

§ 155.1030

for which the U.S. Office of Personnel Management will provide a process for the submission of rate increase justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site as required under §156.210. To ensure consumer transparency, the Exchange must also provide access to the justification on its Internet Web site described in §155.205(b).

(b) *Rate increase consideration.* (1) The Exchange must consider rate increases in accordance with section 1311(e)(2) of the Affordable Care Act, which includes consideration of the following:

(i) A justification for a rate increase prior to the implementation of the increase;

(ii) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act; and

(iii) Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

(2) This paragraph does not apply to multi-State plans for which the U.S. Office of Personnel Management will provide a process for rate increase consideration.

(c) *Benefit and rate information.* The Exchange must receive the information described in this paragraph, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS. Information about multi-State plans may be provided in a form and manner determined by the U.S. Office of Personnel Management. The information identified in this paragraph is:

- (1) Rates;
- (2) Covered benefits; and
- (3) Cost-sharing requirements.

[77 FR 18467, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.

(a) *Review of plan variations for cost-sharing reductions.* (1) An Exchange must ensure that each issuer that offers, or intends to offer a health plan at any level of coverage in the individual market on the Exchange submits the

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required plan variations for the health plan as described in §156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of §156.420.

(2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under §156.135 of this subchapter, in the manner and timeframe established by HHS.

(b) *Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions.* (1) The Exchange must collect and review annually the rate allocation and the actuarial memorandum that an issuer submits to the Exchange under §156.470 of this subchapter, to ensure that the allocation meets the standards set forth in §156.470(c) and (d) of this subchapter.

(2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or stand-alone dental plan offered, or intended to be offered in the individual market on the Exchange.

(3) The Exchange must use the methodology specified in the annual HHS notice of benefit and payment parameters to calculate advance payment amounts for cost-sharing reductions, and must transmit the advance payment amounts to HHS, in accordance with §156.340(a) of this subchapter.

(4) HHS may use the information provided to HHS by the Exchange under this section for oversight of advance payments of cost-sharing reductions and premium tax credits.

(c) *Multi-State plans.* The U.S. Office of Personnel Management will ensure compliance with the standards referenced in this section for multi-State plans, as defined in §155.1000(a).

[78 FR 15534, Mar. 11, 2013, as amended at 79 FR 13839, Mar. 11, 2014]

§ 155.1040 Transparency in coverage.

(a) *General requirement.* The Exchange must collect information relating to coverage transparency as described in §156.220 of this subtitle from QHP issuers, and from multi-State plans in

a time and manner determined by the U.S. Office of Personnel Management.

(b) *Use of plain language.* The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) *Transparency of cost-sharing information.* The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle.

§ 155.1045 Accreditation timeline.

(a) *Timeline.* The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subchapter, except for multi-state plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-state plans.

(b) *Federally-facilitated Exchange.* The accreditation timeline used in federally-facilitated Exchanges follows:

(1) During certification for an issuer's initial year of QHP certification (for example, in 2013 for the 2014 coverage year), a QHP issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity.

(2) Prior to a QHP issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and 2015 for the 2016 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products, or a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or

similar to the administrative policies and procedures used in connection with the QHP.

(3) Prior to the QHP issuer's fourth year of QHP certification and in every subsequent year of certification (for example, in 2016 for the 2017 coverage year and forward), a QHP issuer must be accredited in accordance with § 156.275 of this subchapter.

[78 FR 12865, Feb. 25, 2013]

§ 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 service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

§ 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—