will be charged the interest and penalty described in paragraph (c)(3) of this section.

(2) *Solvency Loans.* Consistent with the terms of the loan agreement, the interest rate for Solvency Loans is equal to the greater of the average interest rate on marketable Treasury securities of similar maturity minus two percentage points or zero percent. If a loan recipient's loan agreement is terminated by CMS, the loan recipient will be charged the interest and penalty described in paragraph (c)(3) of this section.

(3) *Penalty payment.* If CMS terminates a loan recipient's loan agreement because the loan recipient is not in compliance with program rules or the terms of its loan agreement, or CMS has reason to believe that the organization engages in, or has engaged in, 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.

(3) If a plan offered by a loan recipient is deemed to be certified to participate in the Exchanges or loses its deemed status and is no longer certified to participate in the Exchanges, CMS or an entity designated by CMS will provide notice to the Exchanges in which the loan recipient offers CO–OP qualified health plans.

(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.

[76 FR 77411, Dec. 13, 2011, as amended at 77 FR 18474, Mar. 27, 2012]

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.* A qualified high risk pool as defined by section 2744(c)(2) of the Public Health Service Act established on or before November 26, 2014 in any State.

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

[78 FR 39529, July 1, 2013, as amended at 80 FR 10875, Feb. 27, 2015]

§ 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 for recognition as minimum essential coverage.* To be considered for recognition as minimum essential coverage, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator 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, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator 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 Internal Revenue Code and implementing regulations.

[78 FR 39529, July 1, 2013, as amended at 79 FR 30351, May 27, 2014]

§ 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).

Subpart H—Oversight and Financial Integrity Standards for Issuers of Qualified Health Plans in Federally-Facilitated Exchanges

SOURCE: 78 FR 65100, Oct. 30, 2013, unless otherwise noted.

§ 156.705 Maintenance of records for Federally-facilitated Exchanges.

(a) *General standard.* Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:

(1) Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and

(2) Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.

(b) *Records.* The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.

(c) *Record retention timeframe.* Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.

(d) *Record availability.* Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

§ 156.715 Compliance reviews of QHP issuers in Federally-facilitated Exchanges.

(a) *General standard.* Issuers offering QHPs in a Federally-facilitated Exchange may be subject to compliance reviews to ensure ongoing compliance with Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange.

(b) *Records.* In preparation for or in the course of the compliance review, a QHP issuer must make available for HHS to review the records of the QHP issuer that pertain to its activities within a Federally-facilitated Exchange. Such records may include, but are not limited to the following:

(1) The QHP issuer's books and contracts, including the QHP issuer's policy manuals and other QHP plan benefit information provided to the QHP issuer's enrollees;

(2) The QHP issuer's policies and procedures, protocols, standard operating procedures, or other similar manuals related to the QHP issuer's activities in a Federally-facilitated Exchange;

(3) Any other information reasonably necessary for HHS to—

(i) Evaluate the QHP issuer's compliance with QHP certification standards and other Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange;

(ii) Evaluate the QHP's performance, including its adherence to an effective compliance plan, within a Federally-facilitated Exchange;