§ 155.1050

Establishment of Exchange network adequacy standards.

(a) An Exchange must ensure that the provider network of each QHP meets the standards specified in §156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in §156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under §156.235(c) of this subtitle.

§ 155.1055

Service area of a QHP.

The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The Exchange must ensure that the provider network of each QHP meets the standards specified in §156.230 of this subtitle, except for multi-State plans.

(b) The Exchange must ensure that the provider network of each QHP meets the standards specified in §156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under §156.235(c) of this subtitle.

§ 155.1065

Stand-alone dental plans.

(a) General requirements. The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including §155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) Offering options. The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) Sufficient capacity. An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) QHP Certification standards. If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan.
that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

§ 155.1075 Recertification of QHPs.

(a) Recertification process. Except with respect to multi-State plans and CO–OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review of the general certification criteria as outlined in §155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.

(b) Timing. The Exchange must complete the QHP recertification process on or before September 15 of the applicable calendar year.

§ 155.1080 Decertification of QHPs.

(a) Definition. The following definition applies to this section: Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) Decertification process. Except with respect to multi-State plans and CO–OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.

(c) Decertification by the Exchange. The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in §155.1000(c).

(d) Appeal of decertification. The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) Notice of decertification. Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;
(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420;
(3) HHS; and
(4) The State department of insurance.

§ 155.1200 General program integrity and oversight requirements.

(a) General requirement. A State Exchange must:

(1) Keep an accurate accounting of Exchange receipts and expenditures in accordance with generally accepted accounting principles (GAAP).

(2) Monitor and report to HHS on Exchange related activities.

(3) Collect and report to HHS performance monitoring data.

(b) Reporting. The State Exchange must, at least annually, provide to HHS, in a manner specified by HHS, the following data and information:

(1) A financial statement presented in accordance with GAAP by April 1 of each year,

(2) Eligibility and enrollment reports,

(3) Performance monitoring data, and

(4) If the Exchange is collecting premiums under §155.240, a report on instances in which it did not reduce an enrollee’s premium by the amount of the advance payment of the premium tax credit in accordance with §155.340(g)(1) and (2).

(c) External audits. The State Exchange must engage an independent qualified auditing entity which follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review. The State must:

(1) Provide to HHS the results of the annual external audit; and

(2) Inform HHS of any material weakness or significant deficiency identified in the audit and must develop and inform HHS of a corrective action plan for such material weakness or significant deficiency;

(3) Make public a summary of the results of the external audit.

Source: 78 FR 65095, Oct. 30, 2013, unless otherwise noted.