criminal or fraudulent activities or activities that cause material harm to the organization’s members or the government, the loan recipient must repay 110 percent of the aggregate amount of loans received under this subpart. In addition, the loan recipient must pay interest on the aggregate amount of loans received for the period the loans were outstanding equal to the average interest rate on marketable Treasury securities of similar maturity.

(d) Failure to pay. Loan recipients that fail to make loan payments consistent with the repayment schedule or loan modification or workout approved by CMS will be subject to any and all remedies available to CMS under law to collect the debt.

(e) Deeming of CO–OP qualified health plans. Health plans offered by a loan recipient may be deemed certified as a CO–OP qualified health plan to participate in the Exchanges for two years and may be recertified every two years for up to ten years following the life of any loan awarded to the loan recipient under this subpart, consistent with section 1301(a)(2) of the Affordable Care Act.

(1) To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO–OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act, all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO–OP, and the standards of the CO–OP program as set forth in this subpart.

(2) A loan recipient seeking to have a plan deemed as certified to participate in the Exchanges must provide evidence to CMS or an entity designated by CMS that the plan complies with the standards for CO–OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act, all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO–OP, and the standards of the CO–OP program as set forth in this subpart.

(f) Conversions. The loan recipient shall not convert or sell to a for-profit or non-consumer operated entity at any time after receiving a loan under this subpart. The loan recipient shall not undertake any transaction that would result in the CO–OP implementing a governance structure that does not meet the standards in this subpart.


Subpart G—Minimum Essential Coverage

SOURCE: 78 FR 39529, July 1, 2013, unless otherwise noted.

§ 156.600 The definition of minimum essential coverage.

The term minimum essential coverage has the same meaning as provided in section 5000A(f) of the Code and its implementing regulations for purposes of this subpart.

§ 156.602 Other coverage that qualifies as minimum essential coverage.

The following types of coverage are designated by the Secretary as minimum essential coverage for purposes of section 5000A(f)(1)(E) of the Code:

(a) Self-funded student health coverage. Coverage offered to students by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims, are designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of self-funded student health
coverage may apply to be recognized as minimum essential coverage pursuant to the process provided under 45 CFR 156.604.

(b) Refugee Medical Assistance supported by the Administration for Children and Families. Coverage under Refugee Medical Assistance, authorized under section 412(e)(7)(A) of the Immigration and Nationality Act, provides up to eight months of coverage to certain noncitizens who are considered Refugees, as defined in section 101(a)(42) of the Act.

(c) Medicare advantage plans. Coverage under the Medicare program pursuant to Part C of title XVIII of the Social Security Act, which provides Medicare Parts A and B benefits through a private insurer.

(d) State high risk pool coverage. State high risk pools are designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool coverage may apply to be recognized as minimum essential coverage pursuant to the process provided under §156.604.

(e) Other coverage. Other coverage that qualifies pursuant to §156.604.

§ 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.

(a) The Secretary may recognize "other coverage" as minimum essential coverage provided HHS determines that the coverage meets the following substantive and procedural requirements:

(1) Coverage requirements. A plan must meet substantially all the requirements of title I of the Affordable Care Act pertaining to non-grandfathered, individual health insurance coverage.

(2) Procedural requirements. Procedural requirements for recognition as minimum essential coverage. To be considered for recognition as minimum essential coverage, the sponsor of the coverage, or government agency, must submit the following information to HHS:

(i) Identity of the plan sponsor and appropriate contact persons;

(ii) Basic information about the plan, including:

(A) Name of the organization sponsoring the plan;

(B) Name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization;

(C) Address of the individual named above;

(D) Phone number of the individual named above;

(E) Number of enrollees;

(F) Eligibility criteria;

(G) Cost sharing requirements, including deductible and out-of-pocket maximum limit;

(H) Essential health benefits covered; and

(I) A certification by the appropriate individual, named pursuant to paragraph (a)(3)(ii)(b), that the organization substantially complies with the requirements of title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market and any plan documentation or other information that demonstrate that the coverage substantially comply with these requirements.

(b) CMS will publish a list of types of coverage that the Secretary has recognized as minimum essential coverage pursuant to this provision.

(c) If at any time the Secretary determines that a type of coverage previously recognized as minimum essential coverage no longer meets the coverage requirements of paragraph (a)(1) of this section, the Secretary may revoke the recognition of such coverage.

(d) Notice. Once recognized as minimum essential coverage, a plan must provide notice to all enrollees of its minimum essential coverage status and must comply with the information reporting requirements of section 6055 of the Code and implementing regulations.

§ 156.606 HHS audit authority.

The Secretary may audit a plan or program recognized as minimum essential coverage under §156.604 at any time to ensure compliance with the requirements of §156.604(a).