.17 determined by the appeals examiner.

13.18 **Subp. 13. Prehearing conferences.**

13.19 A. The appeals examiner, at the examiner's discretion, prior to an appeal
13.20 hearing may hold a prehearing conference to further the interests of justice or efficiency.
13.21 The parties must participate in any prehearing conference held. A party may request a
13.22 prehearing conference. The prehearing conference may be conducted by telephone, in
13.23 writing, or in person. The prehearing conference may address the following issues:

13.24 (1) disputes regarding access to files, evidence, subpoenas, or testimony;

14.1 (2) the time required for the hearing or any need for expedited procedures
14.2 or decision;

14.3 (3) identification or clarification of legal or other issues that may arise
14.4 at the hearing;

14.5 (4) identification of and possible agreement to factual issues; and

14.6 (5) scheduling and any other matter that will aid in the proper and fair
14.7 functioning of the hearing.

14.8 B. The appeals examiner shall make a record or otherwise contemporaneously
14.9 summarize the prehearing conference in writing, which shall be sent to:

14.10 (1) the parties; and

14.11 (2) the party's attorney or representative.

14.12 **Subp. 14. Disqualification of appeals examiner.**

14.13 A. The chief appeals examiner shall remove an appeals examiner from any
14.14 case where the appeals examiner believes that presiding over the case would create the
14.15 appearance of unfairness or impropriety. No appeals examiner may hear any case where
14.16 any of the parties to the appeal are related to the appeals examiner by blood or marriage. An
14.17 appeals examiner must not hear any case if the appeals examiner has a financial or personal
14.18 interest in the outcome. An appeals examiner having knowledge of such a relationship or
14.19 interest must immediately notify the chief appeals examiner and be removed from the case.

14.20 B. A party may move for the removal of an appeals examiner by written
14.21 application of the party together with a statement of the basis for removal. Upon the
14.22 motion of the party, the chief appeals examiner must decide whether the appeals examiner
14.23 may hear the particular case.

14.24 **Subp. 15. Status of eligibility and benefits pending appeal.**

15.1 A. In appeals involving a redetermination of an appellant's eligibility, the
15.2 appellant shall continue at the level of eligibility and benefits before the redetermination
15.3 being appealed only if the appellant affirmatively elects to receive them during the appeal.

15.4 B. The appeal type, as specified in subpart 1, item A, determines what eligibility
15.5 and benefits are available to be continued pending appeal. The availability of a continuation
15.6 of eligibility and benefits is only available for appellants under subpart 1, item A, subitems
15.7 (1) and (2). If appealing eligibility for advanced payments of premium tax credits and/or
15.8 cost-sharing reductions, at issue is the amount of the advance payments of premium tax
15.9 credits and/or cost-sharing reductions; and if appealing the eligibility to purchase a QHP
15.10 through MNsure, at issue is the eligibility to purchase a QHP through MNsure.

15.11 C. Where an appellant continues at the level of eligibility before the
15.12 redetermination being appealed and the appeal decision upholds the redetermination being
15.13 appealed, the appellant is subject to reconciliation and repayment of any overpayment.

15.14 **Subp. 16. Commencement and conduct of hearing.**

15.15 A. The appeals examiner shall begin each hearing by describing the process to
15.16 be followed in the hearing, including the swearing in of witnesses, how testimony and
15.17 evidence are presented, the order of examining and cross-examining witnesses, and the
15.18 opportunity for an opening statement and a closing statement. The appeals examiner
15.19 shall identify for the parties the issues to be addressed at the hearing and shall explain
15.20 to the parties the burden of proof that applies to the appellant and the agency. The
15.21 appeals examiner shall confirm, prior to proceeding with the hearing, that the appeal
15.22 summary, if prepared, has been properly completed and provided to the parties, and that
15.23 the parties have been provided documents and an opportunity to review the appeal record,
15.24 as provided in this part.

15.25 B. The appeals examiner shall act in a fair and impartial manner at all times.
15.26 At the beginning of the appeal hearing, the agency must designate one person as

16.1 a representative who shall be responsible for presenting the agency's evidence and
16.2 questioning any witnesses. The appeals examiner shall make sure that both the agency and
16.3 the appellant are provided sufficient time to present testimony and evidence, to confront
16.4 and cross-examine all adverse witnesses, and to make any relevant statement at the hearing.
16.5 All testimony in the hearing will be taken under oath or affirmation. The appeals examiner
16.6 shall make reasonable efforts to explain the appeal hearing process to unrepresented
16.7 appellants and shall ensure that the hearing is conducted fairly and efficiently. Upon
16.8 the reasonable request of the appellant or the agency or at the discretion of the appeals
16.9 examiner, the appeals examiner shall direct witnesses to remain outside the hearing room,
16.10 except during individual testimony, when the appeals examiner determines that such
16.11 action is appropriate to ensure a fair and impartial hearing. The appeals examiner shall not
16.12 terminate the hearing before affording the appellant and the agency a complete opportunity
16.13 to submit all admissible evidence and reasonable opportunity for oral or written statement.
16.14 In the event that an appeal hearing extends beyond the time allotted, the appeal hearing
16.15 shall be continued from day to day until completion. Appeal hearings that have been
16.16 continued shall be timely scheduled to minimize delay in the disposition of the appeal.

16.17 C. The appeal hearing shall be a de novo review and shall address the
16.18 correctness and legality of the agency's action and shall not be limited simply to a review
16.19 of the propriety of the agency's action. The appellant may raise and present evidence on
16.20 all legal claims or defenses arising under state or federal law as a basis for the appeal,
16.21 excluding any constitutional claims that are beyond the jurisdiction of the appeal hearing.
16.22 The appeals examiner may take official notice of adjudicative facts.

16.23 D. The burden of persuasion is governed by specific state or federal law and
16.24 regulations that apply to the subject of the hearing. Unless otherwise required by specific
16.25 state or federal laws that apply to the subject of the appeal, the appellant carries the burden
16.26 to persuade the appeals examiner that a claim is true and must demonstrate such by a
16.27 preponderance of the evidence.

17.1 E. The appeals examiner shall accept all evidence, except evidence privileged
17.2 by law, that is commonly accepted by reasonable people in the conduct of their affairs as
17.3 having probative value on the issues to be addressed at the appeal hearing. The appeals
17.4 examiner shall ensure for all cases that the appeal record is sufficiently complete to make a
17.5 fair and accurate decision.

17.6 F. The agency must present its evidence prior to or at the appeal hearing. The
17.7 agency shall not be permitted to submit evidence after the hearing except by agreement at
17.8 the hearing between the appellant, the agency, and the appeals examiner. If evidence is
17.9 submitted after the appeal hearing, based on an agreement, the appellant and the agency
17.10 must be allowed sufficient opportunity to respond to the evidence. When determined
17.11 necessary by the appeals examiner, the appeal record shall remain open to permit an
17.12 appellant to submit additional evidence on the issues presented at the appeal hearing.

17.13 **Subp. 17. Orders of the MNsure board.**

17.14 A. A timely, written decision must be issued in every appeal. Each decision must
17.15 contain a clear ruling on the issues presented in the appeal hearing and contain a ruling
17.16 only on questions directly presented by the appeal and the arguments raised in the appeal.

17.17 B. A written decision must be issued within 90 days of the date the appeal is
17.18 received, as administratively feasible, unless a shorter time is required by law.

17.19 C. The decision must contain both findings of fact and conclusions of law,
17.20 clearly separated and identified. The findings of fact must be based on the entire
17.21 appeal record. Each finding of fact made by the appeals examiner shall be supported
17.22 by a preponderance of the evidence unless a different standard is required by law. The
17.23 legal claims or arguments of a participant do not constitute either a finding of fact or a
17.24 conclusion of law, except to the extent the appeals examiner explicitly adopts an argument
17.25 as a finding of fact or conclusion of law.

17.26 D. The decision shall contain at least the following:

18.1 (1) a listing of the date and place of the appeal hearing and the parties and
18.2 persons appearing at the appeal hearing;

18.3 (2) a clear and precise statement of the issues, including the dispute that is
18.4 the subject of the appeal and the specific points that must be resolved in order to decide
18.5 the case;

18.6 (3) a listing of each of the materials constituting the appeal record that
18.7 were placed into evidence at the appeal hearing, and upon which the appeal hearing
18.8 decision is based;

18.9 (4) the findings of fact based upon the entire appeal record. The findings of
18.10 fact must be adequate to inform the parties and the public of the basis of the decision. If
18.11 the evidence is in conflict on an issue that must be resolved, the findings of fact must state
18.12 the reasoning used in resolving the conflict;

18.13 (5) conclusions of law that address the legal authority for the appeal
18.14 hearing and the ruling, and which give appropriate attention to the claims of the parties;

18.15 (6) a clear and precise statement of the decision made resolving the dispute
18.16 that is the subject of the appeal, including the effective date of the decision; and

18.17 (7) written notice of any existing right to appeal, including taking an appeal
18.18 to the United States Department of Health and Human Services and identifying the time
18.19 frame for an appeal and that the decision is final unless appealed.

18.20 E. The appeals examiner shall not independently investigate facts or otherwise
18.21 rely on information not presented at the appeal hearing. The appeals examiner may not
18.22 contact other agency personnel, except as provided in subpart 16. The appeals examiner's
18.23 recommended decision must be based exclusively on the testimony and evidence
18.24 presented at the appeal hearing, legal arguments presented, and the appeals examiner's
18.25 research and knowledge of the law.

19.1 F. The MNsure board shall review the recommended decision and accept or
19.2 refuse to accept the decision. The MNsure board may accept the recommended order of an
19.3 appeals examiner and issue the order to the parties or may refuse to accept the decision.
19.4 Upon refusal, the MNsure board shall notify the parties of the refusal, state the reasons,
19.5 and allow each party ten days to submit additional written argument on the matter. After
19.6 the expiration of the ten-day period, the MNsure board shall issue an order on the matter
19.7 to the parties. Refusal of the MNsure board to accept a decision must not delay the 90-day
19.8 time limit to issue a decision.

19.9 Subp. 18. **Public access to hearings and decisions.** Appeal decisions must be
19.10 maintained in a manner so that the public has ready access to previous decisions on
19.11 particular topics, subject to appropriate procedures for compliance with applicable state and
19.12 federal laws regarding the privacy, confidentiality, and disclosure, of personally identifiable
19.13 information. Appeal hearings conducted under this part are not open to the public due to
19.14 the not public classification of the information provided for inclusion in the appeal record.

19.15 Subp. 19. **Administrative review.**

19.16 A. Administrative review by the United States Department of Health and
19.17 Human Services may be available for parties aggrieved by an order of the MNsure board.

19.18 B. An appeal under this part must be filed with the United States Department of
19.19 Health and Human Services and MNsure within 30 days of the date of the appeal decision
19.20 according to the process required under the applicable federal regulations.

19.21 Subp. 20. **Judicial review.** An appellant may seek judicial review to the extent it
19.22 is available by law.