



FEDERAL REGISTER

Vol. 76

Wednesday,

No. 159

August 17, 2011

Part III

Department of Health and Human Services

45 CFR Parts 155 and 157

Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 157

[CMS-9974-P]

RIN 0938-AR25

Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers

AGENCY: Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement certain functions of the new Affordable Insurance Exchanges (“Exchanges”), consistent with title I of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses. The specific Exchange functions proposed in this rule include: Eligibility determinations for Exchange participation and insurance affordability programs and standards for employer participation in SHOP.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on October 31, 2011.

ADDRESSES: In commenting, please refer to file code CMS-9974-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-9974-P, P.O. Box 8010, Baltimore, MD 21244-8010.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-9974-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

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

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

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

Naomi Senkeeto at (301) 492-4419 for matters related to part 157.

SUPPLEMENTARY INFORMATION: A detailed Preliminary Regulatory Impact Analysis associated with this proposed rule is available at <http://ccio.cms.gov> under “Regulations and Guidance.” A summary of the aforementioned analysis is included as part of this proposed rule.

Abbreviations

CHIP Children’s Health Insurance Program
 CMS Centers for Medicare & Medicaid Services
 DOL U.S. Department of Labor
 ERISA Employee Retirement Income Security Act (29 U.S.C. section 1001, *et seq.*)
 FPL Federal Poverty Level
 HHS U.S. Department of Health and Human Services
 HMO Health Maintenance Organization
 IHS Indian Health Service
 IRS Internal Revenue Service
 NAIC National Association of Insurance Commissioners
 OMB Office of Management and Budget
 OPM Office of Personnel Management
 PHS Act Public Health Service Act
 QHP Qualified Health Plan
 SHOP Small Business Health Options Program
 SSA Social Security Administration
 The Act Social Security Act
 The Code Internal Revenue Code of 1986

Executive Summary: Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or “Exchanges.” Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses. The Departments of Health and Human Services, Labor and the Treasury (the Departments) are working in close coordination to release guidance related to Exchanges. The first in this series was a Request for Comment relating to Exchanges, published in the **Federal Register** on August 3, 2010 (75 FR 45584). Second, Initial Guidance to States on Exchanges was issued on November 18, 2010. Third, a proposed rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011 (76 FR 13553). Fourth, two proposed regulations were published in the **Federal Register** on July 15, 2011 (76 FR 41866 and 76 FR 41930) to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. Fifth, a proposed regulation for the

establishment of the Consumer Operated and Oriented Plan (CO-OP) Program under section 1322 of the Affordable Care Act was published in the **Federal Register** on July 20, 2011 (76 FR 43237). Sixth, three proposed rules, including this one, are being published in the **Federal Register** on August 17, 2011 to provide guidance on the eligibility determination process related to enrollment in a qualified health plan, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, the Children's Health Insurance Program (CHIP), and participation in SHOP.

45 CFR 155.200(c) proposes that the Exchange perform eligibility determinations. This rule proposes the specific standards for the Exchange eligibility process, in order to implement sections 1311, 1312, 1411, 1412, and 1413 of the Affordable Care Act. Further, it supports and complements rulemaking conducted by the Secretary of the Treasury with respect to section 36B of the Internal Revenue Code (the Code), as added by section 1401(a) of the Affordable Care Act, and by the Secretary of HHS with respect to several sections of the Affordable Care Act regarding Medicaid and CHIP. This proposed rule also contains standards for employers with respect to participation in the Small Business Health Options Program (SHOP), paralleling the Exchange standards for SHOP set forth in the previous Exchange rule.

The aforementioned sections of the Affordable Care Act create a central role for the Exchange in the process of determining an individual's eligibility for enrollment in a qualified health plan (QHP), as well as for "insurance affordability programs." In this proposed rule, "insurance affordability programs" is used to refer to advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and any State-established Basic Health Program, if applicable, as defined in 42 CFR 435.4 of the Medicaid proposed rule. We interpret Affordable Care Act sections 1311(d)(4)(F), and 1413, and section 1943 of the Act, as added by section 2201 of the Affordable Care Act, to establish a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a QHP and insurance affordability programs and receive a determination of eligibility for such programs. We also interpret section 1413(b)(2) to mean that the eligibility and enrollment function should be consumer-oriented, minimizing administrative hurdles and unnecessary paperwork for applicants.

Submitting Comments: We welcome comments from the public on issues set forth in this proposed rule to assist us in fully considering issues and developing policies. Comments will be most useful if they are organized by the section of the proposed rule to which they apply. You can assist us by referencing the file code [CMS-9974-P] and the specific "issue identifier" that precedes the section on which you choose to comment.

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

Table of Contents

- I. Background
 - A. Legislative Overview
 - B. Request for Comment
 - C. Structure of the Proposed Rule
- II. Provisions of the Proposed Regulation
 - A. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act
 - 1. Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs
 - B. Part 157—Employer Interactions With Exchanges and SHOP Participation
 - 1. Subpart A—General Provisions
 - 2. Subpart B—Reserved
 - 3. Subpart C—Standards for Qualified Employers
 - III. Collection of Information Requirements
 - IV. Summary of Regulatory Impact Analysis
 - V. Regulatory Flexibility Act
 - VI. Unfunded Mandates
 - VII. Federalism

I. Background

A. Legislative Overview

Section 1311(b) and section 1321 of the Affordable Care Act outline provisions for the establishment of Exchanges that will facilitate the

purchase of insurance coverage by qualified individuals through qualified health plans (QHPs).

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 establishes provisions to reduce the cost-sharing obligation of certain eligible individuals enrolled in a QHP offered through an Exchange.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the individual responsibility provision.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs. These provisions of the Affordable Care Act are addressed in subpart D of part 155 in this rule.

Section 1402 of the Affordable Care Act outlines standards for determining Indians eligible for certain categories of cost-sharing reductions.

Unless otherwise specified, the provisions in this proposed rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act.

B. Stakeholder Consultation and Input

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

The public response to the RFC yielded comment submissions from consumer advocacy organizations, medical and health care professional

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

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

C. Structure of the Proposed Rule

The regulations outlined in this notice of proposed rulemaking will be codified in 45 CFR part 155 and new part 157. Part 155 outlines the proposed standards for States relative to the establishment of Exchanges and outlines the proposed standards for Exchanges related to minimum Exchange functions. Part 157 outlines the basic standards that employers must meet to voluntarily participate in the Small Business Health Options Program (SHOP).

Subjects included in the Affordable Care Act addressed in prior proposed rulemaking include but are not limited to: (1) Federal standards for States that elect to establish and operate an Exchange; (2) minimum standards for health insurance issuers to participate in an Exchange and offer qualified health plans (QHPs); and (3) basic standards related to the establishment of the Small Business Health Options Program (SHOP).

Subjects included in the Affordable Care Act to be addressed in future separate rulemaking include but are not limited to: (1) Standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility provision and payment under section 1411(a)(4); (2) defining essential health benefits, actuarial value and other benefit design standards; and (3) standards for Exchanges and QHP issuers related to quality.

II. Provisions of the Proposed Regulation

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

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

Under the Affordable Care Act, Exchanges will make QHPs available to qualified individuals. In accordance with our interpretation of the sections of the Affordable Care Act described below; the authority provided by, *inter alia*, section 1321(a); and 45 CFR 155.200(c), which specifies that the Exchange will perform eligibility determinations; we propose that the Exchange will determine eligibility for Exchange participation, as well as for insurance affordability programs. Sections 1312, 1331, 1401, 1402, 2001, 2002, and 2201 of the Affordable Care Act, by creating new law and amending existing law, in conjunction with titles XIX and XXI of the Act, set forth eligibility standards for these programs and benefits; and sections 1311, 1411, 1412, and 1413 of the Affordable Care Act create a central role for the Exchange in the process of determining an individual's eligibility based on those standards. In subpart D, we propose standards related to eligibility determinations for enrollment in a QHP and for insurance affordability programs. Throughout this subpart, we refer to Medicaid and CHIP, but we note that for those States that choose to establish a Basic Health Program, all provisions applicable to Medicaid and CHIP will also be generally applicable to the Basic Health Program. We also note that references in this subpart to "Exchange" refer specifically to functions in connection with the purchase of individual market coverage through the Exchange.

In 45 CFR 155.200(c) (76 FR 41866), we proposed that the Exchange perform eligibility determinations. We interpret Affordable Care Act sections 1311(d)(4)(F) and 1413, and section 1943 of the Act, as added by section 2201 of the Affordable Care Act, to provide for the establishment of a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for insurance affordability programs and receive a determination of eligibility for any such program. Section 1413(b)(2) provides that an individual's eligibility be determined without unduly burdening the individual with

unnecessary paperwork. We note that these approaches were supported by comments that we received in response to the RFC. One option that we considered was whether to establish a system in which the Secretary of HHS would determine eligibility for advance payments of the premium tax credit, with other eligibility and enrollment functions remaining as the responsibility of the Exchange, since premium tax credits are fully Federally-funded and the rules are the same across all States. However, we chose not to take this approach, because isolating one component of the eligibility determination process from the remaining eligibility and enrollment functions would pose significant challenges to ensuring a seamless experience for applicants. It would also limit the role of State Exchanges in this process. We note that States may also work with HHS to leverage technological and operational capabilities provided by HHS to execute Exchange functions in a way that will meet the needs of individuals. We solicit comments on this approach and alternatives.

We also note that throughout this subpart, we propose several transmissions of data, which we intend to occur electronically, using secure interfaces. We note that the standards specified in § 155.260 and § 155.270 regarding privacy and security apply to any data sharing processes and agreements under this subpart.

The proposed eligibility process is designed to minimize opportunities for fraud and abuse, including the use of clear eligibility standards and processes that rely on data sources in an electronic environment. We solicit comments regarding strategies to further limit the risk for fraud and abuse, and we look forward to working with States toward this goal.

Consistent with this streamlined, seamless eligibility and enrollment system, the Affordable Care Act requires a simplification of Medicaid and CHIP eligibility policy and rules, which is in 42 CFR 435.603 and 42 CFR 457.315, proposed by the Secretary of HHS in the Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 rule, published in this issue of the **Federal Register** (the Medicaid proposed rule). Pursuant to the Affordable Care Act, this simplification aligns most of the rules under which individuals will be determined eligible for Medicaid and CHIP with those for advance payments of the premium tax credit and cost-sharing reductions, by generally using modified adjusted gross income (MAGI) as the basis for income

eligibility, effective January 1, 2014. While the use of this standard is referenced throughout this subpart, the use of a MAGI-based standard for Medicaid and CHIP is proposed in the Medicaid proposed rule, pursuant to section 2002 of the Affordable Care Act, and the definition of MAGI will be proposed by the Department of the Treasury in the Health Insurance Premium Tax Credit rule, scheduled for publication in this issue of the **Federal Register**.¹

In this subpart, we have organized the standards we propose for the Exchange in determining eligibility as follows: Eligibility standards, eligibility determination process, and applicant information verification process.

a. Definitions and General Standards for Eligibility Determinations (§ 155.300)

In this section, we propose definitions for this subpart. We note that virtually all of the definitions in this section are from other proposed regulations, including many proposed in the Establishment of Exchanges and Qualified Health Plans rule, published at 76 FR 41866 (July 15, 2011), (Exchange proposed rule).

In paragraph (a), we propose the definition for “adoption taxpayer identification number” to have the same meaning as it does in 26 CFR 301.6109–3(a).

We propose the definition for “applicable Medicaid modified adjusted gross income (MAGI)-based income standard” to have the same meaning as “applicable Medicaid modified adjusted gross income standard” as defined in 42 CFR 435.911(b), applied under the State Medicaid plan or waiver of such plan, and as certified by the State Medicaid agency pursuant to 42 CFR 435.1200(c)(2), for determining Medicaid eligibility. Both 42 CFR 435.911(b) and 435.1200(c)(2) are proposed in the Medicaid proposed rule.

In support of our proposal that the Exchange determine an applicant’s eligibility for CHIP, we propose to define “applicable CHIP modified adjusted gross income (MAGI)-based income standard” as the income standard applied under the State plan under Title XXI of the Act, or waiver of such plan, as defined at 42 CFR 457.305(a), and as certified by the State CHIP Agency pursuant to 42 CFR 457.348(d), for determining eligibility

for child health assistance and enrollment in a separate child health program. The applicable CHIP MAGI-based standard will also vary from State to State depending on the threshold established by the State CHIP agency. Both 42 CFR 457.305 and 457.348(d) are proposed in the Medicaid proposed rule.

We propose to define “application filer” to mean an individual who submits an application for health insurance coverage to the Exchange and responds to inquiries about the application. An application filer may be an applicant or a non-applicant, and may or may not be a primary taxpayer.

We propose to define “Federal Poverty Level” (FPL) to mean the most recently published FPL, updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as of the first day of the annual open enrollment period for coverage in a qualified health plan through the Exchange; the open enrollment period is specified in 45 CFR 155.410. This definition is used for eligibility for advance payments of the premium tax credit and cost-sharing reductions, and matches the definition in the Treasury proposed rule. We note that the Medicaid proposed rule does not specify that FPL is based on the data published as of the first day of the Exchange open enrollment period, which means that the FPL table used in eligibility determinations for Medicaid and CHIP may be different from that used for advance payments of the premium tax credit and cost-sharing reductions, depending on the date of the eligibility determination. However, we note that for the annual open enrollment period for coverage, the FPL tables for Medicaid, CHIP, and advance payments of the premium tax credit and cost-sharing reductions should be the same.

For purposes of determining eligibility for cost-sharing provisions, we propose to codify the definition of “Indian” to mean any individual defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Pub. L. 93–638, 88 Stat. 2203), in accordance with section 1402(d)(1) of the Affordable Care Act. This definition means an individual who is a member of a Federally-recognized tribe. Applicants meeting this definition are eligible for cost-sharing reductions or special cost-sharing rules on the basis of Indian status, which are described in § 155.350 of this subpart.

We propose to define “insurance affordability programs” as described earlier in this section.

We propose that the definition of the term “minimum value” has the meaning given to the term in section 36B(c)(2)(C) of the Code.

We propose to define “non-citizen” to mean any individual who is not a citizen or national of the United States, which is the same meaning as the term alien as defined in section 101(a)(3) of the Immigration and Nationality Act.

We propose to define “primary taxpayer” to mean an individual who (1) attests that he or she will file a tax return for the benefit year, in accordance with 26 CFR 1.6011–8; (2) if married (within the meaning of 26 CFR 1.7703–1), attests that he or she expects to file a joint tax return for the benefit year; (3) attests that he or she expects that no other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and (4) attests that he or she expects to claim a personal exemption deduction on his or her tax return for the family members listed on his or her application, including the primary taxpayer and his or her spouse. We use this term in § 155.305 and § 155.320(c) of this subpart to describe the individual who would receive advance payments of the premium tax credit and would file a tax return to reconcile such advance payments.

We propose to define “State CHIP Agency” to mean the agency that administers a separate child health program established by the State under Title XXI of the Act in accordance with implementing regulations at 42 CFR part 457.

We propose to define “State Medicaid Agency” to mean the agency that administers a Medicaid program established by the State under Title XIX of the Act in accordance with implementing regulations at 42 CFR 430.

We propose to define “tax dependent” to mean a dependent in accordance with section 152 of the Code.

In paragraph (b), we propose to clarify that, in general, references to Medicaid and CHIP regulations in this subpart refer to Medicaid and CHIP State plan provisions implementing those regulations. To the extent that the regulations outlined in this section refer to Medicaid and CHIP regulations, the Exchange would adhere to the rules of the Medicaid and CHIP agencies operating within the service area of the Exchange.

Lastly, in paragraph (c)(1), we propose that except as specified in paragraph (c)(2), for purposes of this subpart, an attestation may be made by the applicant (self-attestation), an application filer, or in cases in which an

¹ Section 3308 of the Affordable Care Act also defines “modified adjusted gross income”; this definition is different from the definitions that are applicable to advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP.

individual cannot attest, the attestation of a parent, caretaker, or someone acting responsibly on behalf of such an individual. In paragraph (c)(2), we propose that the attestations specified in § 155.310(d)(2)(ii) and § 155.315(e)(4)(ii), which result in the authorization of advance payments of the premium tax credit, must be made by the primary taxpayer. This is because these attestations are designed to ensure that the primary taxpayer appreciates and accepts the tax consequences that follow from receipt of advance payments.

b. Eligibility Standards (§ 155.305)

In § 155.305, we propose to codify the eligibility standards for enrollment in a QHP and for insurance affordability programs.

In paragraph (a), we propose that the Exchange determine an applicant eligible for enrollment in a QHP if he or she meets the basic standards for enrollment in a QHP, which are taken from section 1312(f) of the Affordable Care Act. First, in paragraph (a)(1), we propose to codify section 1312(f)(3) that in order to be eligible for enrollment in a QHP, an individual must be a citizen, national, or a non-citizen lawfully present, and be reasonably expected to remain so for the entire period for which enrollment is sought. In proposed § 155.20, the term “lawfully present” is adopted as defined in 45 CFR 152.2. Since the Exchange will also be determining eligibility for Medicaid and CHIP, we intend to align the requirements for lawful presence with that of the State option for Medicaid and CHIP under section 1903(v)(4) of the Act, as added by section 214 of the Children’s Health Insurance Program Reauthorization Act (Pub. L. 111–3, 123 Stat. 8); to the extent that the Secretary amends the definition for Medicaid and CHIP in future rulemaking, we intend to adjust the Exchange rules accordingly.

We solicit comments regarding the codified language in paragraph (a)(1) that an individual be “reasonably expected,” for the entire period for which enrollment is sought, to be a citizen, national, or non-citizen lawfully present, which comes directly from section 1312(f)(3) of the Affordable Care Act. We clarify that the period for which enrollment is sought does not have to be an entire benefit year. In particular, we seek comment on how this policy can be implemented in a way that is straightforward for individuals to understand and for the Exchange to implement.

In paragraph (a)(2), we propose to codify section 1312(f)(1)(B) that in order to be eligible for enrollment in a QHP,

an individual must not be incarcerated, with the exception of incarceration pending the disposition of charges.

In paragraph (a)(3), we propose the standard regarding residency. Section 1312(f) of the Affordable Care Act provides that in order to enroll in a QHP, an individual must reside in the State that established the Exchange. When discussing the residency standard for the Exchange, we use the term “service area of the Exchange” to account for regional or subsidiary Exchanges that serve broader or narrower geographic areas than a single State, as well as for situations in which a Federally-facilitated Exchange is operating in a State. We clarify that this residency standard is designed to apply to all Exchanges, including regional and subsidiary Exchanges. In order to codify the residency standard of section 1312(f) to take account of the options under sections 1311(f)(1) and 1311(f)(2), in paragraph (a)(3)(i), we propose that an individual aged 21 or older who is not institutionalized, is capable of indicating intent, and is not receiving a State supplementary payment (State-funded cash assistance for certain individuals receiving SSI) meets the residency standard for enrollment in a QHP if the applicant intends to reside in the State within the service area of the Exchange through which the individual is requesting coverage.

In general, we propose to align the Exchange residency standard with the residency standards proposed for Medicaid, which are proposed in 42 CFR 435.403 of the Medicaid proposed rule. Such Medicaid residency standards include an “intent to reside” standard. This “intent to reside” standard applies to individuals 21 and over who are seeking coverage through the Exchange and who intend to reside within the service area of the Exchange provided that an individual does not fall into special residency categories described in paragraph (a)(3)(iii). This phrase precludes visitors to the service area of an Exchange from meeting the residency standard, but accommodates those individuals who may transition between service areas of different Exchanges, such as seasonal workers and individuals seeking employment in the State or service area of the Exchange. This also allows individuals who are absent temporarily from the service area of an Exchange to remain within the same Exchange during the temporary absence. Furthermore, while we do not include the words “live” or “living” in the proposed residency requirements, we will interpret these proposed regulations such that an adult’s residency will be based on

where he or she is living, and expect that he or she must also maintain the present intent to reside in the State within the service area of the Exchange that is being claimed. Along these lines and in accordance with the language in section 1312(f)(3) of the Affordable Care Act, which we interpret to allow an applicant to request coverage for less than a full calendar year, we clarify that this residency standard does not require an individual to intend to reside for the entire benefit year. In paragraph (a)(3)(ii), we propose that an individual under age 21 who is not institutionalized, is not receiving payments under Title IV–E of the Act (such as foster care assistance and adoption assistance), is not emancipated, and is not receiving a State supplementary payment, meets the residency standard for enrollment in a QHP if he or she resides within the service area of the Exchange through which he or she is requesting coverage, to account for situations in which an individual under age 21 is unable to express intent.

We note that Medicaid has adopted a number of additional rules regarding residency for special populations, including institutionalized individuals, individuals receiving Title IV–E payments, individuals receiving State supplementary payments, individuals incapable of expressing intent, and emancipated minors. In paragraph (a)(3)(iii) of this section, we propose that the Exchange follow these Medicaid residency standards (which are proposed in the Medicaid proposed rule at 42 CFR 435.403) and the policy of the State Medicaid or CHIP agency to the extent that an individual is specifically described in that section and not in paragraphs (a)(3)(i) or (ii). We continue to work across HHS to ensure that the Exchange, Medicaid, and CHIP can reach a definition or set of definitions of residency that will enable a uniform eligibility determination process for the vast majority of individuals to reduce complexity and confusion for all involved parties; we solicit comments on this topic.

We also recognize that there are a number of situations in which a tax household may include members residing in different service areas served by different Exchanges. In paragraph (a)(3)(iv) of this section, we propose that for a spouse or a tax dependent who resides outside the service area of the primary taxpayer’s Exchange, such as when a non-custodial parent claims a child as a tax dependent, the spouse or tax dependent will be permitted to either: (1) Enroll in a QHP through the Exchange that services the area in which

he or she resides or intends to reside; or (2) enroll in a QHP through the Exchange that services the area in which his or her primary taxpayer intends to reside or resides, as applicable. In either case, if the spouse or tax dependent is covered, he or she will still count as part of the tax household and the advance payment calculation will take account of the policy or policies needed to cover the tax household consistent with the rules proposed in the Treasury proposed rule. We believe that this will provide flexibility to an individual who does not live in the service area of the Exchange in which his or her primary taxpayer lives but want to remain in the same Exchange as the primary taxpayer, including but not limited to students attending out-of-State schools or tax dependents who do not live with their primary taxpayer.

We note that section 1334 of the Affordable Care Act directs the Office of Personnel Management to contract with health insurance issuers to offer at least two private multi-State plans in each Exchange, which we believe may create opportunities for households with members in multiple States to remain covered by the same QHP. We also solicit comment as to whether there are any standards regarding in-network adequacy for out-of-State dependents we should consider.² We also note that the preamble to 42 CFR 435.403, proposed in the Medicaid proposed rule, clarifies that HHS intends to allow State Medicaid agencies to continue to have State-specific rules with respect to residency for students under the Medicaid program, which is not consistent with our approach for the Exchange. We recognize that under the Medicaid proposed rule, State Medicaid agencies will continue to have flexibility with regard to residency for students and we solicit comments on whether different rules should be maintained or whether a unified approach should be adopted.

In paragraph (b), we propose that the Exchange determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in § 155.410 and § 155.420 of this part. The purpose of this provision is to clarify that in addition to determining whether an applicant meets the eligibility standards for enrollment in a QHP specified in paragraph (a) of this section, the Exchange will determine whether or not the applicant is permitted to enroll in a QHP at the time the applicant actually seeks coverage.

Based on sections 1311(d)(4)(F) and 1413 of the Affordable Care Act and section 1943(b)(1)(B) of the Act, we propose that the Exchange determine applicants' eligibility for Medicaid and CHIP, and enroll eligible applicants into these programs. In paragraph (c), we propose the criteria under which the Exchange will determine eligibility for Medicaid for an applicant seeking an eligibility determination for insurance affordability programs as described in § 155.310(b). We propose that the Exchange determine an applicant's eligibility for Medicaid for eligibility categories that use the applicable Medicaid MAGI-based income standard defined in § 155.300.

Specifically, we propose that the Exchange determine an applicant eligible for Medicaid if he or she: (1) Meets the citizenship and immigration requirements described in 42 CFR 435.406 and 1903(v)(4) of the Social Security Act, as certified by the State Medicaid agency under 435.1200(c)(3); (2) meets the proposed requirements described in 42 CFR 435.403 regarding residency; (3) has a household income, as defined in proposed 42 CFR 435.911(b), that is at or below the applicable Medicaid MAGI-based income standard; and (4) falls into one of the categories described in the definition of "applicable Medicaid MAGI-based income standard" in § 155.300(a). We note that 42 CFR 435.406(a), 435.403, and 435.911(b) are proposed in the Medicaid proposed rule and we intend to fully align the standards to which the Exchange will adhere for purposes of Medicaid eligibility with those standards as implemented in the State Medicaid plan.

In paragraph (d), we propose that the Exchange determine an applicant eligible for CHIP if he or she meets the requirements of 42 CFR 457.310 through 457.320 and has a household income within the applicable CHIP MAGI-based income standard.

Section 1331 of the Affordable Care Act provides a State with the option to create a Basic Health Program to provide coverage to some qualified individuals in lieu of Exchange coverage. In paragraph (e), we propose to codify that if a Basic Health Program is operating in the service area of the Exchange, the Exchange will determine an individual's eligibility for the Basic Health Program. We intend to address policies for the Basic Health Program in future rulemaking.

Sections 1401, which creates a new section 36B of the Code, and 1402 of the Affordable Care Act establish a premium tax credit and cost-sharing

reductions that are available to certain individuals, and section 1412 of the Affordable Care Act provides that advance payments of the premium tax credit may be made to QHP issuers on behalf of eligible individuals. In paragraph (f), we propose the eligibility standards for advance payments of the premium tax credit. These provisions are drawn from the standards in section 36B of the Code and implementing regulations at 26 CFR 1.36B-1 through 1.36B-5, in the Treasury proposed rule.

First, in paragraph (f)(1), we propose the eligibility standards for a primary taxpayer, as defined in § 155.300(a), to receive advance payments of the premium tax credit on behalf of him or herself, for his or her spouse, or for one or more of his or her tax dependents. We clarify that while these standards are described in terms of a primary taxpayer, because the primary taxpayer actually receives the premium tax credit on his or her tax return for the benefit year, an individual who is not a primary taxpayer may apply for coverage without the presence of a primary taxpayer throughout the application process. The primary taxpayer's involvement is necessary only at the point at which the Exchange will authorize an advance payment, which is discussed in § 155.310(d)(2)(ii).

We propose that the Exchange determine a primary taxpayer eligible to receive advance payments if the Exchange determines that he or she is expected to have a household income, as defined in proposed 26 CFR 1.36B-1(e), of at least 100 percent but not more than 400 percent of the FPL, as specified in proposed 26 CFR 1.36B-2(b)(1), for the benefit year for which coverage is requested, and one or more applicants for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse (1) meets the standards for eligibility for enrollment in a QHP through the Exchange; and (2) is not eligible for minimum essential coverage, in accordance with proposed 26 CFR 1.36B-2(a)(2) (which excludes coverage purchased through the individual market, as well as employer-sponsored minimum essential coverage for which the employee's contribution exceeds 9.5 percent (in 2014, and indexed in future years) of household income or for which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, unless an individual is enrolled in such employer-sponsored minimum essential coverage). We clarify that the definition of household income in 26

² Network adequacy is addressed in the Exchange proposed rule at 76 FR 41866, 41893-94.

CFR 1.36B–1(e) of the Treasury proposed rule does not include the income of an individual in a primary taxpayer's family who is not required to file.

In addition, in paragraph (f)(2), we propose that the Exchange determine a primary taxpayer eligible for advance payments of the premium tax credit if the Exchange determines that (1) he or she meets the standards specified in paragraph (f)(1) (regarding eligibility for advance payments of the premium tax credit) except for paragraph (f)(1)(i) (household income of at least 100 percent but not more than 400 percent of the FPL); (2) he or she is expected to have a household income of less than 100 percent of the FPL; and (3) one or more applicants, including the primary taxpayer and his or her spouse, for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status.

In paragraph (f)(3), we propose that the Exchange may provide advance payments of the premium tax credit only for an applicant who is enrolled in a QHP through the Exchange. The intent of this provision is to clarify that an applicant does not need to be enrolled in a QHP to be determined eligible for advance payments of the premium tax credit; however, an applicant must be enrolled prior to advance payments being made to a QHP issuer.

In paragraph (f)(4), we propose that the Exchange determine a primary taxpayer ineligible to receive advance payments of the premium tax credit if HHS notifies the Exchange that the primary taxpayer or his or her spouse received advance payments for a prior year for which tax data would be utilized for income verification and did not comply with the requirement to file a tax return for such year, as proposed in 26 CFR 1.6011–8. For example, this requirement means that for open enrollment for coverage in calendar year 2016, which will take place in the fall of 2015, a primary taxpayer on whose behalf advance payments were made for calendar year 2014 must have filed a tax return for 2014. This proposal is intended to prevent a primary taxpayer or spouse who has failed to comply with tax filing rules from accumulating additional Federal tax liabilities due to advance payments of the premium tax credit. An individual may remove this restriction by filing a tax return for the year in question.

In paragraph (f)(5), we propose that in the event the Exchange determines that a primary taxpayer is eligible to receive advance payments of the premium tax credit, the Exchange will calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B–3 of the Treasury proposed rule. Our proposal to adopt the IRS premium tax credit rules for advance payments ensures that, to the extent the information used to calculate a primary taxpayer's advance payments is consistent with the information reporting on the primary taxpayer's income tax return at the end of the taxable year, the advance payment calculation will be consistent with the ultimate premium tax credit calculation, reducing the potential for differences at the time of reconciliation. We also note that in § 155.310(d)(2), we propose the Exchange permit a primary taxpayer to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible.

Lastly, in paragraph (f)(6), we propose that the Exchange must require an application filer to provide the Social Security number (SSN) of the primary taxpayer if an application filer attests that the primary taxpayer has a SSN and filed a tax return for the year for which tax data would be utilized for verification of household income and family size. Sections 1412(b)(1) and 1411(b)(3) of the Affordable Care Act together provide that eligibility determinations for advance payments of the premium tax credit are to be made based on tax return data, to the extent that reasonably recent and representative tax return data is available; the Secretary of the Treasury is only able to provide tax data for primary taxpayers for whom the Exchange provides a SSN or an adoption taxpayer identification number (ATIN). We clarify that taxpayers who have SSNs and who have tax data available that would be used for verification of household income and family size must provide them to the Exchange for purposes of eligibility for advance payments of the premium tax credit. We note that, because the eligibility standards for cost-sharing reductions proposed at § 155.305(g) incorporate the eligibility standards for advance payments of the premium tax credit, this standard also applies for the purposes of eligibility for cost-sharing reductions. Like all other data collections, the use and disclosure of SSNs is subject to the privacy and security safeguards proposed in § 155.260 and § 155.270.

We highlight two key differences between Medicaid and CHIP and advance payments of the premium tax credit. First, while eligibility for Medicaid and CHIP is based on current income, eligibility for advance payments of the premium tax credit is based on annual income. Second, unlike Medicaid and CHIP, the premium tax credit is paid on an advance basis and then reconciled based on information reported on an individual's tax return for the entire year. That is, to the extent that an individual receives advance payments of the premium tax credit based on an initial eligibility determination at 150 percent of the FPL and his or her actual annual household income as reported on his or her tax return is 300 percent of the FPL, he or she will be liable to repay advance payments of the premium tax credit to reduce the credit to the 300 percent level, subject to the statutory caps on repayment proposed in 26 CFR 1.36B–4 of the Treasury proposed rule.

Commenters to the RFC raised concerns regarding the potential for the statutory reconciliation process, in combination with the annual basis of household income for advance payments of the premium tax credit, to render coverage unaffordable for individuals who have substantial decreases in income during the benefit year. A related concern is that the fear of large repayments due to reconciliation after an increase in income could deter enrollment. Both effects could result in a lower participation and a negative impact on the Exchange risk pool. To address these concerns, the Exchange can decrease the difference between the amount of advance payments and the premium tax credit amount based on actual income at the end of the year through a strong initial eligibility process that maximizes accuracy and a strong process by which individuals can report changes that occur during the year. We solicit comments on ways of achieving this outcome.

In paragraph (g), we propose that the Exchange determine an applicant eligible for cost-sharing reductions if he or she meets eligibility standards that we propose to codify from section 1402 of the Affordable Care Act. In accordance with sections 1402(b) and (c) of the Affordable Care Act, in paragraph (g)(1) of this section, we propose that the Exchange must determine an applicant eligible for cost-sharing reductions if he or she is (i) eligible for enrollment in a QHP in accordance with paragraph (a) of this section; (ii) is eligible for advance payments of the premium tax credit in

accordance with paragraph (f) of this section; and (iii) has household income for the taxable year that does not exceed 250 percent of the FPL. We note that there are also special eligibility standards for cost-sharing reductions based on Indian status, which are described in § 155.350 of this subpart.

Section 1402(b) of the Affordable Care Act explicitly provides that an individual is eligible for reduced cost-sharing if his or her household income exceeds 100 percent of the FPL, but does not exceed 400 percent of the FPL. However, section 1402(c)(1)(B)(i)(IV) specifies that cost-sharing reductions for an individual with household income that exceeds 250 percent of the FPL but does not exceed 400 percent of the FPL may not result in the QHP's share of costs exceeding 70 percent, which is the actuarial value standard for a silver-level QHP pursuant to section 1302(d)(1)(B) of the Affordable Care Act, regardless of cost-sharing reductions. Since an individual has to enroll in a silver-level QHP in order to receive cost-sharing reductions, and the actuarial value of a silver-level QHP without cost-sharing reductions is 70 percent, an individual with household income that exceeds 250 percent of the FPL who is not an Indian is not eligible for cost-sharing reductions, which is reflected in paragraph (g)(1)(iii).

Lastly, in paragraph (g)(2), we propose to codify section 1402(b)(1) of the Affordable Care Act, which specifies that an applicant must be enrolled in a QHP in the silver level of coverage in order to receive cost-sharing reductions.

In paragraph (h), we propose three eligibility categories for cost-sharing reductions in accordance with paragraph (g) and section 1402 of the Affordable Care Act. In § 155.340, we propose that the Exchange transmit information about an enrollee's category to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of reductions. The proposed categories are as follows: In paragraph (h)(1), an individual who has household income greater than 100 percent of the FPL and less than or equal to 150 percent of the FPL; in paragraph (h)(2), an individual who has household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL; and in paragraph (h)(3), an individual who has household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL. Additional information regarding the implementation of cost-sharing reductions will be provided in the future. Eligibility standards for cost-sharing provisions that are based in

whole and in part on whether an individual is an Indian are described in § 155.350 of this subpart.

c. Eligibility Determination Process (§ 155.310)

In § 155.310, consistent with sections 1411–1413 of the Affordable Care Act, we propose the process by which the Exchange will determine an individual's eligibility for enrollment in a QHP and for insurance affordability programs.

In paragraph (a)(1), we propose that the Exchange accept applications from individuals in the form and manner described in proposed 45 CFR § 155.405, published in the Exchange proposed rule at 76 FR 41866. Furthermore, in paragraph (a)(2), we propose to prohibit the Exchange from requiring an individual who is not seeking coverage for himself or herself (a 'non-applicant'), including an individual who is applying for coverage on behalf of another party, to provide information regarding the non-applicant's citizenship, status as a national, or immigration status on any application or supplemental form. We also propose that the Exchange may not require such an individual to provide a SSN, except as specified in § 155.305(f)(6), which addresses, for the purposes of eligibility for advance payments of the premium tax credit, primary taxpayers who have SSNs and have tax data on file with the IRS that would be used in the verification of household income and family size. This exception is based on sections 1412(b)(1) and 1411(b)(3) of the Affordable Care Act and is discussed further above.

In paragraph (b), we propose that the Exchange permit an individual to decline an eligibility determination for insurance affordability programs. This proposal is designed to ensure that an individual can bypass the additional steps required for such screening and proceed directly to selecting and enrolling in a QHP. We clarify that this proposal does not allow an applicant to choose to seek a determination only for advance payments of the premium tax credit and cost-sharing reductions (and not for Medicaid and CHIP) or vice versa. Section 36B(c)(2)(B) of the Code states that an applicant is ineligible for advance payments of the premium tax credit to the extent that he or she is eligible for other minimum essential coverage, which includes Medicaid and CHIP. This provision means that the Exchange will consider an applicant's eligibility for Medicaid and CHIP as part of an eligibility determination for advance payments of the premium tax credit.

In paragraph (c), we propose that the Exchange accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during a benefit year. An eligibility determination is a necessary precursor to enrollment; after an applicant is determined eligible for enrollment in a QHP, he or she may select a QHP and will then be able to receive covered health care services. We clarify that this does not supersede the limited enrollment periods in 45 CFR subpart E. In addition, subpart E does not limit an applicant's ability to request and receive an eligibility determination, including an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions, if he or she has previously declined such a determination. We also note that § 155.330 directs the Exchange to accept and process changes reported by enrollees during the benefit year as well.

In paragraph (d)(1), we propose that after the Exchange has collected and verified all necessary data, the Exchange conduct an eligibility determination in accordance with the standards described in § 155.305 of this part.

In paragraph (d)(2)(i), we propose that the Exchange allow an applicant who is determined eligible for advance payments of the premium tax credit to accept less than the expected annual amount of advance payments authorized. This proposal is designed to reduce the enrollee's risk of repayment at the point of reconciliation.

In paragraph (d)(2)(ii), we propose to clarify that the Exchange may provide advance payments on behalf of a primary taxpayer only if the primary taxpayer first attests that he or she will meet the tax-related provisions discussed in the definition of primary taxpayer, including that he or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her tax family. In a scenario in which more than one tax household is covered through a single policy, 26 CFR 1.36B–3 of the Treasury proposed rule proposes that advance payments will be split between the two primary taxpayers; that is, a primary taxpayer may not receive advance payments for which another primary taxpayer is eligible. This proposal also clarifies that while an application filer who is not the primary taxpayer may complete the application process on the primary taxpayer's behalf, the primary taxpayer must actively attest that he or she will comply with the standards for advance payments that are related to tax filing prior to advance payments being made

for his or her family. This is designed to ensure that the primary taxpayer appreciates and accepts the tax consequences that follow from receipt of advance payments.

In paragraph (d)(3), we propose that if the Exchange determines an applicant is eligible for Medicaid or CHIP, the Exchange will notify the State Medicaid or CHIP agency and transmit relevant information, including information from the application and the results of verifications, to such agency promptly and without undue delay in order to enable the applicant to receive benefits.

In paragraph (e), we clarify that upon making eligibility determinations for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, the Exchange will implement the eligibility determinations in accordance with the coverage effective dates specified in subpart E, which are found at 45 CFR 155.410(c) and (f), and 45 CFR 155.420(b). This is designed to ensure that an applicant's entire eligibility determination and any financial assistance to support the purchase of coverage are effective simultaneously.

After the Exchange determines eligibility, in paragraph (f) we propose that the Exchange provide an applicant with a timely, written notice of his or her eligibility determination. For an applicant who requests an eligibility determination for insurance affordability programs, the Exchange will provide information in the notice regarding the applicant's eligibility for all such programs. While we expect that the Exchange will provide an applicant who is applying online with information regarding his or her eligibility determination as the process progresses, we clarify that the Exchange must provide a single written notice to each applicant when the eligibility determination is final. The written notice of eligibility is intended to provide an individual with a record of the steps taken and remaining actions needed to complete the eligibility and enrollment process, as well as information regarding his or her right to appeal. We note that written notice is not necessary at every step of the eligibility process; rather, the Exchange will provide a single notice at the conclusion of the determination, as well as notices when additional information is required. We note that in § 155.230, we proposed general rules regarding notices under this part, which include provisions regarding ensuring that notices be written in plain language and in a manner that meets the needs of diverse populations by providing meaningful access to limited English

proficient individuals and ensure effective communication for people with disabilities. We anticipate proposing additional information to be included in notices in future rulemaking.

In paragraph (g), we propose to codify the reporting rules in section 1411(e)(4)(B)(iii) of the Affordable Care Act, which support the employer responsibility provisions of the Affordable Care Act. We propose that when the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that his or her employer does not provide minimum essential coverage, or provides coverage that is not affordable, as specified in section 36B(c)(2)(C)(i) of the Code, or does not meet the minimum value standard as specified in section 36B(c)(2)(C)(ii) of the Code, the Exchange will notify the employer and identify the employee. We anticipate providing additional information on the content of this notice in future rulemaking.

In paragraph (h), we propose rules regarding the duration of an eligibility determination for an applicant who is determined eligible for enrollment in a QHP but does not select a QHP within his or her enrollment period in accordance with subpart E of this part. The purpose of these proposed rules is to ensure that the information used to support an eligibility determination remains accurate, while limiting burden and creating consistency with the rules for the population that selects a QHP. First, in paragraph (h)(1), we propose that to the extent that such an individual seeks a new enrollment period prior to the date on which he or she would have been subject to an annual redetermination in accordance with § 155.335, the Exchange must receive an attestation from him or her as to whether information affecting his or her eligibility has changed prior to accepting such selection. Second, in paragraph (h)(2), we propose that to the extent that an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment period, and seeks a new enrollment period on or after the date on which he or she would have been subject to an annual redetermination, the Exchange will conduct an annual redetermination in accordance with § 155.335 prior to determining the applicant's eligibility for an enrollment period.

We considered requiring a new determination after a specific period of time, but opted for the proposed language in order to create consistency

with the process for an individual who has been determined eligible for enrollment in a QHP and who actually enrolls during an authorized enrollment period, and to minimize burden on applicants and the Exchange. We solicit comments on this approach, and whether the application process should begin anew in some or all of these situations.

d. Verification Process Related to Eligibility for Enrollment in a QHP (§ 155.315)

Sections 1411(c) and (d) of the Affordable Care Act require the verification of applicant information prior to using such information to determine eligibility. The statute is specific with regard to the verification process for some, but not all, information needed to determine eligibility. Section 1411(d) of the Affordable Care Act provides authority for the Secretary to establish verification procedures for certain categories of information described in section 1411 without a specific process established by the statute. In addition, section 1411(c)(4)(B) of the Affordable Care Act provides authority to the Secretary to modify the statutory verification methods in certain cases.

We propose to split the verification process of the Exchange into two main sections within this subpart: § 155.315, which contains the verification process related to eligibility for enrollment in a QHP, and § 155.320, which contains the verification process related to insurance affordability programs. We also note that § 155.350 contains a process for verification of whether an applicant is an Indian.

In general, the verification processes proposed in this subpart would have the Exchange first rely on sources of electronic data and, to the extent that the Exchange is unable to verify information through such sources, follow specific procedures that include requesting documentation from applicants. Data sources described in this section may include the records of the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS), as well as data sources maintained by other entities.

We also note that we propose to include authority for the Exchange to request documentation from an applicant when information provided by the applicant is not reasonably compatible with other information provided for an applicant or in the records of the Exchange for the applicant; this proposal is designed to enhance program integrity while

limiting additional requests to only those situations in which there is good cause for such requests. The preamble discussion associated with proposed 42 CFR 435.952(b) of the Medicaid proposed rule addresses the “reasonably compatible” standard, which is used throughout the Medicaid proposed rule as well. We intend to interpret this standard the same way here (in the context of the Exchange) as it is interpreted and applied in the context of Medicaid and CHIP.

In paragraph (a), we propose that the Exchange verify or obtain information to determine that an applicant is eligible for enrollment in a QHP as provided in this section, unless an Exchange’s request for modification of the methods used for collection and verification of information is granted pursuant to paragraph (e). Under paragraph (e), described later, we propose the flexibility to develop alternative verification processes that achieve the same goals as those proposed for general use.

In paragraph (b), we propose the process that the Exchange follows to ensure that an individual is a citizen, national, or otherwise lawfully present individual in accordance with sections 1312(f)(3) and 1411(c) of the Affordable Care Act, respectively. This is the first of several proposals regarding verification with the records of Federal officials. For such verifications, we propose to codify the role of the Secretary (through HHS) as an intermediary between the Exchange and other Federal officials, as described in section 1411(c). This proposal is designed to simplify the process for the Exchange as well as for involved Federal agencies.

In paragraph (b)(1), we propose that for an applicant who attests to citizenship and has a Social Security number, the Exchange will transmit the applicant’s Social Security number and other identifying information needed by the Social Security Administration (SSA) to SSA via HHS to verify whether the information matches SSA’s records. We anticipate that SSA may revise its information requirements and that a level of flexibility will be necessary to efficiently use this process. If the information needed to perform this verification with SSA changes, HHS will issue guidance to Exchanges. We anticipate that the single, streamlined application proposed in 45 CFR § 155.405 will contain the necessary information. If SSA can match the individual’s basic identifying information to an SSA record, HHS will notify the Exchange as to whether SSA can substantiate the applicant’s

citizenship. If SSA is unable to match the individual’s basic identifying information to an SSA record, HHS will notify the Exchange regarding the inconsistency.

In paragraph (b)(2), and consistent with section 1411(c)(2)(B) of the Affordable Care Act, we propose that for an applicant who has documentation that can be verified through the Department of Homeland Security (DHS) and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate citizenship through SSA, including an applicant who does not attest to citizenship or does not have a Social Security number, the Exchange will transmit information from the applicant’s documentation and basic identifying information to HHS, which will submit a request to DHS and return the response to the Exchange. Several commenters to the RFC recommended that we utilize the DHS Systematic Alien Verification for Entitlements (SAVE) system to satisfy this standard. The proposed language supports the use of SAVE, and we are working closely with DHS to identify the best technological option available to maximize accuracy and minimize delay.

Section 1411(e)(3) of the Affordable Care Act specifies that in a situation in which the Exchange is unable to verify an applicant’s claim of citizenship, status as a national, or lawful presence through either SSA or DHS, the applicant’s eligibility must be determined in the same manner as an applicant’s eligibility under the Medicaid program under section 1902(ee) of the Act. Section 1902(ee) of the Act includes a number of provisions related to the verification of citizenship, including a process by which a Medicaid agency can request that SSA verify whether an applicant’s attestation of citizenship matches SSA’s records. If such substantiation is unsuccessful, section 1902(ee) of the Act directs the Medicaid agency to: (1) Make a reasonable effort to identify and address the causes of the inconsistency; (2) notify the applicant of the inconsistency if the inconsistency cannot be resolved through this step, provide the applicant with a period of 90 days from receipt of the notice to present satisfactory documentation of citizenship or resolve the inconsistency with SSA, and provide Medicaid coverage during this period; and (3) if the inconsistency is not resolved after the close of the period, disenroll the individual. Section 1902(ee) of the Act also includes details of the relationship between a State Medicaid agency and SSA, as well as the calculation of a payment to the

Secretary related to how often eligibility is provided to applicants who are ultimately determined ineligible, when a State is not using the option to communicate with SSA on a real-time basis. We intend for the process proposed under this section to be near real-time, and therefore, we believe that this calculation does not apply to the Exchange. Further, unlike the choice provided to a State Medicaid agency pursuant to section 1902 of the Act, the Exchange will not automatically have the ability to implement a different verification process; therefore, the use of a penalty provision appears inappropriate here.

This inconsistency process is substantially similar to the inconsistency process for information not related to citizenship, status as a national, or lawful presence, which is described in section 1411(e)(4) of the Affordable Care Act, codified in paragraph (e) of this section, and discussed below. As such, in paragraph (b)(3), we specify that in the case of an inconsistency related to citizenship, status as a national, or lawful presence, the Exchange will follow the procedures specified in paragraph (e), except that the time period for the resolution of inconsistencies related to citizenship, status as a national, or lawful presence is 90 days from the date on which the notice of inconsistency is received, rather than the date on which it is sent, as required by the law. We clarify that the date on which the notice is received means 5 days after the date on the notice, unless the applicant shows that he or she did not receive the notice within the 5-day period. This 5-day period is the standard period used by SSA for the Supplemental Security Income (Title XVI) and Old Age and Disability (Title II) programs to account for mailing a notice and receipt by the individual, and we believe this reasonable standard to adopt for the inconsistency process. We note that this process covers situations in which an applicant has neither a Social Security number nor documentation that can be verified with DHS. Future rulemaking will address the standards that the Exchange will use to adjudicate documentary evidence of citizenship provided by an applicant within this inconsistency process.

In paragraph (c), we propose the verification process to be used by the Exchange to ensure that an individual meets the residency standard specified in § 155.305(a)(3) of this part. This process is parallel to that proposed for Medicaid.

In paragraph (c)(1), to verify residency, we propose that the

Exchange accept an applicant's attestation as to residency without further verification unless, as described in paragraph (c)(2), the State Medicaid or CHIP agency operating in the State in which the Exchange operates chooses not to allow verification of residency based solely on attestation, in which case the Exchange will verify residency in accordance with 42 CFR 435.956(c) and 42 CFR 457.380(c), which are proposed in the Medicaid proposed rule.

Furthermore, in paragraph (c)(3), we propose that the Exchange may examine data sources regarding residency to the extent that information provided for an applicant regarding residency is not reasonably compatible with other information provided for the applicant or in the records of the Exchange. Examples of such data sources include State tax returns, Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families eligibility information, motor vehicles administration information, or other local, State or Federal sources of information.

In paragraph (c)(4), we propose that to the extent information in the data sources examined by the Exchange in accordance with paragraph (c)(3) of this section is not reasonably compatible with information provided for the applicant, the Exchange will request additional documentation in accordance with § 155.315(e) of this section. We also propose that a document that provides evidence of immigration status may not be used alone to determine State residency. As discussed in the preamble to proposed 42 CFR 435.956(c) of the Medicaid proposed rule, this provision is intended to ensure that while documents which provide information regarding immigration status should be used as a source of evidence to verify satisfactory immigration status, they may not, by themselves, be used to demonstrate a lack of residency.

In paragraph (d), we propose that the Exchange verify an applicant's attestation that he or she is not incarcerated, with the exception of incarceration pending the disposition of charges. In paragraph (d)(1), we propose that the Exchange implement this policy by first relying on any electronic data sources that are available to the Exchange and which have been authorized by HHS for verification of incarceration. HHS will approve electronic data sources based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; we note that

this allows for the possibility that no electronic data source will be authorized. In paragraph (d)(2), we propose that to the extent that approved electronic data sources are unavailable, the Exchange accept the applicant's attestation without further verification, except as provided in paragraph (d)(3). In paragraph (d)(3), we propose that in the event that an applicant's attestation is not reasonably compatible with information from the data sources specified in paragraph (d)(1) or with other information provided by the applicant or in the records of the Exchange, the Exchange follow the inconsistency procedures described in § 155.315(e) of this section, in accordance with section 1411(e)(4)(A)(ii)(II) of the Affordable Care Act.

We solicit comment as to what electronic data sources are available and should be authorized by HHS for Exchange purposes, including whether access to such data sources should be provided as a Federally-managed service like citizenship and immigration status information from SSA and DHS. We also note that the proposal regarding documentation is designed only to account for situations in which an attestation is not reasonably compatible with information contained in approved electronic data sources.

In paragraph (e), we propose to codify sections 1411(e)(3) and 1411(e)(4) of the Affordable Care Act to address situations in which an applicant attests to information needed to determine eligibility, and such attestation is inconsistent with other information in the records of the Exchange, including information maintained in the records of applicable Federal officials. As such, we cross-reference this paragraph for a number of verifications within § 155.315 and § 155.320 of this subpart. Such sections may also have specific standards for the adjudication of relevant documentation by the Exchange that are tailored to specific inconsistencies. We also note that given that the process in this paragraph is applied to more than one piece of information, it is possible for an applicant to have multiple inconsistencies simultaneously. In such a situation, the Exchange will continue to use an applicant's attestations for any information that is subject to the inconsistency process in accordance with paragraph (e)(4)(ii) of this section.

Section 1411(e)(3) of the Affordable Care Act, which covers inconsistencies related to citizenship, status as a national, and lawful presence, is substantially similar to section 1411(e)(4) of the Affordable Care Act,

which covers other inconsistencies. The process described in this paragraph is the process under section 1411(e)(4) of the Affordable Care Act; as noted above, paragraph (b)(3) of this section details the modifications required to the procedures described in this section to accommodate the process for inconsistencies related to citizenship, status as a national, and lawful presence.

First, under paragraph (e)(1), the Exchange will make a reasonable effort to identify and resolve the issues. Second, in paragraph (e)(2)(i), if the Exchange is unable to resolve the inconsistencies, the Exchange will notify the applicant of the inconsistency. After providing this notice, in paragraph (e)(2)(ii), the Exchange will provide 90 days from the date on which the notice is sent for the applicant to resolve the issues, either with the Exchange or with the agency or office that maintains the data source that is inconsistent with the attestation.

In paragraph (e)(3), we propose that the period during which an applicant may resolve the inconsistency may be extended by the Exchange if the applicant can provide evidence that a good faith effort has been made to obtain additional documentation. We are adopting this provision in order to align with current Medicaid policy which offers States the flexibility to allow for a good faith extension for individuals to provide documentary evidence of citizenship or immigration status.

In paragraph (e)(4), we propose to codify the provision of sections 1411(e)(3) and 1411(e)(4) of the Affordable Care Act that the Exchange must allow an individual who is otherwise eligible for enrollment in a QHP, advance payments of the premium tax credit or cost-sharing reductions to receive such coverage and financial assistance during the resolution period. However, in paragraph (e)(4)(ii), we clarify that the Exchange will ensure that the primary taxpayer attests to the Exchange that he or she understands that any advance payments of the premium tax credit received during the resolution period are subject to reconciliation in order to receive such advance payments of the premium tax credit.

Lastly, in paragraph (e)(5), we propose that if after the conclusion of the resolution period, the Exchange is unable to verify the applicant's attestation, the Exchange will determine the applicant's eligibility based on the information available from the data sources specified in this subpart, and notify the applicant of such

determination in accordance with the notice standards in § 155.310(f) of this subpart, including notice that the Exchange is unable to resolve the inconsistency. We further propose that the Exchange then implement this eligibility determination no earlier than 10 days after and no later than 30 days after the date on which such notice is sent. We note that we intend to address in the future the timing of notices, including standards related to the time between a notice of an adverse action and the effective date of such action, and we intend to coordinate such requirements with Medicaid. We note that like all other eligibility determinations, an eligibility determination in accordance with paragraph (e)(5)(i) of this section is subject to appeal.

In addition to the authority proposed for the Exchange in paragraph (e)(3), section 1411(b)(4)(A)(ii)(II) of the Affordable Care Act also provides HHS with the authority to extend the resolution period for inconsistencies not involving citizenship, status as a national, or lawful presence for coverage in 2014. We are considering whether and how to implement this authority, such as whether to create a uniform standard or a rule to be applied on a case-by-case basis; we solicit comments on these alternatives to inform our final adoption of these rules.

Lastly, we note that this paragraph does not apply in the event that an application filer attests to household income for an applicant that is at or below the applicable Medicaid or CHIP MAGI-based income standards. Rather, the Exchange will follow the process described in paragraph (c)(2)(ii)(C) for such individuals.

In paragraph (f), we propose to codify section 1411(c)(4)(B) of the Affordable Care Act regarding flexibility in verification methods. We propose that HHS may approve an Exchange plan or a significant change to an Exchange plan to modify the methods for the collection and verification of information as described in this subpart, as well as the specific information to be collected, based on a finding by HHS that the requested modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that any applicable requirements under this subpart and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met. We also note that all information exchanges specified in this section must comply with § 155.260 and

§ 155.270. We solicit comment regarding likely proposals from Exchanges that would meet these criteria.

Section 1411(g)(1) and 1413(b)(2) of the Affordable Care Act direct the Secretary to ensure that an applicant be asked only to provide the minimum amount of information and paperwork needed for purposes of making an eligibility determination. In paragraph (g), we propose to codify section 1411(g)(1) of the Affordable Care Act by specifying that the Exchange must not require an applicant to provide information beyond what is necessary to support the eligibility and enrollment processes of the Exchange, Medicaid, and CHIP, including the process for resolving inconsistencies described in § 155.315(e).

e. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

In § 155.320, we outline the verification process that supports eligibility determinations for insurance affordability programs. To implement section 1411 of the Affordable Care Act, we propose a general policy in paragraph (a)(1), that the Exchange verify information in accordance with this section only for an applicant who is requesting an eligibility determination for insurance affordability programs. In this section, we propose standards related to the verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan; household income and household size; enrollment in or eligibility for qualifying coverage in an eligible employer-sponsored plan; and Medicaid and CHIP immigration status requirements. These verification processes apply to eligibility determinations for insurance affordability programs. These verification processes do not apply to eligibility determinations solely for the purpose of enrollment or to eligibility determinations for benefits provided to Indians based on status as an Indian, which are addressed elsewhere.

Section 36B(c)(2)(B) of the Code specifies that an individual who is eligible for minimum essential coverage through sources other than the Exchange and the individual market is ineligible for advance payments of the premium tax credit. Therefore, in order to accurately determine eligibility for advance payments of the premium tax credit, the Exchange needs to rule out eligibility for other minimum essential coverage. We propose paragraphs (b), (d), and (e) of this section to meet this standard. First, in paragraph (b)(1), we

propose that the Exchange verify whether an individual is eligible for minimum essential coverage other than through an eligible employer-sponsored plan or Medicaid, CHIP, or the Basic Health Program within the State in which the Exchange operates using information obtained from HHS, which will obtain relevant information from selected Federal offices. We are currently working with other Federal agencies to determine where relevant records are maintained, and we solicit comments about specific data sources that HHS should integrate in to this process, as well as data sources that should be utilized directly by the Exchange, keeping in mind the direction from section 1413(c) of the Affordable Care Act regarding the use of data currently authorized for use in Medicaid and CHIP determinations.

In paragraph (b)(2), we propose that the Exchange verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or a Basic Health Program, if applicable, within the State in which the Exchange operates. We believe that this will result in limited, if any additional burden on the Exchange given the high degree of coordination between the Exchange, Medicaid, and CHIP. We also solicit comments as to options for supporting verification across States with the goal of crafting a solution that maximizes accuracy while minimizing administrative burden for applicants and Exchanges.

In paragraph (c), we propose the verification process related to income and family/household size. As discussed earlier, while the statute specifies that income for advance payments of the premium tax credit and cost-sharing reductions is calculated on an annual basis, section 1902(e)(14)(H) of the Act, as added by section 2002(a) of the Affordable Care Act, provides that income for Medicaid is calculated on a current basis. Consequently, in this section, we propose to require the Exchange to verify both annual household income information and current household income information. We also note that the Medicaid proposed rule proposes certain variations from the methodology used for advance payments of the premium tax credit and cost-sharing reductions for both income and household size, which are discussed further in the preamble to 42 CFR 435.603. These differences include the treatment of qualifying relatives claimed as tax dependents by another taxpayer; children claimed as tax dependents by non-custodial parents; pregnant women; lump sum payments; scholarships or

fellowship grants that are used for educational purposes; and certain American Indian/Alaska Native income. We solicit comments regarding how best to ensure a streamlined eligibility process given these underlying differences.

In this section we use the term, application filer, as defined in § 155.300(a). We note that the application filer does not necessarily have to be the primary taxpayer. We believe that the proposed process will support applications received through all channels, including electronically and on paper, although we discuss certain modifications that may be needed to accommodate paper applications later in this section.

First, in paragraph (c)(1)(i)(A), we propose that for all individuals whose income is counted in calculating a primary taxpayer's household income, in accordance with 26 CFR 1.36B-1(e) of the Treasury proposed rule, or an applicant's household income, in accordance with 42 CFR 435.603(d) of the Medicaid proposed rule, and for whom the Exchange has a Social Security number or an adoption taxpayer identification number, the Exchange will request tax return data from the Secretary of the Treasury by submitting identifying information to HHS, which will in turn submit it to the Secretary of the Treasury. This identifying information will include name, Social Security number, and relationship to the primary taxpayer (filer, spouse, dependent), and like all other information submissions, will only include the minimum information needed to complete the verification. In paragraph (c)(1)(i)(B), we propose that in the event that the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed pursuant to the Code, HHS will notify the Exchange, and the Exchange must make a reasonable effort to confirm that the lack of a match is not due to an error in individual identifying information. This proposal is consistent with our proposal in § 155.315(e)(1) and is designed to ensure that the Exchange can maximize the use of available electronic data sources in order to facilitate a streamlined eligibility process.

We solicit comments regarding how the Exchange can best use available data to assist an application filer in navigating the components of the eligibility process related to household income and family/household size. We are particularly interested in comments regarding how to help an application filer determine whether available tax

information is representative of a primary taxpayer's likely situation for the year for which coverage is requested.

We note that this proposal represents a modification of the statutory verification process, based on the authority granted to the Secretary in section 1411(c)(4)(B) to modify the methods for obtaining data, including allowing an applicant to request that the Secretary of the Treasury provide return information directly to the Exchange through the Secretary of HHS. We believe that this approach will be far more efficient for applicants, the Exchange, and the Federal government than the basic procedure described in the statute, which would require an application filer to state MAGI and then have the Exchange check with the Secretary of the Treasury through HHS to see if this was consistent with the records of the Secretary of the Treasury. We believe that requiring an application filer to state MAGI would deter applications by essentially requiring an application filer to possess a copy of the relevant tax return at the point of application, and would also reduce sharply the ability of the Exchange to assist application filers in completing the eligibility process. Further, without the proposed modification, we believe that a large number of applicants would be subject to the inconsistency process for income and household size, which would then drive a rise in the amount of paper documentation required, slowing down the overall eligibility process.

In accordance with the statute, we propose this modification after determining that any applicable requirements under section 1411 of the Affordable Care Act and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, and use of information can and will be met. To this end, we are already working with the Secretary of the Treasury and States to ensure that Treasury-required safeguards for tax information will be met across the Exchange information technology architecture, as specified in 45 CFR 155.260(d).

In order to incorporate Medicaid and CHIP into the streamlined eligibility process, it is necessary to have readily available current income data to fill a similar role to that proposed for Treasury data in paragraph (c)(1)(i) of this section. Medicaid regulations at 42 CFR 435.948(a), proposed in the Medicaid NPRM, specify that a State Medicaid agency must request State quarterly wage information, as well as other sources of current income, for use

in verifying an individual's MAGI-based income information, to the extent that such information is useful in conducting this verification. In this rule, we propose that the Exchange utilize this data for purposes of Exchange determinations of eligibility for Medicaid and CHIP in a similar manner to how we propose the Exchange use tax data for purposes of Exchange determinations of eligibility for advance payments of the premium tax credit and cost-sharing reductions. That is, consistent with Medicaid regulations, we propose that the Exchange treat the list of current data sources described in 42 CFR 435.948(a), proposed in the Medicaid NPRM, as primary sources of MAGI-based income data for purposes of verification.

In paragraph (c)(1)(ii), we propose that the Exchange obtain the most recent income information for all individuals whose income is counted in calculating a primary taxpayer's household income, in accordance with 26 CFR 1.36B-1(e), or an applicant's household income, in accordance with 42 CFR 435.603(d), from the data sources described in 42 CFR 435.948(a) of the Medicaid proposed rule, which lists the data sources for Medicaid eligibility determinations. We believe that this step is necessary to implement our interpretation of the Affordable Care Act regarding the Exchange's role in determining Medicaid eligibility, and does not create significant additional burden as it is an existing procedure in Medicaid programs. We recognize that 42 CFR 435.948(a) includes multiple data sources, and we intend to provide subregulatory guidance regarding how such information can be utilized in a manner that is straightforward and helpful to application filers. We also solicit comment on this topic.

In paragraphs (c)(2) and (c)(3) of this section, we propose the verification process for Medicaid and CHIP and for advance payments of the premium tax credit and cost-sharing reductions, respectively. We note that while we have drafted these sections separately, we expect the Exchange to implement them in an integrated, streamlined process that will avoid redundancy and minimize confusion for applicants.

We also note that the proposed process in these paragraphs are designed to minimize burden on application filers by only requiring an applicant to provide an attestation regarding income if he or she attests that available data sources are not representative of an applicant or primary taxpayer's current or projected financial situation, as applicable. For an electronic application, we believe that

the attestations required can be part of a real-time process, in which an application filer would be shown information computed by the Exchange regarding MAGI-based income and annual household income and then offered the opportunity to affirm it or provide different information. For a paper application, this approach will not be possible, and so the Exchange will instead check the information provided by an application filer on a paper application against data regarding MAGI-based income and annual household income or provide the information computed based on data from sources to the application filer on paper and request confirmation. We solicit comments as to how this process can work most smoothly for both electronic and paper applications.

First, in paragraph (c)(2)(i), we propose the Exchange direct an application filer to attest to the specific individuals who comprise an applicant's household for Medicaid and CHIP, within the meaning proposed in 42 CFR 435.603(f) of the Medicaid NPRM. This provision is designed to define the relevant Medicaid and CHIP household, which is necessary to determine income. We also propose that Exchange accept an application filer's attestation regarding the members of his or her household without further verification, unless the Exchange finds that the attestation is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, in which case the Exchange may utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the application filer's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in 45 CFR 435.952.

Second, in paragraph (c)(2)(ii), we propose that the Exchange verify MAGI-based income for purposes of determining eligibility for Medicaid and CHIP by following the procedures described in 42 CFR 435.948 and 42 CFR 435.952. We solicit comments as to how the Exchange process and the Medicaid and CHIP processes can be streamlined to ensure consistency and maximize the portion of eligibility determinations that can be completed in a single session.

In paragraph (c)(3), we propose the verification process for advance payments of the premium tax credit and cost-sharing reductions, First, in paragraph (c)(3)(i), we propose the

Exchange direct an application filer to attest to the specific individuals who comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions, within the meaning proposed in 26 CFR 1.36B-1(d) of the Treasury proposed rule. This provision is designed to define the relevant primary taxpayer's family, which is necessary to determine income. We also propose the Exchange accept an application filer's attestation of family size without further verification, except as provided in cases in which information is not reasonably compatible with other data. We anticipate that the Exchange will provide education and assistance to an application filer such that attestations will be as close as possible to the ultimate tax filing family. We believe that requiring further verification of this is extremely difficult and may not be possible and that any verification would be of limited use while adding significant burden and delay to the process. We also propose that to the extent the Exchange finds that an application filer's attestation of family size is not reasonably compatible with other information provided by the application filer for the family, the Exchange may utilize data obtained through electronic data sources to verify the attestation. We also propose that if such data sources are unavailable or not reasonably compatible with the attestation, the Exchange will follow the procedures specified in § 155.315(e) of this subpart.

In paragraphs (c)(3)(ii)-(vi), we propose the verification process for income for purposes of advance payments of the premium tax credit and cost-sharing reductions. In paragraph (c)(3)(ii)(A), we propose the Exchange compute annual household income for the family defined by the application filer, based on the electronic data acquired pursuant to paragraph (c)(1)(i) of this section, and that the application filer validate this information by attesting whether it represents an accurate projection of the family's household income for the benefit year for which coverage is requested.

In paragraph (c)(3)(ii)(B), we propose that if tax data are unavailable, or if an application filer attests that the Exchange's computation does not represent an accurate projection of the family's household income for the benefit year for which coverage is requested, the Exchange will direct the application filer to attest to the family's projected household income for the benefit year for which coverage is requested. Lastly, in paragraph (c)(3)(ii)(C), we propose that if the

Exchange finds that an application filer's attestation to a family's projected annual household income is not reasonably compatible with the information regarding projected annual household income computed by the Exchange, including as a result of tax return data being unavailable, the Exchange will proceed in accordance with paragraphs (c)(3)(iii), (c)(3)(iv), and (c)(3)(vi), as applicable, which describe alternate verification processes. Section 1412(b)(2) of the Affordable Care Act provides that the Secretary provide procedures for making advance determinations for advance payments of the premium tax credit and cost-sharing reductions on the basis of information other than a primary taxpayer's most recent tax return, "in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility." The statute specifies that these alternate procedures should apply to a primary taxpayer whose income has decreased by at least 20 percent, is filing an application for unemployment benefits, or is not required to file a tax return, as well as to other primary taxpayers specified by the Secretary.

In paragraphs (c)(3)(iii) and (c)(3)(iv), we propose to codify this provision of the statute by directing that the Exchange use an alternate process for determining income for purposes of advance payments of the premium tax credit and cost-sharing reductions for primary taxpayers in certain situations. In both (c)(3)(iii) and (c)(3)(iv), as section 1412(b)(2) specifies that the alternate process is limited to eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, we propose that the alternate processes are only available to a primary taxpayer for whom an application filer (who can be the primary taxpayer) has not established MAGI-based household income that is at or below the applicable Medicaid or CHIP MAGI-based income standard. That is, if an individual is or may be eligible for Medicaid or CHIP, this step in the verification process is not applicable because the applicant will not be eligible for advance payments of the premium tax credit or cost-sharing reductions.

First, in paragraph (c)(3)(iii), we propose procedures for situations in which an application filer attests that a primary taxpayer's annual household income has increased or is reasonably

expected to increase from the information obtained from his or her tax return. In such a situation, we propose the Exchange accept the application filer's attestation without further verification, except as provided in paragraph (c)(3)(iii)(B). This approach to verification is proposed because such attestation would result in the Federal government providing a lower advance payment than would otherwise be provided based on the primary taxpayer's most recent available tax return.

However, in order to ensure that such an attestation does not understate income, in paragraph (c)(3)(iii)(B), we propose that if the Exchange finds that the application filer's attestation is not reasonably compatible with other information provided by the application filer or the MAGI-based income information acquired by the Exchange pursuant to paragraph (c)(1)(ii), the Exchange may utilize data obtained through electronic data sources to verify the attestation. If this approach is unsuccessful, the Exchange may request additional information in accordance with the procedures specified in § 155.315(e) of this subpart.

In paragraph (c)(3)(iv), we propose to codify the minimum requirements of section 1412(b)(2) of the Affordable Care Act, described above, regarding the circumstances under which an application filer who is attesting to a decrease in income for a primary taxpayer, or is attesting to income because tax return data is unavailable, may utilize an alternate income verification process. We clarify that this provision does not supersede § 155.305(f)(4), which prohibits the Exchange from determining a primary taxpayer eligible for advance payments of the premium tax credit if advance payments were made on behalf of the primary taxpayer or his or her spouse for a year for which tax data would be utilized for verification of household income and family size and the primary taxpayer or his or her spouse did not comply with the requirement to file a tax return for that year as required by 26 CFR 1.6011-8 (proposed in the Treasury proposed rule).

We anticipate that this alternate process may also accommodate a situation in which an applicant does not have a Social Security number or a non-applicant who is listed on an application as a family member does not have or does not provide a Social Security number. We solicit comment on what other situations should justify use of the alternate process. One potential approach is to allow a primary taxpayer with a decrease in income that

does not meet the 20 percent threshold offered in the statute, but meets some other threshold, to use the alternate process. This would create a greater possibility that a primary taxpayer with a fairly significant decrease in income would be able to purchase coverage.

In paragraph (c)(3)(v), we propose the alternative process for verifying income for primary taxpayers for whom an application filer attested to a decrease in household income or for whom tax return data is unavailable, as described in paragraph (c)(3)(iv) of this section. Under these proposed procedures, the Exchange will first attempt to verify the application filer's attestation of projected annual household income for the primary taxpayer by using an annualized version of the MAGI-based income data obtained in accordance with paragraph (c)(1)(ii). In the event that this is unsuccessful, we propose that the Exchange attempt to verify the application filer's attestation using any other electronic data sources that have been approved by HHS. HHS will approve other electronic data sources based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification. In paragraph (c)(3)(v)(C), if such steps are unsuccessful, we propose the Exchange follow the procedures specified in § 155.315(e) of this subpart.

In paragraph (c)(3)(v)(D), we propose to clarify that if at the conclusion of the 90-day period, an application filer has not responded to a request for additional information from the Exchange in accordance with this section and the data sources specified in paragraph (c)(1) indicate that an applicant in the primary taxpayer's family is eligible for Medicaid or CHIP, the Exchange will not provide the applicant with eligibility for advance payments of the premium tax credit or cost-sharing reductions based on the application, in order to ensure that applicants who are eligible for Medicaid or CHIP are not determined eligible for advance payments or cost-sharing reductions as a result of non-compliance. In paragraph (c)(3)(v)(E), we propose that in other situations in which the Exchange remains unable to verify an application filer's attestation, it will determine an applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A). In paragraph (c)(3)(vi), we propose to codify section 1412(b)(1)(B) of the Affordable Care Act regarding primary taxpayers who do not meet the criteria specified in paragraph (c)(3)(iii) or (c)(3)(iv) for use of an alternate income verification process. We propose the

Exchange determine eligibility for these primary taxpayers for advance payments of the premium tax credit and cost-sharing reductions based on the income from the primary taxpayer's tax data. At a minimum, the tax return data used for this purpose should be from the taxable year ending with or within the second calendar year preceding the calendar year in which the benefit year begins.

In paragraph (c)(4), we propose the Exchange provide education and assistance to an application filer regarding the verification process for income and family/household size. We solicit comments as to strategies that the Exchange can employ to ensure that application filers understand the validation process and provide well-informed validations and attestations, including, but not limited to, developing ways to best display the data acquired from data sources and potentially accessing other data sources that might be informative. We intend to provide subregulatory guidance on this topic.

In paragraph (d), we propose that the Exchange verify whether an applicant is enrolled in an eligible employer-sponsored plan by accepting his or her attestation without further verification, except as provided in paragraph (d)(2) in cases in which information is not reasonably compatible with other data. Although section 36B(c)(2)(C) of the Code provides that an individual is eligible for the premium tax credit provided that his or her coverage through an eligible employer-sponsored plan is not affordable or does not provide minimum value, clause (iii) of that subparagraph prohibits eligibility for the premium tax credit if the individual is enrolled in an eligible employer-sponsored plan, regardless of the cost or value of that plan. We propose that the Exchange accept an applicant's attestation without further verification, with provisions in cases in which the attestation is not reasonably compatible with other data, because we believe that an applicant generally understands whether or not he or she is enrolled in an eligible employer-sponsored plan. We solicit comments as to whether this is a reasonable assumption. Similar to the provisions regarding residency and income verification, we propose to allow the Exchange to request additional information regarding whether an applicant is enrolled in an eligible employer-sponsored plan if an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. We solicit

comments regarding the best data sources for this element of the process.

In paragraph (e)(1), we propose that the Exchange require an applicant to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions.

In paragraph (e)(2), we propose that the Exchange verify this information. We solicit comments regarding how the Exchange may handle a situation in which it is unable to gain access to authoritative information regarding an applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan.

Exchanges will interact with employees and their employers in order to make a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions. Specifically sections 1401 and 1402 of the Affordable Care Act establish that an applicant is eligible for advance payments of the premium tax credit or cost-sharing reductions only if he or she is not eligible for qualifying coverage in an eligible employer-sponsored plan that meets a minimum value standard and is affordable under section 36B(c)(2)(C) of the Code, as added by the Affordable Care Act. Section 1411(b) of the Affordable Care Act directs an applicant seeking advance payments of the premium tax credit and cost-sharing reductions through the Exchange to provide to the Exchange specific information for purposes of determining eligibility, including (1) The name, address and Employer Identification Number (if available) of the employer; (2) whether the applicant is a full-time employee and whether the employer provides minimum essential coverage; and (3) if the employer provides minimum essential coverage, the lowest cost option for the applicant's enrollment status and the applicant's contribution under the employer-sponsored plan. Additionally, we recognize that Exchanges may need additional information about employer-sponsored health plans to complete eligibility determinations such as information about whether such plans are available to spouses and dependents and whether they meet the minimum value standard.

Under several statutory reporting provisions, employers already will provide much, if not all, of the information the Exchanges will need to determine eligibility for advance payments of the premium tax credit and cost-sharing reductions. Under these provisions, employers will provide

information either directly to their employees, to the IRS and/or to the Department of Labor. These provisions include, but are not limited to, section 6056 of the Code, as added by section 1514 of the Affordable Care Act (requiring employers to report to the IRS specific information related to employer-sponsored health coverage provided to employees); section 2715 of the PHS Act, as amended by section 1001 of the Affordable Care Act (requiring group health plans and health insurance issuers to disclose to eligible individuals information about the employer-sponsored health plan(s) or coverage option(s) available to them); and section 18B of the Fair Labor Standards Act, as added by section 1512 of the Affordable Care Act (requiring employers to disclose to employees information regarding Exchange coverage options).

In developing the standards for Exchange verification of eligibility for qualifying coverage in an eligible employer-sponsored plan, HHS and the Departments of the Treasury and Labor are working together to coordinate how needed information could be reported in order to make it efficient and easy for employees to access it and to minimize burden on employers. For example, consideration is being given to whether Exchanges could provide a template that both employers and employees could use to capture information already reported under the provisions cited above. A template might help employees to have ready-access to the plan-level information they need for the Exchange application process, and for employers, it might support a uniform verification process that would simplify employers' interactions with the Exchanges.

We are also considering the feasibility of a central database that employers voluntarily could populate as a potential resource for the verification process. A consolidated database could be drawn upon for the purposes of verifying the information provided by applicants seeking eligibility for advance payments of the premium tax credit and cost-sharing reduction. Such database would include the appropriate privacy and security safeguards necessary to protect the information provided. We recognize that employers will need to accumulate both plan-level and employee-level information for purposes of reporting under section 6056 of the Code (as added by section 1514 of the Affordable Care Act). We are considering whether and how the same plan-level information could be incorporated into such a database.

We invite comment on the timing and reporting of information needed to verify whether an employed applicant is eligible for an advance payment of the premium tax credit and cost-sharing reductions and how best for Exchanges to interact and communicate with employers to verify information regarding employer-sponsored coverage. Specifically, we invite comment on (1) whether a template would be helpful and, if so, how it could be designed to capture plan-level information that is already reported to employees, the IRS and/or the Department of Labor, and (2) whether the development of a central database is an attractive option for employers to provide information about the coverage offered under eligible employer-sponsored plans. We note that the Treasury Department and the IRS also intend to request comments on the employer information reporting required under section 6056 of the Code.

In paragraph (f), we propose a process regarding the verification of specific immigration status standards for Medicaid and CHIP. The immigration status standards for eligibility for enrollment in a QHP differ from those for Medicaid and CHIP, with the exception of the standard for pregnant women and children in certain States that have adopted the State option under section 1903(v)(4) of the Act, as added by section 214 of the Children's Health Insurance Program Reauthorization Act (Pub. L. 111-3, 123 Stat. 8), further, the 'reasonably expected' element discussed in § 155.305(a)(1) does not apply to any population in Medicaid or CHIP. In paragraph (f), we propose that the Exchange verify whether an applicant requesting an eligibility determination for insurance affordability programs under § 155.310(b) who is not a citizen or national meets the immigration status and five-year waiting period for Medicaid and CHIP as specified under 42 CFR 435.406, 42 CFR 457.320, 1903(v)(4) of the Act, section 2107(e)(1)(J) of the Act, and section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Pub. L. 104-493, 110 Stat. 2105), as applicable. We clarify that we do not consider eligibility for Medicaid coverage that is restricted to emergency services to qualify an individual as eligible for Medicaid. We anticipate that the Exchange will determine whether an individual meets this standard while verifying the individual's citizenship, status as a national, or lawful presence as required in § 155.315(b).

As section 36B(c)(1)(B) of the Code, which is also referenced in section 1402 of the Affordable Care Act in defining eligibility for cost-sharing reduction, provides that an applicant who is lawfully present in the United States, has household income below 100 percent of the FPL, and is not eligible for Medicaid based on immigration status is eligible for the premium tax credit, we believe that 42 CFR 435.406(a)(2) and section 403 of PRWORA do not apply to advance payments of the premium tax credit and cost-sharing reductions. Therefore, we propose a definition of “lawfully present” that is not limited to “qualified alien” as defined in PRWORA.

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

Section 1411(f)(1)(B) of the Affordable Care Act specifies that the Secretary shall establish procedures by which the Secretary or another Federal official redetermines an individual’s eligibility on a periodic basis. Consistent with our proposal that the Exchange conduct initial eligibility determinations, in § 155.330, we outline procedures for redeterminations during a benefit year consistent with section 1411(f)(1)(B) of the Affordable Care Act. We note that the goal of the eligibility redetermination process is to ensure that an individual’s eligibility reflects his or her circumstances with respect to the eligibility standards specified in § 155.305, while minimizing administrative complexity for enrollees and the Exchange.

The redetermination process that we propose in this section relies primarily on the individual to provide the Exchange with updated information during the benefit year, as opposed to having the Exchange examine electronic data sources and/or contact the individual in order to determine whether a change has occurred during the year. This primary reliance on individuals would eliminate much of the administrative burden associated with periodic electronic data matching and any follow-up with individuals. That said, we have included a provision for State flexibility in this area, and we solicit comments as to whether there should be an ongoing role for Exchange-initiated data matching beyond what is proposed in this rule and the allowance for flexibility. We also solicit comments as to whether the Exchange should offer an enrollee an option to be periodically reminded to report any changes that have occurred.

In paragraph (a), we propose that the Exchange redetermine the eligibility of an enrollee in a QHP during the benefit

year in two situations: first, if an enrollee reports updated information and the Exchange verifies it; and second, if the Exchange identifies updated information through the limited data matching to identify individuals who have died or gained eligibility for a public health insurance program, as described in paragraph (c) of this section.

In paragraph (b)(1), we propose that an individual who enrolls in a QHP with or without advance payments of the premium tax credit or cost-sharing reductions must report any changes to the Exchange with respect to the eligibility standards specified in § 155.305 within 30 days of such change. In paragraph (b)(2), we propose that the Exchange use the verification procedures at the point of initial application for any changes reported by an individual prior to using the self-reported data in an eligibility determination. These changes could include, but are not limited to, changes in incarceration status, residency, immigration status, household income or household size, or in the availability of qualifying coverage in an eligible employer-sponsored plan, which could be driven by changes in employment.

We solicit comments regarding whether we should require or allow the Exchange to limit the requirement on an individual to report changes in income to changes of a certain magnitude. For example, one alternative would be for the Exchange to require an individual to report all changes to non-income information that affect his or her eligibility within 30 days of a change, but only require an individual to report changes of greater than five, ten, or 15 percent of income. This could limit the number of changes reported, but also could add to enrollee confusion regarding when a change is required to be reported. We also note that this provision would have no effect on whether an individual was liable for repayment of excess advance payments of the premium tax credit.

In paragraph (c), we propose that the Exchange periodically examine certain data sources used to support the initial eligibility process, specifically those data sources described in § 155.315(b)(1) and § 155.320(b) of this part, to identify death and eligibility determinations for Medicare, Medicaid, or CHIP. We propose to limit proactive examination to these pieces of information as they come from these data sources and provide clear-cut indications of eligibility for enrollment in a QHP and advance payments of the premium tax credit and cost-sharing reductions. Consequently, in paragraph (d), we do

not propose to require the Exchange to seek or receive an affirmation from an enrollee that such information is accurate prior to using it in an eligibility determination. We note, however, that like all eligibility determinations, such a determination would result in a notice to an enrollee and would be subject to appeal.

In paragraph (c)(2), we propose to allow the Exchange to make additional efforts to identify and act on changes that may affect an enrollee’s eligibility to the extent that HHS approves an Exchange Plan in accordance with § 155.105(d) or a significant change to the Exchange Plan in accordance with § 155.105(e) to modify the process.³ We propose that such approval would be granted if HHS finds that such a modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that such changes would not undermine coordination with Medicaid and CHIP, and that any applicable provisions under § 155.260, § 155.270, § 155.310(f), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met. This provision is consistent with our proposal in § 155.315(e).

As an alternative, we also considered directing the Exchange to use electronic data sources to determine whether other pieces of information regarding an enrollee’s eligibility have changed from the prior eligibility determination in any way that would affect his or her eligibility, or to allow this without the process described in paragraph (c)(2). Under such a scenario, the Exchange could either take action without seeking the enrollee’s confirmation or notify the enrollee of the change and provide him or her with an opportunity to affirm the information. We solicit comments regarding whether and how we should approach additional data matching, whether the Exchange should modify an enrollee’s eligibility based on electronic data in the event that he or she did not respond to a notice regarding the updated information, and whether there are other procedures that could support the goals of the redetermination process for changes during the benefit year.

In paragraph (d), we propose that to the extent that the Exchange verifies updated information reported by an enrollee or identifies updated information through data matching in accordance with paragraph (c), the Exchange determine the enrollee’s

³ This provision is proposed in the Exchange NPRM at 76 FR 41866 (July 15, 2011).

eligibility and provide an eligibility notice in accordance with the process described in § 155.305 and § 155.310(f), respectively. We also note that in accordance with § 155.340(a), the Exchange will notify an enrollee's QHP if it determines that his or her eligibility has changed.

In paragraph (e)(1), we propose that changes resulting from a redetermination during the benefit year be effective for the first day of the month following the notice of eligibility determination described in paragraph (d)(2). In paragraph (e)(2), we allow an exception, subject to the authorization of HHS, in which the Exchange could establish a "cut-off date" for changes resulting from a redetermination during the coverage year to be considered effective for the first day of the month following the month in which changes would otherwise be effective, if not for the existence of the cut-off date. For example, under this proposal, the Exchange could determine that in order to be effective on October 1, a redetermination would have to be completed by September 15th. We solicit comment as to whether this should or should not necessitate an authorization from HHS, and if there should be a uniform timeframe across all Exchanges. In addition, we solicit comment as to whether this is the appropriate policy for the effective date for changes.

In paragraph (e)(3), we propose that if the eligibility determination results in an individual being ineligible to continue his or her enrollment in a QHP, the Exchange will maintain his or her eligibility for enrollment in a QHP for a full month after the month in which the determination notice described in paragraph (d) is sent by the Exchange, although it will discontinue advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in paragraphs (e)(1) and (e)(2). We believe that allowing for this continuity of coverage allows for adequate time for an enrollee to conduct necessary follow-up with the Exchange without providing financial assistance that would later have to be recouped at the point of reconciliation. We note that this does not preclude an enrollee from terminating coverage prior to the termination of his or her eligibility, provided that the termination is permissible under § 155.430. Alternative options could include a shorter or longer time period, or different time periods for specific types of changes. We solicit comment on this topic, as well as on approaches to ensuring that transitions between insurance

affordability programs do not create coverage gaps for individuals.

g. Annual Eligibility Redetermination (§ 155.335)

In § 155.335, we outline procedures for annual redeterminations, consistent with section 1411(f)(1)(B) of the Affordable Care Act. Similar to our rationale for redeterminations during the coverage year, we believe that conducting annual redeterminations at the Exchange level would ensure that the eligibility process for the Exchange, Medicaid, and CHIP is streamlined and seamless.

In paragraph (a), we propose that the Exchange redetermine the eligibility of an enrollee in a QHP on an annual basis, which would ensure that eligibility determinations remain current and follow the process proposed for the Medicaid program in 42 CFR 435.916. We clarify that this redetermination will consider eligibility for enrollment in a QHP, and to the extent that an enrollee has a request for an eligibility determination for insurance affordability programs on file with the Exchange, as described in § 155.310(b), consider his or her eligibility for such programs. We solicit comments on whether the procedures proposed in § 155.330 should satisfy the annual redetermination as well, and if so, whether this should be a Federal standard or an Exchange option. Permitting or requiring a redetermination that occurs during the coverage year to take the place of the annual redetermination could spread some of the eligibility workload for the Exchange across the year and reduce the number of times when an individual has to review and potentially affirm or update eligibility information but might take away from the simplicity offered by a process that occurs at a consistent point in the year for all individuals. Furthermore, determinations of eligibility for advance payments of the premium tax credit and cost-sharing reductions are based on the most recent tax data available, so these determinations need to be made on an annual basis as more recent information becomes available. We solicit comment on how this interaction can be streamlined, and at what point annual redeterminations should occur.

In paragraph (b), we propose that in the case of an annual redetermination for an enrollee who has a request for an eligibility determination for insurance affordability programs on file with the Exchange, the Exchange conduct electronic data matching to obtain updated tax return information and current household income information

from the Secretary of Treasury and other data sources as described in § 155.320(c)(1), and provide such updated information to the enrollee in the notice described in § 155.335(c). We solicit comment regarding whether and how we should approach additional data matching, and whether there are alternatives that could support the goals of the redetermination process.

In paragraph (c), we propose that the Exchange provide an enrollee with an annual redetermination notice. Such notice will include: any updated tax return data and current household income data obtained by the Exchange, if the enrollee requested an eligibility determination for insurance affordability programs; the data used in the enrollee's most recent eligibility determination; and the enrollee's "projected eligibility determination" incorporating any updated income information obtained under paragraph (b), and including, if applicable, the amount of the advance payments of the premium tax credit or level of any cost-sharing reductions for which he or she would be eligible. We solicit comment regarding the contents of the notice and whether additional information should be provided.

In paragraph (d), we propose that the Exchange direct an individual to report any changes relative to the information listed on the redetermination notice within 30 days of the date of the notice. Our goal is to ensure that the timeframe is long enough for individuals to reply, but short enough to serve the purpose of timely redeterminations; we solicit comments as to whether this is an appropriate timeframe. In paragraph (e), we propose that the Exchange verify any changes reported by the individual under paragraph (d) using the same verification procedures used at the point of initial application, including the provisions regarding inconsistencies, with the procedures modified for the specific type of information subject to the inconsistency process.

In paragraph (f)(1), we propose that the Exchange require an enrollee to sign and return the notice specified in paragraph (c). However, in paragraph (f)(2), we propose that if an enrollee does not sign and return the notice, the Exchange will proceed in accordance with the procedures specified in paragraph (g)(1) of this section, meaning that it will redetermine his or her eligibility based on the information provided in the notice. This proposal is designed to minimize the risk of individuals losing coverage when they remain eligible. It is one strategy that has been proven to increase retention rates, and would reduce the

administrative burden and associated costs for the Exchange, as is outlined in several studies that found a majority of individuals were disenrolled based on a failure to return requests for information rather than for no longer meeting the substantive eligibility standards.⁴

We recognize that advance payments of the premium tax credit are subject to reconciliation by the Treasury. If advance payments are made where an enrollee does not respond to a notice to tell the Exchange that he or she will no longer be eligible for advance payments for the coming year (such as where the enrollee has new employment that will provide minimum essential coverage), the enrollee may have to repay some or all of the advance payments as additional tax. Thus, an enrollee has an interest in actively reviewing his or her annual redetermination notice and managing his or her eligibility information to ensure that his or her eligibility for advance payments of the premium tax credit is updated as quickly as possible after a change occurs. We solicit comment on policy and operational strategies to improve the accuracy of determinations and policy options that could allow an individual the choice to opt out of having his or her eligibility redetermined based on the information contained in the annual redetermination notice. We also solicit comment as to what steps the Exchange could take to ensure that redetermination minimizes burden on individuals, QHPs, and the Exchange without increasing inaccuracies.

In paragraph (g)(1), we propose that after the 30-day period specified in paragraph (c) of § 155.335 concludes, the Exchange (i) determine an enrollee's eligibility based on the information provided to the enrollee in the

redetermination notice, along with any information that an enrollee has provided in response to such notice that the Exchange has verified; (ii) notify the enrollee in accordance with the procedures in § 155.310(f); and (iii) if applicable, notify the enrollee's employer, in accordance with the procedures in § 155.310(g). In paragraph (g)(2), we propose that to the extent that the Exchange is unable to verify a change reported by an enrollee as of the close of the 30-day period, the Exchange redetermine the enrollee's eligibility after completing verification. We expect that this redetermination would occur as soon as the verification process is completed.

In paragraph (h), we propose that changes resulting from an enrollee's annual eligibility redetermination follow the same rules regarding effective dates as those proposed in § 155.330. We solicit comment as to whether the effective dates for changes made as a result of an annual redetermination should be different from the effective dates for changes made as a result of a redetermination that occurs during the coverage year.

In paragraph (i), we propose that if an enrollee remains eligible for coverage in a QHP upon annual redetermination, the enrollee will remain in the QHP selected the previous year unless the enrollee takes action to select a new QHP within an enrollment period or terminate coverage in accordance with 45 CFR 155.430, as proposed at 76 FR 41866.

h. Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§ 155.340)

Sections 1412(a) and (c) of the Affordable Care Act direct the Secretary to notify the Secretary of the Treasury of advance determinations for advance payments of the premium tax credit and cost-sharing reductions so that the Secretary of the Treasury may make advance payments of such credit or reductions to the issuer of the QHP selected by an individual. Sections 1311(d)(4)(I)–(J) of the Affordable Care Act also direct that the Exchange report certain information to the Secretary of the Treasury and to employers to facilitate the employer responsibility provisions in the Affordable Care Act. In § 155.340, we propose to codify these reporting provisions for the Exchange, consistent with our proposal that the Exchange conduct eligibility determinations. We also propose that the Exchange simultaneously provide relevant information to the issuer of the QHP selected by an applicant in order to ensure that the issuer can effectuate

any required changes within the effective dates specified in § 155.330 and § 155.335.

In paragraph (a)(1), we propose that in the event of a determination of an individual's eligibility or ineligibility for advance payments of the premium tax credit or cost-sharing reductions, including a change in the level of advance payments of the premium tax credit or cost-sharing reductions for which he or she is eligible, the Exchange provide information to the issuer of the QHP selected by the individual or in which the individual is enrolled.

In paragraph (a)(2), we propose that the Exchange provide eligibility and enrollment information to HHS to enable HHS to begin, end, or adjust advance payments of the premium tax credit and cost-sharing reductions. We solicit comment on whether the information could be used by HHS to support any reporting necessary for monitoring, evaluation, and program integrity. We solicit comment as to how this interaction can work as smoothly as possible and the scope of information that should be transmitted among the relevant agencies.

In paragraph (a)(3), we propose that the notification specified in paragraph (a) include the information necessary to enable the issuer of the QHP to implement or discontinue the implementation of an individual's advance payments of the premium tax credit or cost-sharing reductions, or modify the level of an individual's advance payments of the premium tax credit or cost-sharing reductions. By implementing, we mean that the issuer of the QHP will adjust an enrollee's net premium to reflect the advance payments of the premium tax credit, as well as make any changes needed to ensure that cost-sharing reflects the appropriate level of reductions.

In paragraph (b), we propose to codify the reporting rules in sections 1311(d)(4)(I)(ii)–(iii) and 1311(d)(4)(J), which support the employer responsibility provisions of the Affordable Care Act. Each of the proposed standards in paragraph (b) relates to information about enrollees who are receiving advance payments of the premium tax credit and cost-sharing reductions.

In paragraph (b)(1), we propose that when the Exchange determines that an applicant is eligible to receive advance payments of the premium tax credit based in part on a finding that his or her employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, as described in 26 CFR

⁴ "MaxEnroll Minute: Cutting Red Tape to Keep Eligible Families Enrolled in Massachusetts". Maximizing Enrollment for Kids. <http://www.maxenroll.org/resource/maxenroll-minute-cutting-red-tape-keep-eligible-families-enrolled-massachusetts>. Also see, "Stability and Churning in Medi-Cal and Healthy Families". Fairbrother and Schucter, Child Policy Research Center, Cincinnati Children's Hospital Medical Center. <http://www.cincinnatichildrens.org/assets/0/78/1067/1395/1833/1835/9811/9813/9819/48b3047a-79ac-4e52-9ed8-b7824db1cec3.pdf>; "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies". Summer, Laura, and Mann, Cindy. The Commonwealth Fund. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2006/Jun/Instability-of-Public-Health-Insurance-Coverage-for-Children-and-Their-Families—Causes—Consequence.aspx>, and "Enrollment and Disenrollment in MassHealth and Commonwealth Care". Seifert, Robert, Kirk, Garrett, and Oakes, Margaret. Massachusetts Medicaid Policy Institute. http://www.massmedicaid.org/-/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf.

1.36B–2(c)(3)(v) of the Treasury proposed rule, or does not meet the minimum value standard, as described in 26 CFR 1.36B–2(c)(3)(vi) of the Treasury proposed rule, the Exchange will provide this information to the Secretary of the Treasury. In paragraph (b)(1), we propose that the Exchange transmit such applicant's name and Social Security number to HHS, which will transmit it to the Secretary of the Treasury. This proposed pathway is consistent with our proposals throughout this part that HHS serve as an intermediary between the Exchange and the various Federal agencies with which the Exchange communicates. We note that § 155.310(g) specifies that the Exchange notify the employer of certain information regarding an employee's eligibility for advance payments of the premium tax credit.

In paragraph (b)(2), we propose that in the event that an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he or she has changed employers, the Exchange transmit the enrollee's name and Social Security number to HHS, which will transmit it to Treasury. We note that such a change may also trigger a redetermination of eligibility during the benefit year for advance payments of the premium tax credit and cost-sharing reductions pursuant to § 155.330.

In paragraph (b)(3), we propose that in the event an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage in a QHP during a benefit year, the Exchange transmit his or her name and Social Security number and the effective date of the termination of coverage to HHS, which will transmit it to Treasury, and transmit his or her name and the effective date of the termination of coverage to his or her employer.

Section 36B(f) of the Code directs the Secretary of the Treasury reconcile the amount of advance payments of the premium tax credit received by an individual with the amount allowed based on his or her tax return for the tax year that includes the benefit year. In order to support this reconciliation, section 1412(c)(1) of the Affordable Care Act directs the Secretary to provide information to the Secretary of the Treasury regarding advance determinations. In addition, section 36B(f)(3) of the Code requires the Exchange to provide information to the Treasury Secretary, including an identification of coverage provided, QHP premiums, aggregate amounts of the premium tax credit provided during

the tax year, identifying information, information supporting eligibility determinations, and any information necessary to determine whether excess advance payments of the premium tax credit have been made. The Treasury Secretary is proposing to implement this provision in 26 CFR 1.36B–5 of the Treasury proposed rule; to reinforce this provision and clarify it as a standard for approval of an Exchange, in paragraph (c), we propose that the Exchange comply with the Treasury regulation.

i. Coordination With Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Conditions Insurance Program (§ 155.345)

In § 155.345, we propose standards for coordination across the Exchange, Medicaid, and CHIP in order to implement a streamlined, simplified system for eligibility determinations and enrollment. In this section, we also propose standards for coordination between the Exchange and the Pre-Existing Conditions Insurance Program (PCIP), established pursuant to section 1101 of the Affordable Care Act.

In paragraph (a) of this section, we propose that the Exchange enter into agreements with the Medicaid or CHIP agencies as necessary to fulfill this subpart. Such agreements could support ensuring that Exchange determinations of eligibility for Medicaid and CHIP are consistent with the methods, standards and procedures set forth in the approved State plan and the interpretive policies and procedures of the State agency or agencies administering the Medicaid or CHIP programs. We anticipate that Medicaid and CHIP eligibility determination activities conducted by the Exchange will be conducted in cooperation and coordination with the agency or agencies administering those programs, and will utilize the single eligibility system or shared eligibility service discussed later in this section.

In paragraph (d)(1) of § 155.310 of this subpart, we propose that as part of the eligibility determination process, the Exchange determine an applicant eligibility for Medicaid and CHIP, in accordance with standards described in § 155.305 of this subpart, and as described in (d)(3), notify the State agency administering Medicaid or CHIP and transmit relevant information. Upon making a determination of eligibility for Medicaid or CHIP, the Exchange will also notify the applicant of the determination, as described in § 155.310(f). The agency administering Medicaid or CHIP would then provide the individual with his or her choices of available delivery systems (such as a

managed care organization, a primary care case management program, or other option) and notify the chosen health plan or delivery system of the individual's selection.

The Exchange may also facilitate delivery system and health plan selection, including transmitting enrollment transactions to health plans, if applicable, for individuals determined eligible for Medicaid or CHIP, if the agencies administering Medicaid or CHIP enter into an agreement authorizing the Exchange to perform this function. A greater level of integration in this area could offer an opportunity to reduce administrative costs associated with a two-step process for applicants who are determined eligible for Medicaid or CHIP, particularly because the Exchange will already have the capacity to allow delivery system selection for individuals determined eligible to enroll in a QHP. We solicit comments regarding whether and how this integration could best work for the Exchange, Medicaid, and CHIP.

In paragraph (b)(1), we propose that the Exchange perform a “screen and refer” function for those applicants who may be eligible for Medicaid in a MAGI-exempt category, as described in section 1902(e)(14)(D) of the Act or an applicant that is potentially eligible for Medicaid based on factors not otherwise considered in this subpart. We propose that the Exchange transmit eligibility information related to such applications to the applicable State agency(ies) promptly and without undue delay to complete the remainder of the eligibility determination process.

We also note that a State may choose to establish an eligibility system that conducts all eligibility determinations for the Exchange, Medicaid, and CHIP, including those Medicaid determinations that are based on factors beyond the MAGI-based income standard.

We note that section 36B(c)(2)(B)(i) of the Code provides that an applicant is not eligible for advance payments of the premium tax credit or cost-sharing reductions to the extent that he or she is eligible for other minimum essential coverage, including coverage under Medicaid. We do not believe this provision is intended to exclude an applicant who is otherwise eligible for advance payments of the premium tax credit or cost-sharing reductions from receiving such advance payments or reductions during the time needed for Medicaid or CHIP to complete and effectuate an eligibility determination, particularly an eligibility determination that may involve the review of clinical

information. As such, in paragraph (b)(2), we propose that the Exchange provide advance payments of the premium tax credit and cost-sharing reductions to an individual who is found to be otherwise eligible for advance payments of the premium tax credit and cost-sharing reductions while the agency administering Medicaid completes a more detailed determination. We note that 26 CFR 1.36B-2(c)(2) of the Treasury proposed rule, specifies that if an individual receiving advance payments is approved for government-sponsored minimum essential coverage (including Medicaid), the individual is treated as eligible for minimum essential coverage no earlier than the first day of the first calendar month after approval; that is, an applicant who is referred to the Medicaid agency for additional screening and provided with advance payments in the interim while he or she is enrolled in a QHP would be eligible for the premium tax credit for such months and therefore, would not be liable to repay advance payments upon retroactive eligibility for Medicaid for the period of retroactive eligibility.

In paragraph (c) we propose the Exchange provide an opportunity for an applicant who is not automatically referred to the State Medicaid agency for an eligibility determination under paragraph (b) of this section to request a full screening of eligibility for Medicaid by such agency. Because Medicaid may provide different benefits or greater protections for certain individuals, those applicants who believe they may be eligible for such programs should have the opportunity to receive a conclusive determination of eligibility based on all available eligibility criteria. In paragraph (c)(2), we propose that to the extent that an applicant requests such a determination, the Exchange transmit the applicant's information to the State Medicaid agency promptly and without undue delay. We note that 26 CFR 1.36B-2(c)(2) of the Treasury proposed rule, discussed above, applies to applicants who are determined eligible for retroactive Medicaid coverage.

In order to implement section 1413 of the Affordable Care Act, in paragraph (d), we propose that the Exchange work with the agencies administering Medicaid and CHIP, to establish procedures through which an application that is submitted directly to an agency administering Medicaid or CHIP initiates an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. This is designed to ensure that an application

that is submitted to an agency administering Medicaid or CHIP follows the same processes for a complete MAGI-based determination of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, in a manner identical to that of an application submitted directly to the Exchange.

We encourage States to develop integrated IT systems across the Exchange, Medicaid, and CHIP, which could allow States to leverage administrative functions and resources across coverage programs and ensure a consistent, seamless experience for consumers. We also expect that States will utilize a common or shared eligibility system or service across the Exchange and Medicaid.

Section 1413(c) of the Affordable Care Act provides for secure interfaces and standards for data matching arrangements between the Exchange and the agencies administering Medicaid, and CHIP. In paragraph (e)(1), we propose to codify that the Exchange must utilize a secure, electronic interface for the exchange of data for the purpose of determining eligibility, including verifying whether an applicant requesting an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions has been determined eligible for Medicaid or CHIP, and other functions specified under this subpart. We also note that the standards specified in § 155.260 and § 155.270 regarding privacy and security apply to any data sharing agreements under this section. Lastly, in paragraph (e)(2), we propose that the Exchange utilize any model agreements established by HHS for the purpose of sharing data as described in this section. We solicit comment as to the content of these model agreements.

We propose in paragraph (f), standards for coordination between the Exchange and the Pre-Existing Conditions Insurance Program (PCIP), established pursuant to section 1101 of the Affordable Care Act, which will end coverage for its enrolled population effective January 1, 2014. In accordance with 45 CFR 152.45, we propose to develop procedures for the transition of PCIP enrollees to coverage in QHPs offered through the Exchanges to ensure that PCIP enrollees do not experience a lapse in coverage. We solicit comment on additional responsibilities that should be assigned to Exchanges as part of this process, such as providing dedicated customer service staff for PCIP enrollees or actions that may accelerate or further streamline

eligibility determinations for PCIP enrollees.

j. Special Eligibility Standards and Process for Indians (§ 155.350)

Section 1402(d) of the Affordable Care Act includes special rules regarding cost-sharing for Indians. First, section 1402(d)(1) of the Affordable Care Act specifies that a QHP issuer may not impose any cost-sharing on an Indian who has household income at or below 300 percent of the FPL and is enrolled in a QHP at any level of coverage. We note that this is different from the cost-sharing rules for non-Indians, which specifies that an individual be enrolled in a silver-level plan in order to receive cost-sharing reductions. Second, section 1402(d)(2) of the Affordable Care Act specifies that a QHP may not impose any cost-sharing on an Indian for services furnished directly by the Indian Health Service, an Indian tribe, tribal Organization, or Urban Indian Organization, or through referral under contract health services. This provision applies regardless of an Indian's income or plan level. We note that as defined in § 155.300(a), for the purposes of this section, "Indian" means any individual defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) (Pub. L. 93-638, 88 Stat. 2203), in accordance with section 1402(d)(1) of the Affordable Care Act.

In paragraph (a), we propose to codify section 1402(d)(1) of the Affordable Care Act by requiring the Exchange to determine an applicant who is an Indian eligible for cost-sharing reductions if he or she (i) meets the standards of § 155.305 (related to eligibility for enrollment in a QHP) and (ii) has household income that does not exceed 300 percent of the FPL. We also propose in paragraph (a)(2) to clarify that the Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP.

In paragraph (b), we propose to codify section 1402(d)(2) of the Affordable Care Act by requiring the Exchange to determine an applicant eligible for the special cost-sharing rule described in that section if he or she is an Indian, without requiring the applicant to request an eligibility determination that requires collection or verification of income. This special cost-sharing reduction rule is not tied to income.

In paragraph (c), we propose that the Exchange verify an individual's attestation that he or she is an Indian for purposes of determining whether he or she qualifies for the cost-sharing rules described in paragraphs (a) and (b) of this section. We propose that this

process consist of two phases. First, in paragraph (c)(1), we propose that the Exchange use any relevant documentation verified to support an attestation of citizenship or lawful presence in accordance with § 155.315(e) of this subpart. This is designed to ensure that the Exchange and an application filer will not duplicate the effort related to collecting and processing documentation if an application filer submitted documentation to support an applicant's attestation to citizenship or lawful presence that also satisfies the requirement of this paragraph.

Second, in paragraph (c)(2), we propose that the Exchange rely on any electronic data sources that are available and have been authorized by HHS. HHS will approve electronic data sources based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification.

If an applicant has not submitted satisfactory documentation in accordance with paragraph (c)(1) and the verification process described in paragraph (c)(2) is not applicable (such as because the data are unavailable, do not contain an applicant's information, or are not reasonably compatible with an applicant's attestation), we propose that the Exchange follow the standard inconsistency procedures proposed in § 155.315(e) of this subpart. Within these procedures, we propose that the Exchange follow the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Act. We note that to the extent that the Exchange is unable to verify an applicant's attestation that he or she is an Indian, and the applicant is otherwise eligible for enrollment in a QHP or insurance affordability programs, the Exchange determine the applicant eligible accordingly.

We solicit comment on the availability and usability of electronic data sources, as well as best practices for accepting and verifying documentation related to Indian status. We note that this provision is also intended to facilitate data sharing between tribes and the Exchange for the purposes of this section, to the extent that tribes are willing and able to engage in such data sharing.

k. Right to Appeal (§ 155.355)

Section 1411(f) of the Affordable Care Act directs the Secretary to establish a process for a Federal official to hear and make decisions on appeals of eligibility determinations. Section 1411(e)(4)(C) of the Affordable Care Act also provides that the Exchange notify applicants and

employers of appeal processes when notifying the applicant or employer of an eligibility determination. As described in § 155.200(d) of the Exchange NPRM, published at 76 FR 41866, the Exchange will establish a process to hear individual appeals of eligibility determinations. We propose that an individual may appeal any eligibility determination or redetermination made by the Exchange under subpart D, including determinations of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. We intend to propose the details of the individual eligibility appeals processes, including standards for the Federal appeals process, in future rulemaking.

Pursuant to 1411(f)(2) of the Affordable Care Act, we intend to propose through future rulemaking standards for a process through which an employer would be able to appeal a determination that an employee of the employer is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that the employer did not offer qualifying coverage to the employee.

C. Part 157—Employer Interactions With Exchange and SHOP Participation

1. Subpart A—General Provisions

The Affordable Care Act contains a number of provisions related to employers with respect to employee health coverage. While a number of them are incorporated into the Code, at sections 4980H and 6056, several are to be implemented by the Secretary. In part 157, we propose standards that address qualified employer participation in SHOP. Also, in the preamble, we briefly discuss employer interactions with Exchanges related to the verification of employees' eligibility for qualifying coverage in an eligible employer-sponsored plan. Subpart A outlines the basis and scope for part 157 and defines terms used throughout part 157.

a. Basis and Scope (§ 157.10)

Section 157.10 of subpart A specifies the general statutory authority for the proposed regulations and indicates that the scope of part 157 is to establish the standards for employers in connection with Exchanges.

b. Definitions (§ 157.20)

Under § 157.20, we propose definitions for terms used in part 157 that require clarification. The definitions presented in § 157.20 are taken directly from the statute or based

on definitions we propose in other parts of this proposed rule. The terms “qualified employer,” “qualified employee” and “small employer” have the meaning given to the terms in § 155.20.

We recognize that employers may need to interact with Exchanges for the express purpose of verifying employees' eligibility for qualifying coverage in an eligible employer-sponsored plan for those employees who seek eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, as described in § 155.320(e). We solicit comment earlier in the preamble on the timing of the interactions between employers and Exchanges and how these interactions might be structured.

2. Subpart B—Reserved

3. Subpart C—Standards for Qualified Employers

Section 1311(b)(1)(B) of the Affordable Care Act directs each State that operates an Exchange to provide for the establishment of a Small Business Health Options Program (SHOP), which we describe in subpart H of part 155. Subpart C of this part outlines the general provisions for employer participation in SHOPS. To a significant extent, the proposal for this subpart mirrors and complements subpart H of part 155, proposed in the Exchange NPRM, published at 76 FR 41866.

a. Eligibility of Qualified Employers to Participate in SHOP (§ 157.200)

In § 157.200, we propose the standards for an employer that seeks to offer health coverage to its employees through a SHOP. In paragraph (a), we propose that only qualified employers may participate in a SHOP. SHOP eligibility standards for qualified employers are proposed in 45 CFR 155.710.

In paragraph (b), as proposed in 45 CFR 155.710, a qualified employer participating in the SHOP may continue to participate if it ceases to be a small employer solely because of an increase in the number of employees. In such instances, the employer will continue to be treated as a qualified employer and may continue its participation until the employer either fails to meet the other eligibility criteria or elects to no longer participate in the SHOP.

We note that some small employers may have employees in multiple States or SHOP service areas. In 45 CFR 155.710, we proposed to allow multi-State employers flexibility in offering coverage to their employees. While large employers are more likely than small

employers to have employees in multiple States or SHOP jurisdictions, it is important that the health insurance options available to small employers participating in the SHOP are not limited by the SHOP's geographic location. We note that this does not exempt an employer from the size standard of the SHOP. If an employer has more than 100 employees divided among multiple SHOP service areas, such an employer is still a large employer.

Unlike the individual market, in the SHOP there are no statutory residency standards for either the qualified employer or qualified employee. However, in 45 CFR 155.710, we proposed that small employers either offer employees coverage through the SHOP serving the employer's principle business address or offer coverage to an employee through the SHOP serving the employee's primary worksite. We propose parallel standards here to coordinate with that proposal.

b. Employer Participation Process in the SHOP (§ 157.205)

We propose the process for employer participation in the SHOP in § 157.205. Paragraph (a), directs an employer to adhere to the standards, process, and deadlines set by this part and by the SHOP to maintain eligibility as a qualified employer and have employees enroll in QHPs. As proposed in 45 CFR 155.720, the SHOP will set a uniform process and timeline for each employer seeking to become a qualified employer through the SHOP.

In paragraph (b), we propose that a qualified employer make available QHPs to employees in accordance with the process developed by the SHOP pursuant to 45 CFR 155.705.

In paragraph (c), we propose that a qualified employer participating in SHOP disseminate information to its employees about the methods for selecting and enrolling in a QHP. To address the needs of qualified employees seeking assistance, the information disseminated by qualified employers should include at least the timeframes for enrollment, instructions for how to access the SHOP Web site and other tools to compare QHPs, and the SHOP toll-free hotline. We propose to establish this as a responsibility of the qualified employer because the SHOP will not have employee contact information until employees apply for coverage. However, the SHOP may assist qualified employers, for example by providing an easy to use toolkit to qualified employers explaining the key pieces of information to disseminate to its employees.

In paragraph (d), we propose that a qualified employer submit premium payments according to the process proposed in 45 CFR 155.705. In paragraph (e), we propose that qualified employers provide an employee hired outside of the initial enrollment or annual open enrollment period with information described in paragraph (c). As proposed in 45 CFR 155.725(g), the SHOP will establish a window of time in which a newly hired employee may select coverage through a QHP.

In paragraph (f), we propose that qualified employers provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed. This notice would apply both to newly eligible employees and dependents as well as those no longer eligible for coverage. This includes a COBRA qualifying event, as described in 29 U.S.C. 1163. The SHOP may in turn notify the QHP to process the change in enrollment. The employer retains all notice responsibilities under Federal and State law. We suggest that SHOPs direct employers to provide such notices within thirty (30) days of the change in eligibility.

In paragraph (g), we propose that a qualified employer adhere to the annual employer election period to change program participation for the next plan year. As proposed in 45 CFR 155.725, an employer may begin participating in the SHOP at any time. However, once an employer begins participating, it will adhere to an annual employer election period during which it may change employee offerings.

In paragraph (h), we propose that if an employer remains eligible for coverage and does not take action during the annual employer election period, such employer would continue to offer the same plan, coverage level or plans selected the previous year for the next plan year unless the QHP or QHPs are no longer available. We invite comments regarding the feasibility of the processes established in this section and the implications for small employers and their employees.

III. Collection of Information Requirements

We recognize that this proposed rule contains items that are subject to the Paperwork Reduction Act of 1995. We intend to estimate the burden of complying with the provisions of this rule as part of future rulemaking, per the Paperwork Reduction Act.

IV. Summary of Preliminary Regulatory Impact Analysis

The summary analysis of benefits and costs included in this proposed rule is drawn from the detailed Preliminary Regulatory Impact Analysis (PRIA) that evaluates the impacts of the Exchange proposed rule and the related Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Premium Stabilization) proposed rule, available at <http://ccio.cms.gov> under "Regulations and Guidance." This proposed rule proposes the specific standards for the Exchange eligibility process in order to implement the sections related to eligibility in the Affordable Care Act. As performing eligibility determinations is a minimum function of the Exchange, the costs and benefits of these eligibility provisions are inherently tied to the costs and benefits of the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (Exchange) proposed rule.

A. Introduction

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

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

Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare a written

statement, which includes an assessment of anticipated costs and benefits, before proposing “any rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100,000,000 or more (adjusted annually for inflation) in any one year.” The current threshold after adjustment for inflation is approximately \$136 million, using the most current (2011) Implicit Price Deflator for the Gross Domestic Product.⁵ HHS does not expect this proposed rule to result in one-year expenditures that would meet or exceed this amount.

B. Need for This Regulation

A central aim of Title I of the Affordable Care Act is to expand access to health insurance coverage through the establishment of Exchanges. The number of uninsured Americans is rising due to lack of affordable insurance, barriers to insurance for people with pre-existing conditions, and high prices due to limited competition and market failures. Millions of people without health insurance use health care services for which they do not pay, shifting the uncompensated cost of their care to health care providers. Providers pass much of this cost to insurance companies, resulting in higher premiums that make insurance unaffordable to even more people. The Affordable Care Act includes a number of policies to address these problems, including the creating of Affordable Insurance Exchanges.

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or “Exchanges.” Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses.

This proposed rule provides standards for the Exchange eligibility process, in order to implement sections 1311, 1411, 1412, and 1413 of the Affordable Care Act. Further, it supports and complements rulemaking conducted by the Secretary of the Treasury with respect to section 36B of the Code, as added by section 1401(a) of the Affordable Care Act, and by the

Secretary of HHS with respect to several sections of the Affordable Care Act that create new law and amend existing law regarding Medicaid and CHIP. This proposed rule also contains standards for employers with respect to participation in the Small Business Health Options Program.

C. Summary of Costs and Benefits

This proposed regulation is being published to provide the specific standards for the Exchange eligibility process in order to implement the sections related to eligibility in the Affordable Care Act. As performing eligibility determinations is a minimum function of the Exchange, the costs and benefits of these eligibility provisions are inherently tied to the costs and benefits of the Establishment of Exchanges and Qualified Health Plans (Exchange) proposed rule. A detailed PRIA, available at <http://cciio.cms.gov> under “Regulations and Guidance,” evaluates the impacts of the Exchange proposed rule and the related Premium Stabilization proposed rule. This section summarizes benefits and costs of this proposed rule.

Methods of Analysis

The detailed PRIA references the estimates of the CMS Office of the Actuary (OACT) (CMS, April 22, 2010),⁶ but primarily uses the underlying assumptions and analysis done by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation. Their modeling effort accounts for all of the interactions among the interlocking pieces of the Affordable Care Act including its tax policies, and estimates premium effects that are important to assessing the benefits of the proposed rule. A description of CBO’s methods used to estimate budget and enrollment impacts is available.⁷ The CBO estimates of enrollment in Exchanges are not significantly different than the comparable estimate produced by OACT. Based on our review, we expect that the provisions of these proposed rules will not substantially alter CBO’s estimates of the budget impact of Exchanges or enrollment. The proposed provisions are well within the parameters used in the CBO modeling of the Affordable Care Act and do not diverge from assumptions embedded in the CBO model. Our review and analysis of the proposed provisions

indicate that the impacts are within the model’s margin of error.

Benefits in Response to the Proposed Regulation

This summary focuses on the effects of implementing the provisions of the Affordable Care Act related to eligibility. In this section, we provide evidence on the benefits of increased health insurance coverage and reduced transaction costs. Simple eligibility processes will increase take-up of health insurance leading to improved health. In a recent study, compared to the uninsured group, the insured received more hospital care, more outpatient care, had lower medical debt, better self-reported health, and other health related benefits.⁸ The evaluation concluded that for low-income uninsured adults, coverage has the following benefits:

- Significantly higher utilization of preventive care (mammograms, cholesterol monitoring, etc.),
- A significant increase in the probability of having a regular office or clinic for primary care, and
- Significantly better self-reported health.

In addition, the use of electronic records among State and Federal agencies with information to verify eligibility will minimize the transaction costs of purchasing health insurance improving market efficiency and minimizing time cost for enrollees on enrollment.

Costs in Response to the Proposed Regulation

To support this new eligibility structure, States are expected to build new or modify existing information technology systems. How each State constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. Administrative costs to support the vision for a streamlined and coordinated eligibility and enrollment process will also vary for each State depending on the specific approaches taken regarding the integration between programs and its decision to build a new system or use existing systems; while the Affordable Care Act requires a high level of integration, States have the option to go beyond the requirements of the Act. We also believe that overall administrative costs may increase in the short term as

⁶ Foster, Richard “Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended “April 2011. CMS”.

⁷ Congressional Budget Office. (2007) “CBO’s Health Insurance Simulation Model: A Technical Description.” October.

⁸ Finkelstein, A. et al., (2011). The Oregon Health Insurance Experiment: Evidence from the First Year.” *National Bureau of Economic Research Working Paper Series*, 17190.

⁵ <http://research.stlouisfed.org/fred2/data/GDPDEF.txt>. Accessed on 7/26/2011.

States build information technology systems; however, in the long-term States will see savings through the use of more efficient systems.

As noted in the preamble, we believe the approach we are taking to supporting the verification of applicant information with SSA, IRS, and DHS reduces administrative complexity and associated costs. Administrative costs incurred in the development of information technology infrastructure to

support the Exchange are funded wholly through State Exchange Planning and Establishment Grants. Costs for information technology infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a 90 percent Federal matching rate to assist in development.⁹

Summary of Costs and Benefits

CBO estimated program payments and receipts for outlays related to grants for

Exchange startup. States' initial costs to the creation of Exchanges will be funded by these grants. Eligibility determination is a minimum function of the Exchange, therefore the Exchange costs related to develop the infrastructure for this function these eligibility provisions are covered by these grant outlays.

TABLE 1—ESTIMATED OUTLAYS FOR THE AFFORDABLE INSURANCE EXCHANGES FY 2012–FY 2016, IN BILLIONS OF DOLLARS

Year	2012	2013	2014	2015	2016
Grant Authority for Exchange Start up ¹⁰	0.6	0.8	0.4	0.2	0.0

Source: Congressional Budget Office. (2011). *Cost Estimate of H.R. 1213 A bill to repeal mandatory funding provided to states in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges*. April 27, 2011. <http://www.cbo.gov/ftpdocs/121xx/doc12158/hr1213.pdf>.

Regulatory Options Considered

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

(1) Require Exchanges To Conduct Eligibility Determinations for the MAGI-Exempt Population

Under the proposed rule, the Exchange will determine eligibility for Medicaid and CHIP for eligibility categories that use a MAGI-based income standard. In this NPRM, we propose the Exchange perform a “screen and refer” function for those applicants who may be eligible for Medicaid in a category that does not use a MAGI-based income standard. For these applicants, we propose that the Exchange transmit eligibility information to the State Medicaid agency to complete the remainder of the eligibility determination process.

This alternative would require the Exchange to determine eligibility for applicants that may fall into Medicaid eligibility categories that do not use a MAGI-based income standard. It would require Exchanges to conduct lengthier investigations of these applications than what is required for eligibility determinations for applicants eligible based on MAGI. It would also require Exchanges develop the capability to evaluate this information and other income information not required for MAGI-based eligibility determinations. This would require additional resources

and increase costs to Exchanges and Federal agencies.

(2) Require a Paper-Driven Process for Conducting Eligibility Determinations

In the proposed rule, to verify applicant information used to support an eligibility determination, we generally propose the Exchange first use electronic data, where available, prior to requesting paper documentation. Under this proposal, individuals will be asked to provide only the minimum amount of information necessary to complete an eligibility determination, and will only be required to submit paper if electronic data cannot be used to complete the verification process.

We believe using technology to minimize burden on individuals and States will help increase access to coverage by streamlining the eligibility process, and will reduce administrative burden on Exchanges, while increasing accuracy by relying on trusted data for eligibility.

Under this alternative, the Exchange would require individuals to submit paper documentation to verify information necessary for an eligibility determination. This would not only increase the amount of burden placed on individuals to identify and collect this information, which may not be readily available to the applicant, but would also necessitate additional time and resources for Exchanges to accept and verify the paper documentation needed for an eligibility determination.

Summary of Costs for Each Option

While it would extend a more streamlined eligibility process to individuals ineligible for a MAGI-based eligibility determination, option 1 would require the Exchange to generate additional resources and funds to be able to determine eligibility for applicants that may fall into an eligibility category that does not use a MAGI-based income standard, including one that involves the consideration of clinical or other income information. The paper-driven process outlined under option 2 would ultimately increase the amount of time it would take for an individual to receive health coverage, would reduce the number of States likely to operate an Exchange due to increased administrative costs, and would dissuade individuals from seeking coverage through the Exchange.

D. Accounting Statement

For full documentation and discussion of these estimated costs and benefits, see the detailed Exchange PRIA, available at <http://cciio.cms.gov> under “Regulations and Guidance.” Since eligibility determination is a minimum function of the Exchange, the costs and benefits of these eligibility provisions are included in the costs and benefits of Exchange establishment. Therefore, this accounting statement is identical to the one published in the Establishment of Exchanges and Qualified Health Plans (Exchange) proposed rule.

⁹ Federal Funding for Medicaid Eligibility Determination and Enrollment Activities; Final Rule, April 19, 2011 [42 CFR part 433 page 21950].

¹⁰ OACT estimates that the initial start-up costs for Exchanges will be \$4.4 billion for 2011–2013 (Sisko, A.M., et al., “National Health Spending

Projections: The Estimated Impact of Reform through 2019,” *Health Affairs*, 29, no. 10 (2010): 1933–1941.

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

V. Regulatory Flexibility Act

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

As discussed above, this proposed rule is necessary to implement certain standards related to the establishment and operation of Exchanges as authorized by the Affordable Care Act. Specifically, this rule proposes standards for Exchanges related to eligibility determinations for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP; and qualified employer participation in SHOP.

For the purposes of the regulatory flexibility analysis, we expect the following types of entities to be affected by this proposed rule—(1) QHP issuers; and (2) employers. We believe that

health insurers would be classified under the North American Industry Classification System (NAICS) Code 524114 (Direct Health and CMS–9989–P 166 Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$7 million or less would be considered small entities this NAICS code. Health issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be \$10 million or less.

QHP Issuers

This rule proposes standards on Exchanges that address eligibility determinations for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP. Although these standards are for Exchanges, they also affect health plan issuers that choose to participate in an Exchange. QHP issuers receive information from an Exchange about an enrollee’s category in order to enable the QHP issuer to provide the correct level of cost-sharing reductions. The issuer of the QHP will adjust an enrollee’s net premium to reflect the advance payments of the premium tax credit, as well as make any changes required to ensure that cost-sharing reflects the appropriate level of reductions. Issuers benefit significantly from advance payments of the premium tax credit and cost-sharing reductions, but may face some administrative costs relating to receiving enrollee information from an Exchange.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS

examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business established by the SBA (currently \$7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).¹¹

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than \$7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may

¹¹ “Table of Size Standards Matched To North American Industry Classification System Codes,” effective November 5, 2010, U.S. Small Business Administration, available at <http://www.sba.gov>.

overstate the actual number of small health insurance issuers offering such coverage, because it does not include receipts from these companies' other lines of business.

Employers

The establishment of SHOP in conjunction with tax incentives for some employers will provide new opportunities for employers to offer affordable health insurance to their employees. A detailed discussion of the impact on employers related to the establishment of the SHOP is found in the PRIA, available at <http://cciio.cms.gov> under "Regulations and Guidance."

Subpart D of part 157 proposes standards that address qualified employer participation in SHOP. This rule proposes 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 would meet the SBA Standard for small entities. Since participation in the SHOP is voluntary, this proposed rule does not place any requirements on small employers.

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

VI. Unfunded Mandates

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

VII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments,

pre-empts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange, State decisions will ultimately influence both administrative expenses and overall premiums. However, because States are not required to create an Exchange, these costs are not mandatory. For States electing to create an Exchange, the initial costs of the creation of the Exchange will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources left to the discretion of the State. In the Department's view, while this proposed rule does not impose substantial direct on State and local governments, it has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each State electing to establish a State-based Exchange must adopt the Federal standards contained in the Affordable Care Act and in this proposed rule, or have in effect a State law or regulation that implements these Federal standards. However, the Department anticipates that the Federalism implications (if any) are substantially mitigated because States have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require States to establish an Exchange; but if a State elects not to establish an Exchange or the State's Exchange is not approved, HHS must establish and facilitate an Exchange in that State. Additionally, States will have the opportunity to participate in State Partnership Exchanges.

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

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

for the attached proposed regulation in a meaningful and timely manner.

List of Subjects

45 CFR Part 155

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

45 CFR Part 157

Employee benefit plans, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

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

SUBTITLE A—DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B—REQUIREMENTS RELATING TO HEALTH CARE ACCESS

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

1. Part 155, as proposed to be added at 76 FR 13564, March 14, 2011 is amended by adding subpart D to read as follows:

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

Sec.

155.300 Definitions and general standards for eligibility determinations.

155.305 Eligibility standards.

155.310 Eligibility determination process.

155.315 Verification process related to eligibility to enroll in a QHP through the Exchange.

155.320 Verification process related to eligibility for insurance affordability programs.

155.330 Eligibility redetermination during a benefit year.

- 155.335 Annual eligibility redetermination.
 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.
 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Program.
 155.350 Special eligibility standards and process for Indians.
 155.355 Right to appeal.

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

§ 155.300 Definitions and General Standards for Eligibility Determinations

(a) *Definitions.* In addition to those definitions proposed in 45 CFR 155.20, for purposes of this subpart, the following terms have the following meaning:

Adoption taxpayer identification number has the same meaning as it does in 26 CFR 301.6109–3(a).

Applicable Children's Health Insurance Program (CHIP) MAGI-based income standard means the applicable income standard applied under the State plan under title XXI of the Act, or waiver of such plan, as defined at 42 CFR 457.305(a), and as certified by the State CHIP Agency pursuant to 42 CFR 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

Applicable Medicaid modified adjusted gross income (MAGI)-based income standard has the same meaning as "applicable modified adjusted gross income standard," as defined at 42 CFR 435.911(b), applied under the State Medicaid plan or waiver of such plan, and as certified by the State Medicaid agency pursuant to 42 CFR 435.1200(c)(3) for determining eligibility for Medicaid.

Application filer means an individual who submits an application for health insurance coverage to the Exchange and responds to inquiries about the application, regardless of whether he or she is seeking health insurance coverage for him or herself.

Federal poverty level means the most recently published federal poverty level, updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as of the first day of the annual open enrollment period for coverage in a qualified health plan through the Exchange, as specified in 45 CFR 155.410.

Indian means any individual as defined in section 4(d) of the Indian Self-Determination and Education

Assistance Act (Pub. L. 93–638, 88 Stat. 2203).

Insurance affordability programs means advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, as applicable, in accordance with 42 CFR 435.4.

Minimum value, in connection with an eligible employer-sponsored plan, has the meaning given to the term in section 36B(c)(2)(C) of the Code.

Non-citizen means an individual who is not a citizen or national of the United States, in accordance with section 101(a)(3) of the Immigration and Nationality Act.

Primary taxpayer. (1) *Primary taxpayer* means an individual who indicates that he or she expects—

(i) To file a tax return for the benefit year, in accordance with 26 CFR 1.6011–8;

(ii) If married (within the meaning of 26 CFR 1.7703–1), to file a joint tax return for the benefit year;

(iii) That no other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(iv) That he or she expects to claim a personal exemption deduction under section 151 of the Code on his or her tax return for one or more applicants, including himself or herself and his or her spouse.

(2) This term can mean either spouse within a married couple.

Qualifying coverage in an eligible employer-sponsored plan means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in 26 CFR 1.36B–2(c)(3).

State CHIP Agency means the agency that administers a separate child health program established by the State under title XXI of the Act in accordance with implementing regulations at 42 CFR 457.

State Medicaid Agency means the agency established by the State under title XIX of the Act that administers the Medicaid program in accordance with implementing regulations at 42 CFR parts 430 through 456.

Tax dependent has the same meaning as the term dependent under section 152 of the Code.

(b) *Medicaid and CHIP.* In general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented by the State Medicaid or CHIP agency.

(c) *Attestation.*

(1) Except as specified in paragraph (c)(2) of this section, for the purposes of this subpart, an attestation may be made by the applicant (self-attestation), an

application filer, or in cases in which an individual cannot attest, the attestation of a parent, caretaker, or someone acting responsibly on behalf of such an individual.

(2) The attestations specified in § 155.310(d)(2)(ii) and § 155.315(e)(4)(ii) of this subpart must be provided by a primary taxpayer.

§ 155.305 Eligibility standards.

(a) *Eligibility for enrollment in a QHP through the Exchange.* The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange if he or she meets the following requirements:

(1) *Citizenship, status as a national, or lawful presence.* Is a citizen or national of the United States or a non-citizen lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(2) *Incarceration.* Is not incarcerated, other than incarceration pending the disposition of charges; and

(3) *Residency.*

(i) In the case of an individual age 21 and over who is not institutionalized, is capable of indicating intent, and is not receiving an optional State supplementary payment, intends to reside in the State within the service area of the Exchange, including without a fixed address, in which the applicant is requesting coverage.

(ii) In the case of an individual under the age of 21, who is not institutionalized, is not receiving assistance pursuant to Title IV–E of the Social Security Act, is not emancipated, and is not receiving an optional State supplementary payment, resides in the State within the service area of the Exchange in which he or she is requesting coverage, including with a parent or caretaker or without a fixed address.

(iii) *Other special circumstances.* In the case of an individual who is not described in paragraphs (a)(3)(i) or (ii) of this section, the Exchange must apply the residency requirements described in 42 CFR 435.403 with respect to the service area of the Exchange.

(iv) *Special rule for family members living outside the service area of the Exchange of the primary taxpayer.* A tax dependent or spouse who lives outside the service area of the Exchange of the primary taxpayer may request coverage through either the Exchange that services the area in which the spouse or tax dependent resides or intends to reside, as applicable pursuant to the standard identified in paragraphs (a)(3)(i), (ii), or (iii) of this section, or the

Exchange that services the area in which the primary taxpayer resides or intends to reside, as applicable pursuant to the standard identified in subparagraphs (a)(3)(i), (ii), or (iii).

(b) *Eligibility for QHP enrollment periods.* The Exchange must determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in § 155.410 and § 155.420 of this part.

(c) *Eligibility for Medicaid.* The Exchange must determine an applicant eligible for Medicaid if he or she meets the citizenship and satisfactory immigration status requirements of 42 CFR 435.406, the residency requirements of 42 CFR 435.403, has a household income, as defined in 42 CFR 435.911(b), that is at or below the applicable Medicaid MAGI-based income standard and—

(1) Is pregnant, as defined in the Medicaid State Plan pursuant to 42 CFR 435.4;

(2) Is under age 19;

(3) Is a parent or caretaker relative of a dependent child, as defined in the Medicaid State plan pursuant to 42 CFR 435.4; or

(4) Is not described in paragraph (b)(1), (b)(2), or (b)(3) of this section, is under age 65 and is not entitled to or enrolled for benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of the Social Security Act.

(d) *Eligibility for CHIP.* The Exchange must determine an applicant eligible for CHIP if he or she meets the requirements of 42 CFR 457.310 through 457.320 and has a household income within the applicable CHIP MAGI-based income standard.

(e) *Eligibility for Basic Health Program.* If a Basic Health Program is operating in the service area of the Exchange, the Exchange must determine an applicant eligible for the Basic Health Program if he or she meets the requirements specified in section 1331(e) of the Affordable Care Act and regulations implementing that section.

(f) *Eligibility for advance payments of the premium tax credit.*

(1) *In general.* The Exchange must determine a primary taxpayer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of at least 100 percent but not more than 400 percent of the FPL, as specified in 26 CFR 1.36B-2(b)(1), for the benefit year for which coverage is requested; and

(ii) One or more applicants for whom the primary taxpayer expects to claim a

personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section; and

(B) Is not eligible for minimum essential coverage, in accordance with 26 CFR 1.36B-2(a)(2).

(2) *Special rule for non-citizens lawfully present who are ineligible for Medicaid.* The Exchange must determine a primary taxpayer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she meets the requirements specified in paragraph (f)(1) of this section, except for paragraph (f)(1)(i);

(ii) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of less than 100 percent of the FPL, as specified in 26 CFR 1.36B-2(b)(5), for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the primary taxpayer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid, as specified in 26 CFR 1.36B-2(b)(5)(i), by reason of immigration status.

(3) *Enrollment required.* The Exchange may provide advance payments of the premium tax credit only on behalf of a primary taxpayer if one or more applicants for whom the primary taxpayer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the primary taxpayer and his or her spouse, is enrolled in a QHP through the Exchange.

(4) *Compliance with filing requirement.* The Exchange may not determine a primary taxpayer eligible for advance payments of the premium tax credit if HHS notifies the Exchange as part of the process described in § 155.320(c)(4) of this subpart that advance payments of the premium tax credit were made on behalf of the primary taxpayer or his or her spouse for a year for which tax data would be utilized for verification of household income and family size and the primary taxpayer or his or her spouse did not comply with the requirement to file a tax return for that year as required by 26 CFR 1.6011-8.

(5) *Calculation of advance payments of the premium tax credit.* The Exchange must calculate advance payments of the premium tax credit in

accordance with the rules specified in 26 CFR 1.36B-3.

(6) *Collection of Social Security numbers.* The Exchange must require an application filer to provide the Social Security number of the primary taxpayer if an application filer attests that the primary taxpayer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.

(g) *Eligibility for cost-sharing reductions.*

(1) The Exchange must determine an applicant eligible for cost-sharing reductions if he or she—

(i) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section;

(ii) Meets the requirements for advance payments of the premium tax credit, as specified in paragraph (f) of this section; and

(iii) Has household income for the taxable year that does not exceed 250 percent of the Federal Poverty Level (FPL).

(2) The Exchange may only provide cost-sharing reductions to an enrollee who is not an Indian if he or she is enrolled in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act, purchased through the Exchange.

(h) *Eligibility categories for cost-sharing reductions.* The Exchange must use the following eligibility categories for cost-sharing reductions when making eligibility determinations under this section—

(1) An individual who has household income greater than 100 percent of the FPL and less than or equal to 150 percent of the FPL;

(2) An individual who has household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL; and

(3) An individual who has household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL.

§ 155.310 Eligibility determination process.

(a) *Application.*

(1) The Exchange must accept applications from individuals in the form and manner proposed in 45 CFR 155.405.

(2) *Information collection from non-applicants.* The Exchange may not require an individual who is not seeking coverage for himself or herself to provide information regarding his or her citizenship, status as a national, or immigration status on any application

or supplemental form. The Exchange may not require such an individual to provide a Social Security number, except as described in § 155.305(f)(6) of this subpart.

(b) *Choice to request determination of eligibility for insurance affordability programs.* The Exchange must permit an applicant to decline an eligibility determination for the programs described in paragraphs (c) through (g) of § 155.305 of this subpart; however, the Exchange may not permit an applicant to decline an eligibility determination for a subset of the programs listed in those paragraphs.

(c) *Timing.* The Exchange must accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(d) *Determination of eligibility.*

(1) The Exchange must determine an applicant's eligibility in accordance with the standards specified in § 155.305 of this subpart.

(2) *Special rules relating to advance payments of the premium tax credit.*

(i) The Exchange must permit an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible.

(ii) The Exchange may authorize advance payments of the premium tax credit on behalf of a primary taxpayer only if the primary taxpayer first attests that—

(A) He or she will file a tax return for the benefit year, in accordance with 26 CFR 1.6011-8;

(B) If married (within the meaning of 26 CFR 1.7703-1), he or she will file a joint tax return for the benefit year;

(C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the primary taxpayer and his or her spouse, in accordance with § 155.320(c)(3)(i).

(3) *Special rule relating to Medicaid and CHIP.* To the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the State Medicaid or CHIP agency and transmit relevant information to such agency promptly and without undue delay.

(e) *Effective dates.* Upon making an eligibility determination, the Exchange must implement the eligibility determination under this section for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing

reductions in accordance with the dates specified in 45 CFR 155.410(c) and (f), and 45 CFR 155.420(b).

(f) *Notification of eligibility determination.* The Exchange must provide timely notice to an applicant of any eligibility determination made in accordance with this subpart.

(g) *Notice of an employee's eligibility for advance payments of the premium tax credit and cost-sharing reductions to an employer.* The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions upon determination that an employee is eligible for advance payments of the premium tax credit or cost-sharing reductions. Such notice must identify the employee.

(h) *Duration of eligibility determinations without enrollment.* To the extent that an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment period in accordance with subpart E of this part, and seeks a new enrollment period—

(1) Prior to the date on which he or she would have been redetermined in accordance with § 155.335 of this subpart had he or she enrolled in a QHP, the Exchange must require the applicant to attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for an enrollment period, and must process any changes reported in accordance with the procedures specified in § 155.330 of this subpart.

(2) On or after the date on which he or she would have been redetermined in accordance with § 155.335 of this subpart had he or she enrolled in a QHP, the Exchange must apply the procedures specified in § 155.335 of this subpart before determining his or her eligibility for an enrollment period.

§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

(a) *General requirement.* Unless a request for modification is granted pursuant to paragraph (e) of this section, the Exchange must verify or obtain information as provided in this section in order to determine that an applicant is eligible for enrollment in a QHP through the Exchange.

(b) *Verification of citizenship, status as a national, or lawful presence.*

(1) *Verification with records from the Social Security Administration.* For an applicant who attests to citizenship and has a Social Security number, the

Exchange must transmit the applicant's Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) *Verification with the records of the Department of Homeland Security.* For an applicant who has documentation that can be verified through the Department of Homeland Security and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the Department of Homeland Security.

(3) *Inconsistencies and inability to verify information.* For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the Social Security Administration or the Department of Homeland Security, the Exchange must follow the procedures specified in paragraph (e) of this section, except that the Exchange must provide the applicant with a period of 90 days from the date on which the notice described in § 155.315(e)(2)(i) of this section is received for the application filer to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security, as applicable. The date on which the notice is received means 5 days after the date on the notice, unless the applicant shows that he or she did not receive the notice within the 5-day period.

(c) *Verification of residency.*

(1) Except as provided in paragraphs (c)(2) through (c)(4) of this section, the Exchange must verify an applicant's residency in the service area of the Exchange by accepting his or her attestation without further verification.

(2) If the State Medicaid or CHIP agency operating in the State in which the Exchange operates elects to examine electronic data sources for all applicants to verify residency, the Exchange must proceed in accordance with 42 CFR 435.956(c) and 42 CFR 457.380(c), and the policy of the State Medicaid or CHIP agency.

(3) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange the Exchange may examine information in data sources.

(4) If the information in such data sources is not reasonably compatible with the information provided by the applicant, the Exchange must follow the procedures specified in § 155.315(e) of this section. A document that provides evidence of immigration status may not be used alone to determine State residency.

(d) *Verification of incarceration status.* The Exchange must verify an applicant's attestation that he or she meets the requirements of § 155.305(a)(2) of this subpart by—

(1) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and offer less administrative complexity than paper verification; or

(2) Except as provided in paragraph (d)(3) of this section, if an approved data source is unavailable, accepting his or her attestation without further verification.

(3) To the extent that an applicant's attestation is not reasonably compatible with information from approved data sources described in paragraph (d)(1) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(e) of this subpart.

(e) *Inconsistencies.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, the Exchange—

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, such as by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If the Exchange is unable to resolve the inconsistency through the process described in paragraph (e)(1) of this section, must—

(i) Notify the applicant of the inconsistency; and

(ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (e)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence or otherwise resolve the inconsistency.

(3) The Exchange may extend the period described in paragraph (e)(3) for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

(4) During the period described in paragraph (e)(2)(ii) of this section, must—

(i) Proceed with all other elements of eligibility determination using the application filer's attestation for the applicant, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified; and

(ii) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305 of this subpart, if the primary taxpayer attests to the Exchange that he or she understands that any advance payments of the premium tax credit received are subject to reconciliation.

(5) If, after the period described in paragraph (e)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must—

(i) Determine the applicant's eligibility based on the information available from the data sources specified in this subpart, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(f) of this subpart, including notice that the Exchange is unable to verify the attestation; and

(ii) Implement the determination specified in paragraph (e)(5)(i) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in paragraph (e)(5)(i) of this section is sent.

(f) *Flexibility in information collection and verification.* HHS may approve an Exchange Plan in accordance with § 155.105(d) or a significant change to the Exchange Plan in accordance with § 155.105(e) of this part to modify the methods to be used for collection of information and verification of information as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that any applicable requirements under § 155.260, § 155.270, paragraph (g) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(g) *Applicant information.* The Exchange must not require an applicant to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medicaid, CHIP, and the

Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, described in this subpart.

§ 155.320 Verification process related to eligibility for insurance affordability programs.

(a) *General requirements.*

(1) The Exchange must verify information in accordance with this section only for an applicant who is requesting an eligibility determination for insurance affordability programs in accordance with § 155.310(b) of this subpart.

(2) Unless a request for modification is granted pursuant to § 155.315(e) of this subpart, the Exchange must verify or obtain information in accordance with this section before making an eligibility determination for insurance affordability programs, and must use such information in such determination.

(b) *Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.*

(1) The Exchange must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the Basic Health Program, using information obtained by transmitting identifying information specified by HHS to HHS.

(2) The Exchange must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program 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.

(c) *Verification of household income and family/household size.*

(1) *Data.*

(i) *Tax return data.*

(A) For all individuals whose income is counted in calculating a primary taxpayer's household income, in accordance with 26 CFR 1.36B-1(e), or an applicant's household income, in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number or an adoption taxpayer identification number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury by transmitting identifying information specified by HHS to HHS.

(B) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed pursuant to section 6103(l)(21) of the

Code and its accompanying regulations, the Exchange must proceed in accordance with § 155.315(e)(1) of this subpart.

(ii) *Data regarding MAGI-based income.* For all individuals whose income is counted in calculating a primary taxpayer's household income, in accordance with 26 CFR 1.36B-1(e), or an applicant's household income, in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

(2) *Verification process for Medicaid and CHIP.*

(i) *Household size.*

(A) The Exchange must require an application filer to attest to the individuals that comprise an applicant's household for Medicaid and CHIP, within the meaning of 42 CFR 435.603(f).

(B) The Exchange must verify the information in paragraph (c)(2)(i)(A) of this section by accepting an application filer's attestation without further verification, unless the Exchange finds that an application filer's attestation to the individuals that comprise an applicant's household for Medicaid and CHIP is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, in which case the Exchange may utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the application filer's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in 45 CFR 435.952.

(ii) *Verification process for MAGI-based household income.* The Exchange must verify MAGI-based income, within the meaning of 42 CFR 435.603(d), for the household described in paragraph (c)(2)(i)(A) of this section in accordance with the procedures specified in 42 CFR 435.948 and 42 CFR 435.952.

(3) *Verification process for advance payments of the premium tax credit and cost-sharing reductions.*

(i) *Family size.*

(A) The Exchange must require an application filer to attest to the individuals that comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions, within the meaning of 26 CFR 1.36B-1(d).

(B) The Exchange must verify an applicant's family size for advance payments of the premium tax credit and cost-sharing reductions by accepting an application filer's attestation without

further verification, unless the Exchange finds that an application filer's attestation of family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, in which case the Exchange may utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the application filer's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in § 155.315(e) of this subpart.

(ii) *Basic verification process for annual household income.*

(A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the tax return data described in paragraph (c)(1)(i) of this section, and require the application filer to validate this information, by attesting whether it represents an accurate projection of the family's household income for the benefit year for which coverage is requested.

(B) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an application filer attests that it does not represent an accurate projection of the family's household income for the benefit year for which coverage is requested, the Exchange must require the application filer to attest to the family's projected household income for the benefit year for which coverage is requested and accept the application filer's attestation without further verification, except as provided in paragraph (c)(3)(ii)(C) of this section.

(C) If the Exchange finds that an application filer's attestation to the family's projected household income for the benefit year for which coverage is requested is not reasonably compatible with the information described in paragraph (c)(3)(ii)(A) of this section, including as a result of data under paragraph (c)(1)(i) of this section being unavailable, the Exchange must proceed in accordance with paragraphs (c)(3)(iii), (c)(3)(iv), and (c)(3)(vi) of this section, as applicable.

(iii) *Verification process for increases in household income.*

(A) If an application filer attests that a primary taxpayer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section to the benefit year for which the applicant(s) in the primary taxpayer's family are requesting coverage and have not established

MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section that is within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the application filer's attestation for the primary taxpayer's family without further verification, except as provided in paragraph (c)(3)(iii)(B) of this section.

(B) If the Exchange finds that an application filer's attestation of annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, the Exchange may utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the application filer's attestation, the Exchange must request additional documentation using the procedures specified in § 155.315(e) of this subpart.

(iv) *Eligibility for alternate verification process for decreases in annual household income and situations in which tax return data is unavailable.*

The Exchange must determine a primary taxpayer's annual household income for advance payments of the premium tax credit and cost-sharing reductions based on the alternate verification procedures described in paragraph (c)(3)(v) of this section, if an application filer attests to projected annual household income in accordance with paragraph (c)(3)(ii)(B) of this section, the primary taxpayer does not meet the criteria specified in paragraph (c)(3)(iii) of this section, the applicants in the primary taxpayer's family have not established MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section that is within the applicable Medicaid or CHIP MAGI-based income standard, and

(A) The Secretary of the Treasury does not have tax return data for the primary taxpayer that is at least as recent as the calendar year two years prior to the calendar year for which advance payments of the premium tax credit or cost-sharing reductions would be effective, including a situation in which this is as a result of an individual not being required to file;

(B) The application filer attests that the primary taxpayer's applicable family size has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage;

(C) The application filer attests that the primary taxpayer's annual household income has decreased or is reasonably expected to decrease from the data described in paragraph (c)(1)(i)

of this section by 20 percent or more to the benefit year for which the applicants in his or her family are requesting coverage; or

(D) An applicant in the primary taxpayer's family has filed an application for unemployment benefits.

(v) *Alternate verification process for decreases in annual household income and situations in which tax return data is unavailable.* If a primary taxpayer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section, the Exchange must attempt to verify the application filer's attestation of projected annual household income for the primary taxpayer by—

(A) Using annualized data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section;

(B) Using other electronic data sources that have been approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(C) If electronic data are unavailable or do not support an application filer's attestation, the Exchange must follow the procedures specified in § 155.315(e) of this subpart.

(D) If, following the 90-day period described in paragraph (c)(3)(v)(C) of this section, an application filer has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the primary taxpayer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange.

(E) If, at the conclusion of the period specified in paragraph (c)(3)(v)(C) of this section, the Exchange remains unable to verify the application filer's attestation, the Exchange must determine an applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(f) of this subpart, and implement such determination in accordance with the effective dates specified in § 155.330(e)(1)–(2) of this subpart.

(vi) *Primary taxpayers not meeting criteria for use of the alternate verification process.* For a primary taxpayer who does not qualify for the alternate verification process based on the requirements specified in paragraph

(c)(3)(iv) of this section, the Exchange must determine household income for purposes of advance payments of the premium tax credit and cost-sharing reductions based on the information specified in paragraph (c)(3)(ii)(A) of this section.

(4) The Exchange must provide education and assistance to an application filer regarding the process specified in this paragraph.

(d) *Verification related to enrollment in an eligible employer-sponsored plan.*

(1) Except as provided in paragraph (d)(2) of this section, the Exchange must verify whether an applicant requesting an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions is enrolled in an eligible employer-sponsored plan by accepting his or her attestation without further verification.

(2) If the Exchange finds that an applicant's attestation of enrollment in an eligible employer-sponsored plan is not reasonably compatible with other information provided by the applicant or in the records of the Exchange, the Exchange may utilize data obtained through data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the individual's attestation, the Exchange may request additional documentation to support the attestation within the procedures specified in paragraph (g) of this subpart.

(e) *Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan.*

(1) The Exchange must require an applicant to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, and to provide information identified in section 1411(b)(4) of the Affordable Care Act.

(2) The Exchange must verify whether an applicant is eligible for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(f) *Additional verification related to immigration status for Medicaid and CHIP.*

(1) For purposes of determining eligibility for Medicaid, the Exchange must verify whether an applicant who is not a citizen or a national meets the requirements of 42 CFR 435.406 and section 1903(v)(4) of the Social Security Act, in accordance with the Medicaid State Plan.

(2) For purposes of determining eligibility for CHIP, the Exchange must verify whether an applicant who is not a citizen or a national meets the requirements of 42 CFR 457.320(d) and section 2107(e)(1)(f) of the Social Security Act, in accordance with the State Child Health Plan.

§ 155.330 Eligibility redetermination during a benefit year.

(a) *General requirement.* The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (c) of this section.

(b) *Requirement for individuals to report changes.* The Exchange must—

(1) Require an enrollee to report changes with respect to the eligibility standards specified in § 155.305 of this subpart within 30 days of such change; and

(2) Verify any information reported by an enrollee in accordance with the processes specified in § 155.315 and § 155.320 of this subpart prior to using such information in an eligibility redetermination.

(c) *Requirement for Exchange to periodically examine certain data sources.*

(1) The Exchange must periodically examine available data sources described in § 155.315(b)(1) and § 155.320(b) of this subpart to identify the following changes:

(i) Death; and

(ii) Eligibility determinations for Medicare, Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange.

(2) *Flexibility.* The Exchange may make additional efforts to identify and act on changes that may affect an enrollee's eligibility for enrollment in a QHP through the Exchange if HHS approves an Exchange Plan in accordance with § 155.105(d) or a significant change to the Exchange Plan in accordance with § 155.105(e) of this part to modify the requirements, based on the criteria specified in § 155.315(e) of this subpart.

(d) *Redetermination and notification of eligibility.* If the Exchange verifies updated information reported by an enrollee or identifies updated information through the data matching described in paragraph (c) of this section, the Exchange must:

(1) Redetermine the enrollee's eligibility in accordance with the

standards specified in § 155.305 of this subpart, and

(2) Notify the enrollee regarding the determination in accordance with the requirements specified in § 155.310(f) of this subpart and notify the enrollee's employer, as applicable, in accordance with the requirements specified in § 155.310(g) of this subpart.

(e) *Effective dates.*

(1) In general, changes resulting from a redetermination under this section are effective on the first day of the month following the date of the notice described in paragraph (d)(2) of this section.

(2) Subject to the authorization of HHS, the Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month specified in paragraph (e)(1) of this section.

(3) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions, for a full month following the month in which the notice described in paragraph (d)(2) of this section is sent.

§ 155.335 Annual eligibility redetermination.

(a) *General requirement.* The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange on an annual basis.

(b) *Updated income and family size information.* In the case of an enrollee who requests an eligibility determination for insurance affordability programs in accordance with § 155.310(b) of this subpart, the Exchange must request updated tax return information and data regarding MAGI-based income as described in paragraph (c)(1) of § 155.320 of this subpart for use in the enrollee's eligibility redetermination.

(c) *Notice to enrollee.* The Exchange must provide an enrollee with an annual redetermination notice including the following:

(1) The data obtained under paragraph (b) of this section, if applicable; and

(2) The data used in the enrollee's most recent eligibility determination; and

(3) The enrollee's projected eligibility determination for the following year, after considering any updated information described in paragraph

(c)(1) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and level of cost-sharing reductions.

(d) *Changes reported by enrollees.* The Exchange must require an enrollee to report any changes with respect to the information listed in the notice within 30 days from the date of the notice.

(e) *Verification of reported changes.* The Exchange must verify any information reported by an enrollee under paragraph (d) of this section in accordance with § 155.315 and § 155.320 of this subpart, including the relevant provisions in those sections regarding inconsistencies, before using such information to determine eligibility.

(f) *Response to redetermination notice.*

(1) The Exchange must require an enrollee to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that an enrollee does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (d) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

(g) *Redetermination and notification of eligibility.*

(1) After the 30-day period specified in paragraph (d) of this section has elapsed, the Exchange must—

(i) Redetermine the enrollee's eligibility in accordance with the standards specified in § 155.305 of this subpart using the information provided to the individual in the notice specified in paragraph (c) of this section, as supplemented with any information reported by the enrollee and verified by the Exchange pursuant to paragraphs (d) and (e) of this section;

(ii) Notify the enrollee in accordance with the requirements specified in § 155.310(f) of this subpart; and

(iii) If applicable, notify the enrollee's employer, in accordance with the requirements specified in § 155.310(g) of this subpart.

(2) If an enrollee reports a change with respect to the information provided in the notice specified in paragraph (c) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (d) of this section, the Exchange must redetermine the enrollee's eligibility after completing verification.

(h) *Effective dates.* The rules specified in § 155.330(e) of this part regarding effective dates apply to changes

resulting from a redetermination under this section.

(i) *Renewal of coverage.* If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee will remain in the QHP selected the previous year unless such enrollee terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with 45 CFR § 155.430.

§ 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

(a) *Requirement to provide information to enable advance payments of the premium tax credit and cost-sharing reductions.* In the event that the Exchange determines that an applicant is eligible for advance payments of the premium tax credit or cost-sharing reductions or that an enrollee's eligibility has changed, the Exchange must, simultaneously and at such time and in such manner as HHS may specify—

(1) Notify the issuer of the applicable QHP;

(2) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change the individual's advance payments of the premium tax credit or cost-sharing reductions;

(3) Transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of an individual's advance payments of the premium tax credit or cost-sharing reductions, as applicable, including:

(i) The dollar amount of the individual's advance payment; and

(ii) The individual's cost-sharing reductions eligibility category.

(b) *Requirement to provide information related to employer responsibility.*

(1) In the event that the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, as specified in 26 CFR 1.36B-2(c)(3)(v), or does not meet the minimum value requirement specified in 26 CFR 1.36B-2(c)(3)(vi), the Exchange must transmit the individual's name and taxpayer identification number to HHS.

(2) If an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he

or she has changed employers, the Exchange must transmit the enrollee's name and Social Security number to HHS.

(3) In the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions disenrolls from a QHP through the Exchange during a benefit year, the Exchange must—

(i) Transmit the individual's name and Social Security number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and

(ii) Transmit the individual's name and the effective date of the termination of coverage to his or her employer.

(c) *Requirement to provide information related to reconciliation of advance payments of the premium tax credit.* The Exchange must comply with the requirements specified in section 36B(f)(3) of the Code and 26 CFR 1.36B-5 regarding reporting to the IRS and to taxpayers.

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

(a) *Agreements.* The Exchange must enter into agreements with Medicaid or CHIP agencies as are necessary to fulfill the requirements of this subpart.

(b) *Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups.*

(1) The Exchange must conduct basic screening for an applicant requesting an eligibility determination for insurance affordability programs under § 155.310(b) of this subpart to determine if an applicant is potentially eligible for Medicaid based on factors not otherwise considered in this subpart, including disability, and must transmit to the State Medicaid agency promptly and without undue delay the name of such applicant, other identifying information, and all other information provided on the application submitted by or on behalf of such applicant to, and obtained and verified by, the Exchange.

(2) If the applicant is otherwise eligible for advance payments of the premium tax credit and cost-sharing reductions, the Exchange must provide the applicant with such advance payments of the premium tax credit or cost-sharing reductions until the other program notifies the Exchange that the applicant is eligible for such program.

(c) *Individuals requesting additional screening.* The Exchange must—

(1) Provide an opportunity for an applicant to request a full determination of eligibility for Medicaid based on

eligibility criteria that are not described in § 155.305.

(2) If an applicant requests such a determination, transmit promptly and without undue delay the applicant's name, other identifying information, and all other information provided on the application submitted by or on behalf of such applicant to, and obtained and verified by, the Exchange to the State Medicaid agency.

(d) *Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the Basic Health Program.* The Exchange, in consultation with the agencies administering Medicaid, CHIP, and the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, and the applicant is determined ineligible for such programs based on the applicable MAGI. Such procedures must—

(1) Not require the Exchange to duplicate any eligibility and verification findings already made by the agency administering Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, or cost-sharing reductions; and

(2) Provide for following the same eligibility determination processes for eligibility determinations regardless of the agency that initially receives an application.

(e) *Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP, and the Basic Health Program.*

(1) The Exchange must utilize a secure electronic interface to exchange data with the agencies administering Medicaid, CHIP, and the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, for the purpose of determining eligibility, including verification as to whether an applicant for advance payments of the premium tax credit or cost-sharing reductions has been determined eligible for Medicaid, CHIP, or the Basic Health Program as specified in § 155.320(b)(2) of this subpart and 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.

(f) *Transition from the Pre-existing Condition Insurance Program (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.

§ 155.350 Special eligibility standards and process for Indians.

(a) *Eligibility for cost-sharing reductions.*

(1) The Exchange must determine an applicant who is an Indian eligible for cost-sharing reductions if he or she—

(i) Meets the requirements specified in § 155.305(a) of this subpart; and

(ii) Has household income for the taxable year that does not exceed 300 percent of the FPL.

(2) The Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP through the Exchange.

(b) *Special cost-sharing rule for Indians regardless of income.* The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination for cost-sharing reductions in accordance with § 155.310(b) of this subpart in order to qualify for this rule.

(c) *Verification related to Indian status.* To the extent that an applicant attests that he or she is an Indian, the Exchange must verify such attestation by—

(1) Utilizing any relevant documentation verified in accordance with § 155.315(e) of this subpart;

(2) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources conflict with an applicant's attestation, the Exchange must follow the procedures specified in § 155.315(e) of this subpart and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.

§ 155.355 Right to appeal.

(a) *Individual appeals.* The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any determination notice issued to the applicant pursuant to § 155.310(f), § 155.330(d), or § 155.335(h) of this subpart.

(b) [Reserved]

2. Part 157 is added as follows:

PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

Subpart A—General Provisions

Sec.

157.10 Basis and scope.

157.20 Definitions.

Subpart B—[Reserved]

Subpart C—Standards for Qualified Employers

157.200 Eligibility of qualified employers to participate in a SHOP.

157.205 Qualified employer participation process in a SHOP.

Authority: Title I of the Affordable Care Act, Sections 1311, 1312, 1321, 1411, 1412.

Subpart A—General Provisions

§ 157.10 Basis and scope.

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

1311. Affordable choices of health benefits plans.

1312. Consumer Choice.

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

1411. Procedures for determining eligibility for Exchange participation, advance payments of the premium tax credit and cost-sharing reductions, and individual responsibility exemptions.

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

(b) *Scope.* This part establishes the requirements for employers in connection with the operation of Exchanges.

§ 157.20 Definitions.

The following definitions apply to this part, unless otherwise indicated:

Qualified employee has the meaning given to the term in § 155.20.

Qualified employer has the meaning given to the term in § 156.20.

Small employer has the meaning given to the term in § 155.20.

Subpart B—[Reserved]

Subpart C—Standards for Qualified Employers

§ 157.200 Eligibility of qualified employers to participate in a SHOP.

(a) *General requirement.* Only a qualified employer may participate in the SHOP in accordance with 45 CFR 155.710.

(b) *Continuing participation for growing small employers.* A qualified employer may continue to participate in the SHOP if it ceases to be a small employer pursuant to 45 CFR 155.710.

(c) *Participation in multiple SHOPS.* A qualified employer may participate in multiple SHOPS pursuant to 45 CFR 155.710.

§ 157.205 Qualified employer participation process in a SHOP.

(a) *General requirements.* When joining the SHOP, a qualified employer must comply with the requirements, processes, and timelines set forth by this part and must remain in compliance for the duration of the employer's participation in the SHOP.

(b) *Selecting QHPs.* During an election period, a qualified employer may make coverage in a QHP available through the SHOP in accordance with the processes developed by the SHOP pursuant to 45 CFR 155.705.

(c) *Information dissemination to employees.* A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.

(d) *Payment.* A qualified employer must submit any contribution towards the premiums of any qualified employee according to the standards and processes described in 45 CFR 155.705.

(e) *Employees hired outside of the initial or annual open enrollment period.* Qualified employers must

provide employees hired outside of the initial or annual open enrollment period with a specified period to seek coverage in a QHP beginning on the first day of employment and information about the enrollment process pursuant to 45 CFR 155.725.

(f) *New employees and changes in employee eligibility.* Qualified employers participating in the SHOP must provide the SHOP with information about individuals or employees whose eligibility status for coverage purchased through the employer in the SHOP has changed, including:

(1) Newly eligible individuals and employees; and

(2) Loss of qualified employee status.

(g) *Annual employer election period.* Qualified employers must adhere to the annual employer election period to change the program participation for the next plan year described in 45 CFR 155.725(c).

(h) *Employer participation renewal.* If a qualified employer does not take action during the annual employer election period, and remains eligible to continue participating in the SHOP, such qualified employer will, for the next plan year, continue to offer the same plan, coverage level (as defined by section 1302(d)(1) of the Affordable Care Act), or combination of plans at the same contribution level as selected during the previous year, if such options remain available.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 4, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 9, 2011

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2011–20776 Filed 8–12–11; 8:45 am]

BILLING CODE 4120–01–P