45 CFR Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act					
Subpart A - General Provisions					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.10	Basis and Scope	Outlines the statutory provisions of the ACA that create the health insurance exchanges and make up 45 CFR Part 155.	77 FR 18444 (Mar. 27, 2012)	Presentation - Affordable Insurance Exchanges Final Rule (March 2012)	
§ 155.20	Definitions	Defines the relevant terms used in 45 CFR Part 155 and throughout the ACA, such as employer, exchange, grandfathered health plan, group health plan, minimum essential coverage, qualified health plan, SHOP, state, and small group market.	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 39523 (July 1, 2013); 78 FR 42313 (July 15, 2013); 78 FR 54134 (Aug. 30, 2013)		10 CCR § 6410
Subpart B - General Standards Related to the Establishment of an Exchange					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.100	Establishment of a State Exchange	Allows each state to establish an exchange for the individual market and for small businesses. States are permitted to establish a SHOP-only exchange, with the federal government establishing the individual market exchange in such state. HHS must establish and operate an exchange in a state if such state does not elect, or is unable, to operate its own exchange	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 54134 (Aug. 30, 2013)	Guidance on FFE (May 16, 2012); Guidance on State Partnership Exchange (Jan. 3, 2013); Letter to Issuers on FFE and Partnership Exchange (April 5, 2013)	
§ 155.105	Approval of a State Exchange	Outlines the basic process (further delineated in this Part) for states	77 FR 18444	FAQ on Exchange Blueprint (Nov.	

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		to receive HHS approval of their exchanges, such as submitting an Exchange Blueprint and demonstrating operational readiness. Requires HHS to establish an exchange if a state is unable or unwilling to.	(Mar. 27, 2012); 78 FR 42313 (July 15, 2013); 78 FR 54134 (Aug. 30, 2013)	9, 2012); Exchange Blueprint (Nov. 16, 2012)	
§ 155.106	Election to operate an Exchange after 2014	Requires a state to provide 12 months notice to HHS of a determination to operate an exchange or cease operating an exchange	77 FR 18444 (Mar. 27, 2012)		
§ 155.110	Entities eligible to carry out Exchange functions	Establishes the parameters of an exchange (e.g., run by the state or an entity designated by the state, but not a health insurance issuer). Also requires exchanges to have a governing board and adopted certain governance principles (e.g., ethics, conflict of interest standards, transparency, disclosure of financial interest).	77 FR 18444 (Mar. 27, 2012)		
§ 155.120	Non-interference with Federal law and non-discrimination standards	Prohibits an exchange from establishing rules that conflict with, or prevent the application of, these exchange-related regulations.	77 FR 18444 (Mar. 27, 2012)		
§ 155.130	Stakeholder consultation	Requires exchanges to regularly consult with relevant stakeholders (e.g., QHP enrollees, public health experts, health care providers, large employers, issuers, and agents and brokers).	77 FR 18444 (Mar. 27, 2012)		
§ 155.140	Establishment of a regional Exchange or subsidiary Exchange	Permits the creation of a regional exchange between two or more states (that do not have to be contiguous) or a subsidiary exchange that serves a geographically distinct area within a state.	77 FR 18444 (Mar. 27, 2012); 78 FR 54134 (Aug. 30, 2013)		
§ 155.150	Transition process for existing State health insurance exchanges	Deems the Massachusetts Health Connector to satisfy the requirements of this Part.	77 FR 18444 (Mar. 27, 2012)		
§ 155.160	Financial support for continued operations	Exchanges must be self-sufficient beginning in year two (January 1, 2015) and may impose user fees on participating issuers. Exchange establishment grants provided by the ACA (through HHS/CCIIO) will not be awarded after this deadline.	77 FR 18444 (Mar. 27, 2012)	FAQ (July 10, 2013)	
§ 155.170	Additional required benefits	States may require QHPs to offer benefits in addition to the	77 FR 18444		

		essential health benefits (EHB) package, but the state will be responsible for the added costs of such benefits.	(Mar. 27, 2012); 78 FR 12865 (Feb. 25, 2013)		
Subpart C - General Functions of an Exchange					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.200	Functions of an Exchange	Outlines the minimum requirements of exchanges, referencing other Subparts of these regulations and the ACA.	77 FR 18444 (Mar. 27, 2012); 78 FR 39523 (July 1, 2013); 78 FR 54134 (Aug. 30, 2013)		
§ 155.205	Consumer assistance tools and programs of an Exchange	Requires exchanges to maintain a toll-free call center and a website that contains information regarding each QHP (e.g., premium, cost-sharing, quality ratings, medical loss ratio) and exchange fees and administrative costs. Also mandates that exchanges provide information in plain language that is accessible to individuals with disabilities and limited English proficiency. Exchanges must provide consumer assistance, outreach, and education.	77 FR 18444 (Mar. 27, 2012); 78 FR 42859 (July 17, 2013)		10 CCR § 6452; 10 CCR § 6800
§ 155.210	Navigator program standards	Establishes the basic standards for the Navigator program, which will provide impartial education to consumers to facilitate the selection of a QHP. Navigators may be community and consumer-focused groups, agents and brokers, chambers of commerce, unions, and trade, industry, and professional associations. Exchange establishment grants may not be used to pay for the Navigator program grants, however, they may be used to fund non-Navigator assistance personnel carrying out consumer assistance functions.	77 FR 18444 (Mar. 27, 2012); 78 FR 42859 (July 17, 2013)	FAQ - Navigator Funding Announcement (April 9, 2013)	

§ 155.215	Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under 155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.	Establishes standards applicable to Navigators in federal exchanges and non-Navigator assistance personnel in state exchanges. Conflict of interest standards prevent such entities from being a health insurance issuer or issuer of stop loss insurance, a subsidiary of such, or an association that includes members of (or lobbies on behalf of) the insurance industry. Training standards include certification and recertification requirements (e.g., HHS-approved training, at least annually, regarding QHPs, insurance affordability programs, tax implications, eligibility for premium tax credit subsidies, health insurance concepts, and privacy and security standards). Also requires that services are provided in a culturally and linguistically appropriate manner and to individuals with disabilities.	78 FR 42859 (July 17, 2013)		10 CCR § 6650 (definitions for enrollment assistance); 10 CCR § 6654 (Certified Enrollment Entities application requirements); 10 CCR § 6660 (CEE training standards); 10 CCR § 6662 (appeals process); 10 CCR § 6664 (responsibilities for CEEs and CECs); 10 CCR § 6666 (conflict of interest standards); 10 CCR § 6700 et seq (Certified Plan-Based Enrollment Program) (Note: Click on "Article

					9" hyperlink)
§ 155.220	Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs	Allows states to permit agents and brokers to enroll applicants in QHPs in the individual or small group market and assist consumers with applying for premium tax credit subsidies and cost-sharing reductions.	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 42859 (July 17, 2013); 78 FR 54134 (Aug. 30, 2013)	Guidance - Role of Agents and Brokers (May 1, 2013)	10 CCR § 6800 et seq. (Certified Insurance Agents) (Note: Click on "Article 10" hyperlink) Covered California - Certified Insurance Agent FAQs; Covered California - Certified Insurance Agent Training and Certification;
§ 155.225	Certified application counselors	Requires exchanges to have a certified application counselor program that will certify staff members or volunteers to provide information to consumers about the full range of QHP options and affordability programs, and to assist individuals to apply for, and enroll in, coverage.	78 FR 42859 (July 17, 2013)	Guidance - Certified Application Counselor Program in FFE and Partnership Exchanges (July 12, 2013); Certified Application Counselor Application (July 12, 2013)	10 CCR § 6652 (outlines entities and individuals eligible to serve as a Certified Enrollment Entity); 10 CCR § 6658 (Requires CEEs to submit fingerprint and

					criminal background checks); 10 CCR § 6668 (outlines compensation parameters for CEEs)
§ 155.227	Authorized representatives	Exchanges must permit applicants to designate an individual or organization to serve as the authorized representative of the applicant.	78 FR 42313 (July 15, 2013)		10 CCR § 6508
§ 155.230	General standards for Exchange notices	Outlines the basic standards of exchange notices to individuals and employers (e.g., must explain the action reflected in the notice and the effective date, provide relevant factual findings and citations to regulations, explain appeal rights, and provide contact information for customer service resources).	77 FR 18444 (Mar. 27, 2012); 78 FR 42313 (July 15, 2013)		10 CCR § 6454
§ 155.240	Payment of premiums	Requires exchanges to permit individuals to pay applicable premiums directly to QHP issuers.	77 FR 18444 (Mar. 27, 2012)	See 45 CFR § 156.1240	
§ 155.260	Privacy and security of personally identifiable information	Ensures that the privacy and security of personally identifiable information is guaranteed by requiring exchanges to implement adequate standards regarding individual access, transparency, collection and disclosure limitations, data quality and integrity, and safeguards. Exchanges must ensure the same or more stringent privacy and security standards outlined herein as a condition of contract or agreement with individuals and entities (e.g., Navigators) that collect, use, disclose, or gain access to personally identifiable information.	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6456 (requires fingerprinting and criminal background checks for individuals who will have access to tax information, personally-identifiable

					information, personal health information, cash and other forms of payment, and technology systems of the exchange); 10 CCR § 6804; 10 CCR § 6806
§ 155.270	Use of standards and protocols for electronic transactions	Requires adherence to HIPAA and HIT enrollment standards and protocols for electronic transactions.	77 FR 18444 (Mar. 27, 2012); 78 FR 54134 (Aug. 30, 2013)		
§ 155.280	Oversight and monitoring of privacy and security requirements	HHS will oversee and monitor exchanges (federal and state) and non-exchange entities for compliance with the privacy and security standards for personally identifiable information.	78 FR 54134 (Aug. 30, 2013)		
Subpart D - Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.300	Definitions and general standards for eligibility determinations	Outlines the basic definitions governing the regulations in this Subpart, such as insurance affordability program, minimum value, and qualifying coverage in an eligible employer-sponsored plan.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)	Fact Sheet (July 5, 2013)	
§ 155.302	Options for conducting eligibility determinations	Requires processes for determining eligibility for Medicaid, CHIP, insurance affordability programs, advance payments of the premium tax credit subsidies, and cost-sharing reductions. These processes must be streamlined and coordinated across HHS, the exchange, state Medicaid and CHIP agencies and must protect personally	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6470

		identifiable information.			
§ 155.305	Eligibility standards	Outlines how the exchanges must determine applicant eligibility for enrollment in a QHP (e.g., citizen or non-citizen lawfully present in the US), Medicaid, CHIP, Basic Health Plan, advance payments of premium tax credits (income between 100-400% of FPL), cost sharing reductions (income at 250% or less of FPL), and catastrophic plans. This section outlines the general eligibility requirements and references other regulations.	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 42314 (July 15, 2013)		10 CCR § 6472 (outlines requirements for eligibility for enrollment in a QHP); 10 CCR § 6474 (premium tax credit subsidies and cost-sharing reductions)
§ 155.310	Eligibility process	Requires exchanges to accept applications for coverage as required in these regulations (e.g., single, streamlined application for QHP, Medicaid, CHIP, and premium tax credits/cost-sharing reductions). Exchanges are required to collect Social Security numbers to assist with eligibility determinations and promptly notify state Medicaid or CHIP agencies of an applicant's eligibility for such coverage. Exchanges also must notify employers if employees have been determined eligible for premium tax credits and cost-sharing reductions and that the employer may be liable for a shared responsibility payment.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013); 78 FR 54134 (Aug. 30, 2013)		10 CCR § 6470; 10 CCR § 6476
§ 155.315	Verification process related to eligibility for enrollment in a QHP through the Exchange	Outlines the process that exchanges must utilize to determine an applicant's eligibility for enrollment in a QHP. This includes verification of Social Security numbers, citizenship status, and residency through the transmission and exchange of information with other federal agencies (SSA, IRS, Homeland Security, and HHS), other data sources, and applicant attestations.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6478; 10 CCR § 6492
§ 155.320	Verification process related to eligibility for insurance affordability programs	Establishes the requirement that exchanges verify applicant eligibility for insurance affordability programs. Verification of the	77 FR 18444 (Mar. 27, 2012);	FAQ (Aug. 5, 2013)	10 CCR § 6480; 10 CCR § 6482;

		following types of information is required: eligibility for minimum essential coverage other than coverage through an employer-sponsored plan, Medicaid, CHIP, or the Basic Health Plan; household income; increases or decreases in household income; household/family size. The regulations outline the process for verifying each of these data points, including the transmission of information between the exchange and HHS, IRS, applicant attestations, employers, other data sources, and review of tax return data.	78 FR 42314 (July 15, 2013); 78 FR 54134 (Aug. 30, 2013)		10 CCR § 6484; 10 CCR § 6486; 10 CCR § 6490; 10 CCR § 6492 (outlines process for addressing inconsistencies)
§ 155.330	Eligibility redetermination during a benefit year	Requires exchanges to redetermine an enrollee's eligibility for a QHP during the year if the exchange receives and verifies new information reported by an enrollee or identifies updated information through required periodic reviews of available data sources used to determine an enrollee's death or eligibility for Medicare, Medicaid, CHIP, or the Basic Health Plan.	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 42314 (July 15, 2013)		10 CCR § 6496
§ 155.335	Annual eligibility redetermination	Exchanges must annually redetermine enrollees' eligibility for enrollment in QHPs and provide a notice to enrollees that include projected eligibility for the following year, including any amount of premium tax credits and cost-sharing reductions and eligibility for Medicaid, CHIP, or the Basic Health Plan. Enrollee eligibility notifications must occur with the annual open enrollment period notification (September 1-30) for 2015 and 2016 coverage years.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6498
§ 155.340	Administration of advance payments of the premium tax credit and cost-sharing reductions	Exchanges must promptly transmit information to HHS, employers, the IRS, and QHP issuers regarding eligibility for premium tax credits and cost-sharing reductions, or that such eligibility has changed. Exchanges facilitating the payment of premiums to QHP issuers must reduce the monthly amount owed by the enrollee by the amount of any advance payment of premium tax credits. Exchanges must rectify within 45 days situations where the exchange failed to reduce an enrollee's premiums to account for	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013); 78 FR 42314 (July 15, 2013); 78 FR 65095 (Oct. 30, 2013)		

		advance payments of premium tax credits			
§ 155.345	Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan	Exchanges are required to coordinate with state Medicaid and CHIP agencies to determine whether an applicant not otherwise deemed eligible for Medicaid under these regulations may be eligible based on other factors and information provided on the application. Applicants will be deemed ineligible for Medicaid unless the state agency notifies the exchange otherwise.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013); 78 FR 54134 (Aug. 30, 2013)		
§ 155.350	Special eligibility standards and process for Indians	Cost-sharing reductions will be available to Indians with household incomes below 300% of the FPL.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6494
§ 155.355	Right to appeal	Eligibility notices provided to applicants must include a notice of the right to appeal the eligibility determination and instructions regarding how to file an appeal.	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6510
Subpart E - Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.400	Enrollment of qualified individuals into QHPs	Exchanges must accept an eligible applicant's enrollment into a QHP and transmit eligibility and enrollment information to HHS and QHP issuers promptly. Enrollment information must be reconciled with QHP issuers at least monthly.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6500
§ 155.405	Single streamlined application	Exchanges must provide to applicants a single application that will be used to determine eligibility for enrollment in a QHP, premium tax credit subsidies, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Plan.	77 FR 18444 (Mar. 27, 2012)	Guidance - State Alternative Applications (June 18, 2013); Individual Application (April 30, 2013); Family Application (April 30, 2013)	10 CCR § 6452 (requires applications to be provided in plain language and accessible to individuals

					living with disabilities or who are limited English proficient); 10 CCR § 6470
§ 155.410	Initial and annual open enrollment periods	The initial open enrollment period runs from October 1, 2013 through March 31, 2014. For enrollment selections made on or before December 23, 2013, coverage must be effective January 1, 2014. Between December 24, 2013 and March 31, 2014, coverage will be available the first day of the following or second following month. The annual open enrollment period for 2015 will be November 15 through January 15. Annual open enrollment periods for coverage beginning January 1, 2016 will be from October 15 through December 7 of the preceding calendar year, with coverage beginning on January 1.	77 FR 18444 (Mar. 27, 2012); 78 FR 76218 (Dec. 17, 2013)		10 CCR § 6502
§ 155.415	Allowing issuer application assisters to assist with eligibility applications	Permits issuer application assisters to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage.	78 FR 54134 (Aug. 30, 2013)		
§ 155.420	Special enrollment periods	Provides for special enrollment periods outside of the annual open enrollment period for certain triggering events. The following triggering events will enable an individual to enroll or change enrollment in a QHP: birth; adoption; placement for adoption; placement in foster care; marriage; loss of minimum essential coverage; gain/loss of dependent; gaining status as citizen or lawfully present individual; enrollment in a QHP was the result of an error, misrepresentation, or inaction by any agent of the exchange	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)	Guidance - Hardship Exemption and Special Enrollment Periods (June 26, 2013)	10 CCR § 6504

		or HHS; the QHP violated a material provision of its contract; enrollee is newly eligible or ineligible for premium tax credits or cost-sharing reductions; or the enrollee gains access to new QHPs due to a permanent move.			
§ 155.430	Termination of coverage	Enrollees are permitted to terminate coverage in a QHP with appropriate notice (14 days). Exchanges and QHPs may terminate coverage if the enrollee is no longer eligible for QHP coverage, for non-payment of premiums, if coverage is rescinded, or if the QHP terminates or is decertified.	77 FR 18444 (Mar. 27, 2012); 78 FR 42314 (July 15, 2013)		10 CCR § 6506
Subpart F - Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.500	Definitions	Provides additional definitions relevant to this Subpart, including appeal request, appeals entity, and appellant.	78 FR 54136 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	10 CCR § 6600
§ 155.505	General eligibility appeals requirements	Exchanges must permit applicants to appeal determinations of QHP eligibility, the amount of premium tax credits and cost-sharing reductions, redeterminations of the same, exemptions from the shared responsibility payment, and failure of an exchange to provide timely notice of an eligibility determination.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6602
§ 155.510	Appeals coordination	Exchanges and all other entities relevant to the appeals process must coordinate such processes to minimize the burden on appellants.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6602
§ 155.515	Notice of appeal procedures	Exchanges must notify applicants of the appeal procedures when the applicant submits an application and when the exchange sends the eligibility determination.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6604
§ 155.520	Appeal requests	Exchanges must permit appeals to be made within 90 days of the notice of eligibility determination or within a timeframe consistent with the state Medicaid agency's requirement for submitting fair	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6606

		hearing requests - but not less than 30 days.			
§ 155.525	Eligibility pending appeal	Exchanges must permit enrollees to remain eligible pending the outcome of an appeal.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6608
§ 155.530	Dismissals	An appeal must be dismissed if the appellant withdraws the appeal, fails to appear at a hearing without good cause, fails to submit a valid appeal request, or dies while the appeal is pending.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6610
§ 155.535	Informal resolution and hearing requirements	Exchanges operated by HHS will have an informal appeals resolution process. State exchanges may adopt an informal appeals resolution process as well.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6612; 10 CCR § 6614
§ 155.540	Expedited appeals	Requires a process for an expedited appeals process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6616
§ 155.545	Appeal decisions	Appeals decisions must be based on the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeals process. Written notice of the appeals decision must be provided to the appellant within 90 days of the decision, or as expeditiously as reasonably possible under an expedited appeal.	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6618
§ 155.550	Appeal record	Appeals records must be provided to the appellant and made publicly available (subject to all applicable laws regarding privacy, confidentiality, disclosure, and personally identifiable information).	78 FR 54136 (Aug. 30, 2013)		10 CCR § 6620
§ 155.555	Employer appeals process	Creates an appeals process to be run by the exchange or HHS for employers to appeal a determination that the employer does not provide minimum essential coverage or that the employer-provided coverage is not affordable with respect to an employee.	78 FR 54136 (Aug. 30, 2013)		
Subpart G - Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California***

					Regulation
§ 155.600	Definitions and general requirements	Provides definitions applicable to this Subpart, including applicant, exemption, shared responsibility payment, and tax filer.	78 FR 39523 (July 1, 2013)		
§ 155.605	Eligibility standards for exemptions	Exchanges are required to grant exemptions from the shared responsibility payment under the following circumstances: the applicant is a member of a recognized religious sect or division described in section 1402(g)(1) of the Internal Revenue Code; the applicant is a member of a health care sharing ministry; the applicant is incarcerated; or the applicant is a member of an Indian tribe. An exchange must grant a hardship exemption from the shared responsibility payment under circumstances that prevented the purchase of a QHP (e.g., expense would cause a serious deprivation of food, shelter, clothing, or other necessities). An exemption must be granted if an applicant is unable to afford coverage due to a lack of affordable coverage options, if an applicant is ineligible for Medicaid because his or her state did not expand coverage under the ACA, or the applicant is an Indian eligible for services through an Indian health care provider. The IRS may grant an exemption if the applicant's gross income was below the filing threshold and if the aggregate cost of self-only employer-sponsored coverage for all employed members of a family exceeds 8% of household income.	78 FR 39523 (July 1, 2013)	HHS Fact Sheet (June 26, 2013); Guidance - Hardship Exemption and Special Enrollment Periods (June 26, 2013); CCIIO Q&A - Shared Responsibility Provision Question and Answer (Oct. 28, 2013)	
§ 155.610	Eligibility process for exemptions	Exchanges must accept applications for exemptions from the shared responsibility payment and must determine eligibility for an exemption promptly and without undue delay. Exchanges must timely notify an applicant of any exemption determination.	78 FR 39523 (July 1, 2013)		
§ 155.615	Verification process related to eligibility for exemptions	Requires exchanges to verify or obtain information in accordance with this section in order to determine that an applicant is eligible for an exemption from the shared responsibility payment.	78 FR 39523 (July 1, 2013); 78 FR 42314		

			(July 15, 2013)		
§ 155.620	Eligibility redeterminations for exemptions during a calendar year	Individuals granted exemptions from the shared responsibility payment must report to the exchange any changes with respect to the eligibility standards. Exchanges must redetermine eligibility exemptions if the exchange receives and verifies new information reported by an individual. This requirement does not apply to exemptions granted based on a hardship caused by the lack of affordable coverage based on an applicant's projected income.	78 FR 39523 (July 1, 2013)		
§ 155.625	Options for conducting eligibility determinations for exemptions	Permits exchanges to accomplish the requirements of this Subpart directly or through contracting arrangements with entities permitted to operate the insurance exchanges. For exemption applications submitted prior to October 15, 2014, the exchange may adopt an eligibility determination made by HHS.	78 FR 39523 (July 1, 2013)		
§ 155.630	Reporting	Exchanges must submit information to the IRS if they grant an exemption to the shared responsibility payment to an applicant.	78 FR 39523 (July 1, 2013)		
§ 155.635	Right to appeal	In any eligibility notification provided to an applicant under this Subpart, the exchange must include a notice of the right to appeal and instructions regarding how to file an appeal.	78 FR 39523 (July 1, 2013)		
Subpart H - Exchange Functions: Small Business Health Options Program (SHOP)					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.700	Standards for the establishment of a SHOP	Requires exchanges to establish a SHOP exchange in accordance with the requirements outlined in this Subpart.	77 FR 18444 (Mar. 27, 2012); 78 FR 54134 (Aug. 30, 2013)	Presentation - Affordable Insurance Exchanges Final Rule (March 2012); Guidance - SHOP Only Marketplace (May 10, 2013)	
§ 155.705	Functions of a SHOP	Outlines the unique functions of the SHOP as opposed to the individual market exchange. For plan years beginning on or after	77 FR 18444 (Mar. 27, 2012);		

		January 1, 2015, a SHOP must allow employers to choose a single plan tier (e.g., bronze, silver), from which their employees may select any QHP (i.e., "employee choice"). In the federal exchanges, employers may only select one QHP for all employees for 2014. Beginning in 2015, a SHOP must provide employers with a monthly bill identifying the employer and employee contributions, the total amount due to QHP issuers, and collect from each employer the total amount due and make payments to the QHP issuers. SHOPs must utilize a premium calculator that takes into account the employer's contribution to facilitate QHP comparisons.	78 FR 15532 (Mar. 11, 2013); 78 FR 15557 (Mar. 11, 2013); 78 FR 33239 (June 4, 2013); 78 FR 54134 (Aug. 30, 2013)		
§ 155.710	Eligibility standards for SHOP	Exchanges must offer coverage to small employers (up to 100 employees; state option for a 50-employee threshold in 2014 and 2015), provided they are located in the geographic area of the SHOP and the employer offers coverage to all full-time employees.	77 FR 18444 (Mar. 27, 2012)		
§ 155.715	Eligibility determination process for SHOP	Requires SHOPs to verify applicants' employment with a small business submitting an application for coverage for its employees. SHOPs also must make reasonable efforts to identify and address any errors or inconsistencies in the employer application or employee application. Notification to employers and employees of their approval or denial of eligibility must be provided.	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6520; 10 CCR § 6522; 10 CCR § 6524
§ 155.720	Enrollment of employees into QHPs under SHOP	Requires SHOPs to establish and follow a timeline that provides for the following: determination of employer eligibility; employer selection of QHPs and levels of coverage for employees; employee completion of application and follow-up; verification of employee eligibility; processing employees into QHPs; transmission of enrollment information to QHP issuers; and payment of employer contributions and employee premiums to QHP issuers. SHOPs also must transmit employer participation, employer contribution, and employee enrollment information to the IRS.	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6520; 10 CCR § 6522; 10 CCR § 6532
§ 155.725	Enrollment periods under SHOP	SHOPs must adhere to the initial open enrollment period of October	77 FR 18444		10 CCR § 6526;

		1, 2013 through March 31, 2014. SHOPs are required to permit employers to purchase coverage for their small group at any point during the year and to establish an enrollment period for new employees to obtain coverage. Similar to the individual market exchanges, a SHOP is required to establish special enrollment periods for certain triggering events.	(Mar. 27, 2012); 78 FR 15557 (Mar. 11, 2013); 78 FR 33239 (June 4, 2013)		10 CCR § 6528; 10 CCR § 6530; 10 CCR § 6534; 10 CCR § 6536
§ 155.730	Application standards for SHOP	SHOPs must use a single employer application and a single employee application.	77 FR 18444 (Mar. 27, 2012); 78 FR 54134 (Aug. 30, 2013)	SHOP Employee Application (May 31, 2013); SHOP Employer Application (May 31, 2013); Guidance - State Alternative SHOP Applications (Aug. 9, 2013)	
§ 155.735	Termination of coverage	SHOPs must establish requirements (e.g., timing, form, and manner) for the termination of coverage in a QHP, including under the following circumstances: at the request of employer; non-payment of premiums; employee or dependent loss of eligibility; at the request of the employee; the QHP terminates or is decertified; enrollee changes from one QHP to another during annual an open enrollment or a special enrollment period; and the enrollee's coverage is rescinded. This section outlines the timing for terminating QHP coverage in the federally-facilitated SHOPs.	78 FR 54134 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	10 CCR § 6538
§ 155.740	SHOP employer and employee eligibility appeals requirements	Requires SHOPs to establish an appeals process for employer and employee denials of eligibility or failure to make a timely eligibility determination.	78 FR 54134 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	
Subpart K - Exchange Functions: Certification of Qualified Health Plans					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 155.1000	Certification standards for QHPs	Exchanges may only offer health plans that are certified as QHPs. Requires exchanges to certify health plans as QHPs if they meet the	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6420 (Covered

		certification requirements outlined in 45 CFR § 156 Subpart C. Prohibits an exchange from denying QHP certification on the basis that a plan is a fee-for-service plan, through the imposition of price controls, or on the basis that the plan provides end-of-life preventive treatments that the exchange determines are inappropriate or too costly.			California will operate as an "active purchaser," meaning, the exchange will selectively contract with QHPs); 10 CCR § 6422 (requires issuers to comply with all requirements in the QHP solicitation; 10 CCR § 6440 (provides criteria the CA Exchange Evaluation Team will consider, such as value, delivery system improvements, and affordability for the consumer and small employer)
§ 155.1010	Certification process for QHPs	Exchanges must certify QHPs prior to the initial and annual open enrollment periods and monitor ongoing compliance with the	77 FR 18444 (Mar. 27, 2012)		10 CCR § 6442 (Covered

		certification requirements. Multi-state plans offered under contract with the Office of Personnel Management and CO-OP plans are deemed certified.			California will provide each successful bidder with a QHP certification); 10 CCR § 6444 (outlines the process by which bidders may protest a decision not to be selected)
§ 155.1020	QHP issuer rate and benefit information	Exchanges must require QHPs to submit a justification (which must be made public) for any rate increase prior to the implementation of such rate increase. Exchanges must take this information, along with any recommendations provided by the state, into consideration when determining whether to approve a QHP.	77 FR 18444 (Mar. 27, 2012)		
§ 155.1030	QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions	Exchanges must ensure that QHPs submit the required information regarding the actuarial values, silver plan variation, and estimates and supporting documentation necessary for receiving advance payments of premium tax credits and cost-sharing reductions. The exchange must provide this information to HHS.	77 FR 18444 (Mar. 27, 2012); 78 FR 15532 (Mar. 11, 2013)		
§ 155.1040	Transparency in coverage	Exchanges must collect the following transparency information from QHPs, which must be provided in plain language to exchanges and individuals: claims payment policies and practices; periodic financial disclosures; enrollment and disenrollment data; data on rating practices and the number of claims that are denied; out-of-network cost-sharing information; and information on enrollee rights under the ACA. Exchanges also must monitor whether a QHP provides	77 FR 18444 (Mar. 27, 2012)		

		timely cost-sharing information to enrollees upon request regarding a specific item or service.			
§ 155.1045	Accreditation timeline	Exchanges must establish a timeline for QHP accreditation.	77 FR 18444 (Mar. 27, 2012); 78 FR 12865 (Feb. 25, 2013)	Presentation - EHB, AV, Accreditation Final Rule (Feb. 25, 2013)	
§ 155.1050	Establishment of Exchange network adequacy standards	Exchanges must ensure that each QHP meets the network adequacy standards outlined in 45 CFR § 156.230	77 FR 18444 (Mar. 27, 2012)		
§ 155.1055	Service area of a QHP	Exchanges are required to evaluate the service areas of QHPs, which must cover a minimum geographical area that is at least the entire area of a county or group of counties and that the service area has been established without regard to racial, ethnic, language, health status, or other factors that exclude high-utilizing, high cost, or medically-underserved populations.	77 FR 18444 (Mar. 27, 2012)		
§ 155.1065	Stand-alone dental plans	Exchanges must allow for the offering of limited scope dental plans as a stand-alone plan or in conjunction with a QHP, provided the plan covers the pediatric dental essential health benefit.	77 FR 18444 (Mar. 27, 2012)	Guidance - Issuers of Stand-alone Dental Plans (Jan. 28, 2013)	10 CCR § 6446 (outlines the requirements for issuers of pediatric essential health benefits dental plans)
§ 155.1075	Recertification of QHPs	Exchanges must establish a process to recertify QHPs, which must occur by September 15 of the applicable calendar year.	77 FR 18444 (Mar. 27, 2012)		
§ 155.1080	Decertification of QHPs	Exchanges must establish a process for the decertification of QHPs (with appropriate notice and appeal) for QHPs that fail to comply with the general certification criteria outlined in this Subpart.	77 FR 18444 (Mar. 27, 2012)		
Subpart M - Oversight and Program Integrity Standards for State Exchanges					

Citation	Title	Summary	Final Rule(s)	Sub-Regulatory Guidance	Covered California Regulation
§ 155.1200	General program integrity and oversight requirements	Requires exchanges to maintain accurate accounting of exchange receipts and expenditures and annually monitor and report to HHS a financial statement, eligibility and performance reports, performance monitoring data, and information regarding failure to reduce premiums for individuals eligible for advance payments of premium tax credit subsidies. Exchanges must conduct external audits and present audit results to HHS.	78 FR 65095 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
§ 155.1210	Maintenance of records	Exchanges must require contractors, subcontractors, and agents to maintain records for ten years relating to financial operations, eligibility determinations, enrollment transactions, appeals, QHP contracting data, and consumer outreach and Navigator oversight.	78 FR 65095 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
Subpart N - State Flexibility					
Citation	**Title**	**Summary**	**Final Rule(s)**	**Sub-Regulatory Guidance**	**Covered California Regulation**
§ 155.1300	Basis and purpose	This Subpart implements the Waivers for State Innovation, which permits states to waive provisions of the ACA with HHS approval, beginning in 2017. A Waiver for State Innovation must: (1) provide coverage that is at least as comprehensive as the essential health benefits package; (2) provide coverage and cost-sharing protections at least as affordable as the ACA; (3) provide coverage to at least as many residents as would otherwise have been covered; and (4) not increase the federal deficit.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1302	Coordinated waiver process	Permits Waivers for State Innovation to be combined with waivers under other federal health programs (Medicare, Medicaid, CHIP).	77 FR 11718 (Feb. 27, 2012)		

§ 155.1304	Definitions	Defines the following terms: complete application; public notice; and Section 1332 waiver.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1308	Application procedures	A state must submit an application for a Section 1332 waiver to HHS, which will conduct a preliminary review within 45 days to determine whether the application is complete. A complete application must detail compliance with the state public notice requirements, provide a comprehensive description and legislative language of the state legislation and program to implement the Section 1332 waiver, detail which provisions of law the state seeks to waive, and provide sufficient data, assumptions, and analyses conducted (e.g., actuarial, economic) to evaluate the proposed waiver.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1312	State public notice requirements	States are required to conduct a public notice and comment period and conduct a public hearing prior to submitting a Section 1332 waiver.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1316	Federal public notice and approval process	HHS and Treasury must provide for a public notice and comment period for a state's Section 1332 waiver application. The final approval or denial decision must be made within 180 days of receipt of a complete application.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1320	Monitoring and compliance	States must hold annual public forums to solicit comments from the public about the progress of an approved Section 1332 waiver. The federal government has authority to independently evaluate any component of a waiver.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1324	State reporting requirements	States are required to submit quarterly and annual progress reports to HHS.	77 FR 11718 (Feb. 27, 2012)		
§ 155.1328	Periodic evaluation requirements	HHS and IRS will periodically evaluate a state's Section 1332 waiver.	77 FR 11718 (Feb. 27, 2012)		

45 CFR Part 156 - Health Insurance Standards Under the Affordable Care Act, Including Standards Related to Exchanges					
Subpart A - General Provisions					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.10	Basis and Scope	Outlines the parts of the ACA implemented by 45 CFR Part 156.	77 FR 18468 (Mar. 27, 2012)		
§ 156.20	Definitions	Defines the relevant terms pertinent to this Part, including, actuarial value, essential health benefits package, and level of coverage. Also references other regulatory definitions.	77 FR 18468 (Mar. 27, 2012); 78 FR 12865 (Feb. 25, 2013); 78 FR 15535 (Mar. 11, 2013); 78 FR 39897 (July 2, 2013); 78 FR 54142 (Aug. 30, 2013); 78 FR 65096 (Oct. 30, 2013)		
§ 156.50	Financial Support	Outlines the general requirement that participating issuers remit user fees to the state exchange or federally-facilitated exchange.	77 FR 18468 (Mar. 27, 2012); 78 FR 15535 (Mar. 11, 2013); 78 FR 39897 (July 2, 2013)		
§ 156.80	Single Risk Pool	Requires issuers to utilize a single risk pool for all enrollees in the individual market in a state and a single risk pool for all enrollees in the small group market in a state - regardless of enrollment through an exchange plan. States may merge the individual and small group	78 FR 13441 (Feb. 27, 2013); 78 FR 39898 (July 2, 2013);		

		markets. This requirement is effective January 1, 2014.	78 FR 65096 (Oct. 30, 2013)		
Subpart B - Essential Health Benefits Package					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.100	State selection of benchmark	Outlines the four EHB-benchmark plans that a state may select: (1) largest health plan by enrollment in any of the three largest small group market plans; (2) any of the largest three state employee health plan options by enrollment; (3) any of the largest three Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the plan with the largest insured commercial non-Medicaid HMO enrollment in the state. If a state does not select an EHB-benchmark plan, the default will be the largest plan by enrollment in the state's small group market.	78 FR 12865 (Feb. 25, 2013)	Fact Sheet (Feb. 20, 2013)	
§ 156.105	Determination of EHB for multi-state plans	Requires a multi-state plan to meet benchmark standards set by the Office of Personnel Management.	78 FR 12865 (Feb. 25, 2013)	Multi-State Plan Insurance FAQs	
§ 156.110	EHB-benchmark plan standards	Requires EHB-benchmark plans to provide coverage of the following ten ACA-mandated benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Outlines requirements for states to supplement the EHB-benchmark plans if coverage is not provided in one of the ten categories.	78 FR 12865 (Feb. 25, 2013)	Fact Sheet (Feb. 20, 2013)	10 CCR § 6426 (outlines Standard Benefit Plan Designs that QHP issuer bidders must use to submit bids) Covered California - Regulations Providing the 2014 Standard

					Benefit Plan Designs
§ 156.115	Provision of EHB	Defines the "provision of EHB" as a health plan providing benefits that: are substantially equal to the EHB-benchmark plan; do not exclude an enrollee from coverage in an EHB category; include behavioral health treatment services; include preventive health services; and include habilitative services. Permits an issuer to substitute certain benefits that are actuarially equivalent to the benefit being replaced.	78 FR 12865 (Feb. 25, 2013)	Presentation - EHB, AV, Accreditation Final Rule (Feb. 25, 2013)	
§ 156.122	Prescription drug benefits	Requires plans to provide coverage for prescription drugs that covers the greater of one drug in every US Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan. Also requires health plans to adopt procedures that allow an enrollee to request and gain access to non-covered clinically-appropriate drugs.	78 FR 12865 (Feb. 25, 2013)		10 CCR § 6426 (outlines Standard Benefit Plan Designs that QHP issuer bidders must use to submit bids) Covered California - Regulations Providing the 2014 Standard Benefit Plan Designs
§ 156.125	Prohibition on discrimination	Prohibits plans from discriminating on the basis of an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.	78 FR 12865 (Feb. 25, 2013)	FAQ Part XII (Feb. 20, 2013)	
§ 156.130	Cost-sharing requirements	Limits cost-sharing for plan years beginning in 2014 for self-only coverage to the annual high-deductible health plan (HDHP) limit for self-only coverage ($6,350). Limits cost-sharing for plan years	78 FR 12865 (Feb. 25, 2013)		

		beginning in 2014 for family coverage to the HDHP limit for family coverage ($12,700). Annual deductibles for small group market plans may not exceed $2,000 for self-only coverage or $4,000 for family coverage in 2014. These amounts are indexed annually for average per capita premium growth rates.			
§ 156.135	AV calculation for determining level of coverage	Requires issuers to use the AV calculator developed by HHS to determine a plan's actuarial value.	78 FR 12865 (Feb. 25, 2013)	AV Calculator; AV Calculator Methodology	
§ 156.140	Levels of coverage	Outlines the ACA-established criteria that bronze plans will have an AV of 60%, silver plans have an AV of 70%, gold plans have an AV of 80%, and platinum plans will have an AV of 90%. Also permits a de minimis variation of 2%.	78 FR 12865 (Feb. 25, 2013)	Presentation - EHB, AV, Accreditation Final Rule (Feb. 25, 2013)	10 CCR § 6426 (outlines Standard Benefit Plan Designs that QHP issuer bidders must use to submit bids) Covered California - Regulations Providing the 2014 Standard Benefit Plan Designs
§ 156.145	Determination of minimum value	Outlines the methods to determine whether an employer-sponsored plan provides minimum value, which requires a 60% AV.	78 FR 12865 (Feb. 25, 2013)	MV Calculator; MV Calculator Methodology	
§ 156.150	Application to stand-alone dental plans inside the Exchange	Requires stand-alone dental plans to offer pediatric dental EHB at a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85% (allowing for a 2% de minimis variation).	78 FR 12865 (Feb. 25, 2013)		
§ 156.155	Enrollment in catastrophic plans	Outlines the requirements for catastrophic health plans, which must provide coverage for a least three primary care visits prior to reaching the deductible, cover individuals under age 30, provide	78 FR 13442 (Feb. 27, 2013); 78 FR 65096		

		preventive services without cost-sharing, and provide coverage for EHB only when the annual limit for self-only coverage under Section 156.130 is reached.	(Oct. 30, 2013)		
Subpart C - Qualified Health Plan Minimum Certification Standards					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.200	QHP issuer participation standards	Outlines the requirements for QHP issuers to participate in the exchanges. These requirements include: providing EHB; limiting cost-sharing as outlined in 45 CFR § 156.130; implementing a quality improvement strategy and enrollee satisfaction survey; and offering at least one QHP in the silver and gold levels of coverage.	77 FR 18469 (Mar. 27, 2012); 78 FR 15535 (Mar. 11, 2013)		10 CCR § 6420 (Covered California will operate as an "active purchaser," meaning, the exchange will selectively contract with QHPs); 10 CCR § 6422 (requires issuers to comply with all requirements in the QHP solicitation; 10 CCR §6424 (requires bidders to adhere to the instructions in the solicitation); 10 CCR § 6440

					(provides criteria the CA Exchange Evaluation Team will consider, such as value, delivery system improvements, and affordability for the consumer and small employer)
§ 156.210	QHP rate and benefit information	Requires QHP issuers to submit a publicly-available justification for any premium rate increase prior to the publication of the increase.	77 FR 18469 (Mar. 27, 2012)		
§ 156.215	Advance payments of the premium tax credit and cost-sharing reduction standards	Requires QHP issuers to meet the requirements related to advance payments of the premium tax credit and cost-sharing reductions outlined in Subpart E.	77 FR 18469 (Mar. 27, 2012); 78 FR 15535 (Mar. 11, 2013)		
§ 156.220	Transparency in coverage	Requires QHP issuers to provide the following information to HHS, exchanges, and the relevant state insurance commissioner (in plain language): claims payment policies and practices; periodic financial disclosures; enrollment and disenrollment data; data on rating practices and the number of claims that are denied; out-of-network cost-sharing information; and information on enrollee rights under the ACA. This information will be publicly available.	77 FR 18469 (Mar. 27, 2012)		
§ 156.225	Marketing and Benefit Design of QHPs	Requires QHPs and their agents to comply with state marketing laws and prohibits employing marketing practices or benefit designs that discourage enrollment of individuals with significant health needs.	77 FR 18469 (Mar. 27, 2012)		
§ 156.230	Network adequacy standards	Requires issuers to ensure that the provider network of each QHP includes essential community providers, maintains a network sufficient in the number and type of providers to assure that services	77 FR 18469 (Mar. 27, 2012)		

		will be accessible without undue delay, and is consistent with network adequacy standards.			
§ 156.235	Essential community providers	Requires QHP issuers to have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals.	77 FR 18469 (Mar. 27, 2012)	FAQ (May 13, 2013)	
§ 156.245	Treatment of direct primary care medical homes	Allows QHP issuers to provide coverage through a direct primary care medical home.	77 FR 18469 (Mar. 27, 2012)		
§ 156.250	Health plan applications and notices	Requires QHP issuers to provide all applications and notices to enrollees in accordance with certain standards (e.g., plain language, accessible and timely to individuals living with disabilities, and accessible to individuals who are limited English proficient).	77 FR 18469 (Mar. 27, 2012)		
§ 156.255	Rating variations	Permits QHP issuers to vary premiums by geographic rating areas established by the relevant state, however, the same premium rate must be charged regardless of whether the plan is offered through an exchange, directly from the issuer, or through an agent.	77 FR 18469 (Mar. 27, 2012)		
§ 156.260	Enrollment periods for qualified individuals	Requires QHP issuers to abide by the initial, annual, and special enrollment periods, and the effective date of coverage established by the exchange.	77 FR 18469 (Mar. 27, 2012)		10 CCR §6500
§ 156.265	Enrollment process for qualified individuals	QHP issuers may only enroll individuals whom the exchange has certified to the issuer as a qualified individual and has transmitted enrollment information to such issuer. QHP issuers also are required to accept premium payments directly from enrollees.	77 FR 18469 (Mar. 27, 2012); 78 FR 76218 (Dec. 17, 2013)		10 CCR §6500
§ 156.270	Termination of coverage for qualified individuals	Requires a QHP to establish a policy for termination of coverage due to non-payment of premium, which must allow for a three-month grace period for enrollees receiving advance payments of the premium tax credit (if the enrollee has paid at least one full month's premium). The QHP issuer must pay all claims during the first month of the grace period and may pend claims for services	77 FR 18469 (Mar. 27, 2012); 78 FR 42322 (July 15, 2013); 78 FR 54142 (Aug. 30, 2013)		10 CCR §6506

		rendered in the second and third months of the grace period. Requires the QHP to notify providers of the possibility for denied claims in the second and third months of the grace period.			
§ 156.275	Accreditation of QHP issuers	Requires QHP issuers to be accredited on the basis of local performance in several categories, including clinical quality measures, patient experience, consumer access, provider credentialing, complaints and appeals, and network adequacy and access. This section also outlines the process for an entity to be designated an accrediting entity.	77 FR 18469 (Mar. 27, 2012); 78 FR 12865 (Feb. 25, 2013)	Presentation - EHB, AV, Accreditation Final Rule (Feb. 25, 2013)	
§ 156.280	Segregation of funds for abortion services	Outlines the requirements for the segregation of funds for coverage of abortion services for which public funding is prohibited and for which public funding is permitted.	77 FR 18469 (Mar. 27, 2012)		
§ 156.285	Additional standards specific to SHOP	Requires QHP issuers to adhere to SHOP-specific requirements, such as premium payment, the various enrollment periods, enrollment process, and termination of coverage.	77 FR 18469 (Mar. 27, 2012); 78 FR 15535 (Mar. 11, 2013); 78 FR 15558 (Mar. 11, 2103); 78 FR 33239 (June 4, 2013); 78 FR 54142 (Aug. 30, 2013)		
§ 156.290	Non-renewal and decertification of QHPs	Outlines the requirement that QHP issuers notify enrollees and/or the exchange when the QHP issuer elects not to seek recertification or is decertified.	77 FR 18469 (Mar. 27, 2012)		
§ 156.295	Prescription drug distribution and cost reporting	Requires QHP issuers to provide information to HHS (confidentially) regarding prescription drugs provided through retail versus mail order pharmacies, percentage of generic drugs prescribed where such generic drug was available, and rebates, discounts, or price concessions attributable to patient utilization and that are passed	77 FR 18469 (Mar. 27, 2012)		

		through to the QHP issuer.			
Subpart D - Federally-Facilitated Exchange Qualified Health Plan Issuer Standards					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.330	Changes of ownership of issuers of qualified health plans in federally-facilitated exchanges	Requires QHP issuers to notify HHS of changes in ownership at least 30 days prior to the effective date of the change.	78 FR 65097 (Oct. 30, 2013)		
§ 156.340	Standards for downstream and delegated entities	QHP issuers will maintain responsibility for the compliance of delegated or downstream entities with regard to QHP certification, SHOP functions, use of agents and brokers to enroll individuals in QHPs, maintenance of records, and compliance reviews.	78 FR 54143 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	
Subpart E - Health Insurance Issuer Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.400	Definitions	Outlines the definitions that apply to this Subpart, including annual limitation on cost sharing, maximum annual limitation on cost sharing, silver plan variation, and standard plan.	78 FR 15535 (Mar. 11, 2013); 78 FR 65097 (Oct. 30, 2013)		
§ 156.410	Cost-sharing reductions for enrollees	Requires QHP issuers to assign enrollees eligible for cost-sharing reductions into the appropriate silver plan variation, which enables the enrollee to take advantage of the applicable cost-sharing reductions. QHP issuers failing to provide an enrollee with sufficient cost-sharing reductions must make the enrollee or provide whole within 45 days. If a QHP issuer provides greater cost-sharing than required, the issuer may not seek reimbursement of any excess cost-sharing reductions. QHP issuers must reassign enrollees to the appropriate plan if an improper assignment was made.	78 FR 15535 (Mar. 11, 2013); 78 FR 65097 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	

§ 156.420	Plan variations	Outlines the various silver plan variations, which will offer silver plans to enrollees eligible for cost-sharing reductions. For individuals with incomes between 100-150% of FPL, their silver plan variation will be a QHP with an AV of 93%. For individuals with incomes greater than 150% and less than 200% of FPL, the AV of their plan will equal 87%. For individuals with incomes greater than 200% and up to 250% of FPL, the AV of their plan will equal 73%. A de minimis variation of 1% is permitted.	78 FR 15535 (Mar. 11, 2013)		
§ 156.425	Changes in eligibility for cost-sharing reductions	Upon notification by exchanges of changes in eligibility, QHP issuers must change the individual's assignment in a silver plan or silver plan variation as of the effective date established by the exchange.	78 FR 15535 (Mar. 11, 2013)		
§ 156.430	Payment for cost-sharing reductions	QHP issuers must provide to exchanges an estimate of the total dollar amount of cost-sharing reductions to be provided over the benefit year. HHS will provide advance payments to issuers for cost-sharing reductions. HHS will periodically reconcile advance payments of cost-sharing reductions with actual amounts utilized and discrepancies will be paid by either HHS or the QHP issuer.	78 FR 15535 (Mar. 11, 2013); 78 FR 15551 (Mar. 11, 2013); 78 FR 65098 (Oct. 30, 2013)		
§ 156.440	Plans eligible for advance payments of the premium tax credit and cost-sharing reductions	Cost-sharing reductions may not be paid to catastrophic plans, stand-alone dental plans, or child-only plans. Meaning, enrollees in these plans are not eligible for cost-sharing reductions.	78 FR 15535 (Mar. 11, 2013)		
§ 156.460	Reduction of enrollee's share of premium to account for advance payments of the premium tax credit	Requires QHP issuers to reduce an enrollee's monthly premium by the amount of the advance payment of the premium tax credit. Requires QHP issuers to refund excess premiums paid by the enrollee or apply such excess to future monthly premium obligations of the enrollee.	78 FR 15535 (Mar. 11, 2013); 78 FR 65100 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
§ 156.470	Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit	Requires QHP issuers to annually provide to the exchange for approval an allocation of the rate and expected allowed claims costs for each plan with respect to EHB and any other services or benefits offered by the plan.	78 FR 15535 (Mar. 11, 2013)		

§ 156.480	Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.	Requires QHP issuers to ensure that delegated and downstream entities adhere to the maintenance of records requirements outlined in §156.705. QHP issuers must annually report to HHS summary information regarding the administration of cost-sharing reductions and advance payments of the premium tax credit subsidies.	78 FR 65100 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
Subpart F - Consumer Operated and Oriented Plan Program					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.500	Basis and scope	Outlines the Consumer Operated and Oriented Plan (CO-OP) program, which will foster the creation of new consumer-governed, private, nonprofit health insurance issuers (CO-OPs). Under this program, start-up and solvency loans are awarded to encourage the development of CO-OPs.	76 FR 77411 (Dec. 13, 2011)	FAQ (Mar. 8, 2012); Fact Sheet (Dec. 8, 2011)	*Note: No CO-OPs were awarded in California and the US Congress has halted new entrants into the program.*
§ 156.505	Definitions	Outlines the definitions applicable to the CO-OP program, including CO-OP, member, pre-existing issuer, related entity, solvency loan, and start-up loan.	76 FR 77411 (Dec. 13, 2011); 77 FR 18469 (Mar. 27, 2012)		
§ 156.510	Eligibility	Requires CO-OPs to be nonprofit member organizations. The organization or sponsor may not be (or receive 25% or more of its total funding from) a pre-existing issuer, holding company that controls a pre-existing issuer, trade association comprised of pre-existing issuers whose purpose is to represent the interests of the health insurance industry, a foundation established by a pre-existing issuer, or a related entity	76 FR 77411 (Dec. 13, 2011); 77 FR 18469 (Mar. 27, 2012)		
§ 156.515	CO-OP standards	Outlines the standards that CO-OPs must satisfy, including policies designed to foster and ensure member control of the organization	76 FR 77411 (Dec. 13, 2011)		

		and board of director standards (e.g., ethics, conflict of interest, disclosure). CO-OPs also must ensure that at least two-thirds of the policies or contracts for health insurance issued in the state must be CO-OP QHPs offered in the individual and small group markets.			
§ 156.520	Loan terms	Allows CO-OPs to apply for start-up and solvency loans. Start-up loans have a repayment period of five years and solvency loans have a 15 year repayment period. CO-OPs receiving loans are prohibited from converting or selling to a for-profit or non-consumer operated entity at any time after receiving a loan.	76 FR 77411 (Dec. 13, 2011); 77 FR 18469 (Mar. 27, 2012)		
Subpart G - Minimum Essential Coverage					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.600	The definition of minimum essential coverage	Defines minimum essential coverage as defined under the Internal Revenue Code, 26 USC 5000A(f). This includes government sponsored programs (e.g., Medicare, Medicaid, CHIP, TRICARE) and other coverage defined in 45 CFR § 156.602.	78 FR 39529 (July 1, 2013)	HHS Fact Sheet (June 26, 2013)	
§ 156.602	Other coverage that qualifies as minimum essential coverage	Defines other coverage that qualifies as minimum essential coverage through IRS regulations. This includes self-funded student health plans for plan/policy years beginning in 2014, Refugee Medical Assistance, Medicare Advantage plans, and state high-risk pools for plan/policy years beginning in 2014.	78 FR 39529 (July 1, 2013)		
§ 156.604	Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart	Outlines the process whereby HHS may recognize other coverage as minimum essential coverage. Such coverage must meet substantially all the requirements of Title I of the ACA and the sponsor must submit detailed information to HHS, including cost-sharing requirements and EHB covered. Self-funded student health plans and state high risk pools must utilize this process to qualify as minimum essential coverage for plan/policy years beginning January 1, 2015 or after.	78 FR 39529 (July 1, 2013)		

§ 156.606	HHS audit authority	Permits HHS to audit a plan or program recognized as minimum essential coverage under 45 CFR § 156.604.	78 FR 39529 (July 1, 2013)		
Subpart H - Oversight and Financial Integrity Standards for Issuers of Qualified Health Plans in Federally-Facilitated Exchanges					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.705	Maintenance of records for Federally-facilitated exchanges	QHP issuers must maintain for ten years financial records to enable HHS to audit financial records and conduct compliance reviews of an issuers' adherence to exchange standards.	78 FR 65100 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
§ 156.715	Compliance reviews of QHP issuers in Federally-facilitated exchanges	QHP issuers in federally-facilitated exchanges will be subject to compliance reviews to ensure ongoing compliance with exchange standards. QHP issuers must make available to HHS exchange-related records, contracts, policies, and procedures. QHP issuers may be subject to a compliance review within ten years of the plan's last benefit year or ten years from the last day the QHP certification is effective.	78 FR 65100 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
Subpart I - Enforcement Remedies in Federally-Facilitated Exchanges					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.800	Available remedies; Scope	Permits HHS to impose civil monetary penalties or decertify QHP issuers that are not in compliance with standards applicable to issuers participating in the federally-facilitated exchanges.	78 FR 54143 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	
§ 156.805	Bases and process for imposing civil monetary penalties in Federally-facilitated exchanges	Outlines the grounds for imposing civil monetary penalties on QHP issuers in the federally-facilitated exchanges, the factors that will be used to determine the amount of penalties, the maximum penalty amounts, and the notice requirement when a penalty is going to be imposed.	78 FR 54143 (Aug. 30, 2013)		
§ 156.810	Bases and process for decertification	Outlines the grounds for decertifying a QHP issuer in a federally-	78 FR 54143		

	of a QHP offered by an issuer through a Federally-facilitated exchange	facilitated exchange. Also establishes a standard and accelerated decertification process.	(Aug. 30, 2013)		
Subpart J - Administrative Review of QHP Issuer Sanctions in Federally-Facilitated Exchanges					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.901	Definitions	Defines relevant terms for this Subpart. A respondent is the QHP entity that has received a notice of a proposed assessment of a civil monetary penalty (CMP) or notice of decertification.	78 FR 65101 (Oct. 30, 2013)		
§ 156.903	Scope of Administrative Law Judge's (ALJ) authority	Provides the ALJ with authority to impose a CMP or the decertification of a QHP.	78 FR 65101 (Oct. 30, 2013)		
§ 156.905	Filing of request for hearing	Permits a QHP issuer assessed a CMP or notice of decertification to request a hearing before an ALJ within 30 days.	78 FR 65101 (Oct. 30, 2013)		
§ 156.907	Form and content of request for hearing	Requires a request for an ALJ hearing to identify factual or legal bases with which the respondent disagrees and describe the basis (including providing facts or legal arguments) for the disagreement.	78 FR 65101 (Oct. 30, 2013)		
§ 156.909	Amendment of notice of assessment or decertification request for hearing	Absent undue prejudice, the ALJ may permit CMS to amend its notice of assessment or decertification or allow a respondent to amend a request for hearing.	78 FR 65101 (Oct. 30, 2013)		
§ 156.911	Dismissal of request for hearing	Outlines the factors whereby an ALJ will order a request for hearing dismissed (e.g., not filed within 30 days, fails to meet the form and content requirements).	78 FR 65101 (Oct. 30, 2013)		
§ 156.913	Settlement	Provides HHS with authority to settle any issue or case without the consent of the ALJ at any time before or after an ALJ's decision.	78 FR 65101 (Oct. 30, 2013)		
§ 156.915	Intervention	Permits the ALJ, in certain circumstances, to grant the request of an entity other than the respondent to intervene. Provides the Department of Labor and IRS with authority to intervene.	78 FR 65101 (Oct. 30, 2013)		
§ 156.917	Issues to be heard and decided by	Provides the ALJ with authority to determine whether a basis exists	78 FR 65101		

	ALJ	to assess a CMP, whether the amount assessed is reasonable, and whether a basis exists to decertify a QHP. An ALJ may reduce, sustain, or increase the CMP assessed by HHS.	(Oct. 30, 2013)		
§ 156.919	Forms of hearing	Outlines how an ALJ hearing may take place (argument or testimony in writing, in person, or over the phone). Hearings will be on the record.	78 FR 65101 (Oct. 30, 2013)		
§ 156.921	Appearance of counsel	Requires attorneys to file a notice of appearance with the ALJ.	78 FR 65101 (Oct. 30, 2013)		
§ 156.923	Communications with the ALJ	Prohibits any party from communicating with the ALJ on any matter related to a case unless upon notice and opportunity for both parties to participate.	78 FR 65101 (Oct. 30, 2013)		
§ 156.925	Motions	Requires requests for an order or ruling to be made by motion.	78 FR 65101 (Oct. 30, 2013)		
§ 156.927	Form and service of submissions	Outlines the form and requirements every submission filed with the ALJ must take.	78 FR 65101 (Oct. 30, 2013)		
§ 156.929	Computation of time and extensions of time	Outlines how to compute periods of time (e.g., weekends, holidays).	78 FR 65101 (Oct. 30, 2013)		
§ 156.931	Acknowledgment of request for hearing	Requires the ALJ to send to the parties an acknowledgment of the request for hearing.	78 FR 65101 (Oct. 30, 2013)		
§ 156.935	Discovery	Outlines the requirements for discovery.	78 FR 65101 (Oct. 30, 2013)		
§ 156.937	Submission of briefs and proposed hearing exhibits	Requires a respondent to file its briefs and supporting documentation within 60 days of receipt of the acknowledgment of request for hearing. Requires CMS to submit its briefs and supporting documentation within 30 days of receipt of the respondent's submission. A respondent may file a reply to the CMS brief with the ALJ within 15 days of receipt of CMS's submission.	78 FR 65101 (Oct. 30, 2013)		
§ 156.939	Effect of submission of proposed hearing exhibits	Hearing exhibits will become part of the record unless a party objects, and the ALJ rules to exclude it from the record.	78 FR 65101 (Oct. 30, 2013)		

§ 156.941	Prehearing conferences	Permits the ALJ to schedule prehearing conferences.	78 FR 65101 (Oct. 30, 2013)		
§ 156.943	Standard of proof	Establishes the burden and standard of proof for CMS and respondents.	78 FR 65101 (Oct. 30, 2013)		
§ 156.945	Evidence	Provides the ALJ with the authority to determine the admissibility of evidence.	78 FR 65101 (Oct. 30, 2013)		
§ 156.947	The record	The record will comprise of transcripts of any testimony, exhibits, other admitted evidence, and all pleadings or documents filed in the case.	78 FR 65101 (Oct. 30, 2013)		
§ 156.951	Posthearing briefs	Permits each party to file proposed findings and conclusions in a posthearing brief.	78 FR 65101 (Oct. 30, 2013)		
§ 156.953	ALJ decision	An ALJ's decision is final, unless modified or vacated by the CMS Administrator.	78 FR 65101 (Oct. 30, 2013)		
§ 156.955	Sanctions	Permits the ALJ to sanction a party or attorney for failing to comply with an order or directive, for abandonment of a case, or for actions that interfere with the speedy, orderly, or fair conduct of the hearing.	78 FR 65101 (Oct. 30, 2013)		
§ 156.957	Review by Administrator	Permits the CMS Administrator to review in whole or in part any ALJ decision.	78 FR 65101 (Oct. 30, 2013)		
§ 156.959	Judicial review	Permits a QHP issuer to file an appeal of a final order imposing CMPs or decertification with the US District Court for DC or for any district in which the QHP issuer is located.	78 FR 65101 (Oct. 30, 2013)		
§ 156.961	Failure to pay assessment	Entities that fail to pay a final penalty assessment will be referred to the Attorney General.	78 FR 65101 (Oct. 30, 2013)		
§ 156.963	Final order not subject to review	Prohibits the validity and appropriateness of a CMP from being subject to review in matters referred to the Attorney General.	78 FR 65101 (Oct. 30, 2013)		
Subpart K - Cases Forwarded to Qualified Health Plans and Qualified Health Plan Issuers in Federally-facilitated Exchanges					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***

§ 156.1010	Standards	Requires QHP issuers to resolve cases brought by a complainant expressing dissatisfaction with a specific person or entity (subject to federal or state laws regulating insurance) concerning the person or entity's activities related to the offering of insurance.	78 FR 54145 (Aug. 30, 2013)		
Subpart L - Quality Standards					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.1105	Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in exchanges	Requires a QHP enrollee satisfaction survey vendor to be approved by HHS and outlines the standards necessary for approval (e.g., application submission, annual survey vendor training, adherence to survey protocols and privacy and security standards).	78 FR 65105 (Oct. 30, 2013)	Fact Sheet - Program Integrity Rule (Oct. 24, 2013)	
Subpart M - Qualified Health Plan Issuer Responsibilities					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 156.1210	Confirmation of HHS payment and collections reports	Requires QHP issuers to confirm to HHS or describe any inaccuracy of the amounts identified in the payment and collections report within 15 days.	78 FR 65105 (Oct. 30, 2013)		
§ 156.1230	Direct enrollment with the QHP issuer in a manner considered to be through the Exchange	Permits exchanges to allow QHP issuers to directly enroll applicants in a QHP if contacted directly by the potential applicant. The issuer must notify the applicant of the availability of other QHP products offered through the exchange. Federally-facilitated exchanges will permit this option.	78 FR 54145 (Aug. 30, 2013)	Fact Sheet (Aug. 28, 2013)	10 CCR §6500
§ 156.1240	Enrollment process for qualified individuals	Requires QHP issuers to accept as payment for premiums, at a minimum, checks, cashier's checks, money orders, electronic funds transfer, and pre-paid debit cards.	78 FR 54145 (Aug. 30, 2013)		10 CCR §6500

45 CFR Part 157 - Employer Interactions With Exchanges and SHOP Participation					
Subpart A - General Provisions					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 157.10	Basis and Scope	Outlines the provisions of the ACA that are discussed by 45 CFR Part 157.	77 FR 18474 (Mar. 27, 2012)		
§ 157.20	Definitions	References definitions outlined in 45 CFR Part 155, including federally-facilitated SHOP, full-time employee, large employer, and small employer.	77 FR 18474 (Mar. 27, 2012); 78 FR 15539 (Mar. 11, 2013)		
Subpart C - Standards for Qualified Employers					
Citation	***Title***	***Summary***	***Final Rule(s)***	***Sub-Regulatory Guidance***	***Covered California Regulation***
§ 157.200	Eligibility of qualified employers to participate in a SHOP	Permits only qualified employers (as defined in 45 CFR § 155.20) to participate in a SHOP.	77 FR 18474 (Mar. 27, 2012)		
§ 157.205	Qualified employer participation process in a SHOP	Outlines requirements for qualified employers to participate in the SHOP exchange, as prescribed in 45 CFR Part 155, including selecting QHPs, payment of employer contributions, providing coverage to employees hired outside of the initial or annual open enrollment period, and providing the SHOP with information about newly eligible dependents and employees and loss of qualified employee status.	77 FR 18474 (Mar. 27, 2012)		