(2) The regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with §155.105(c).

(b) *Subsidiary Exchange.* A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) *Exchange standards.* Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its service area in accordance with subpart H of this part; and

(ii) Encompass the same geographic area for its regional or subsidiary SHOP and its regional or subsidiary Exchange except:

(A) In the case of a regional Exchange established pursuant to §155.100(a)(2), the regional SHOP must encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of States establishing the regional SHOP; and

(B) In the case of a subsidiary Exchange established pursuant to §155.100(a)(2), the combined geographic area of all subsidiary SHOPs established in the State must encompass the geographic area of the individual market Exchange established to serve the State.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 54134, Aug. 30, 2013]

§155.150 Transition process for existing State health insurance exchanges.

(a) *Presumption.* Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State exchange meets the standards under this part if:

(1) The exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act, according to the Congressional Budget Office estimates for projected coverage in 2016 that were published on March 30, 2011.

(b) *Process for determining non-compliance.* Any State described in paragraph (a) of this section must work with HHS to identify areas of non-compliance with the standards under this part.

§155.160 Financial support for continued operations.

(a) *Definition.* For purposes of this section, participating issuers has the meaning provided in §156.50.

(b) *Funding for ongoing operations.* A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) States may generate funding, such as through user fees on participating issuers, for Exchange operations; and

(2) No Federal grants under section 1311 of the Affordable Care Act will be awarded for State Exchange establishment after January 1, 2015.

§155.170 Additional required benefits.

(a) *Additional required benefits.* (1) A State may require a QHP to offer benefits in addition to the essential health benefits.

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.

(b) *Payments.* The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an enrollee, as defined in §155.20 of this subchapter; or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) *Cost of additional required benefits.* (1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the State.

[78 FR 12865, Feb. 25, 2013, as amended at 81 FR 12337, Mar. 8, 2016]

Subpart C—General Functions of an Exchange

§ 155.200 Functions of an Exchange.

(a) *General requirements.* An Exchange must perform the functions described in this subpart and in subparts D, E, F, G, H, K, M, and O of this part unless the State is approved to operate only a SHOP by HHS under §155.100(a)(2), in which case the Exchange operated by the State must perform the functions described in subpart H of this part and all applicable provisions of other subparts referenced in that subpart. In a State that is approved to operate only a SHOP, the individual market Exchange operated by HHS in that State will perform the functions described in this subpart and in subparts D, E, F, G, K, M, and O of this part.

(b) *Certificates of exemption.* The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.

(c) *Oversight and financial integrity.* The Exchange must perform required functions and cooperate with activities related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act and as required under this part, including overseeing its Exchange programs and non-Exchange entities as defined in §155.260(b)(1).

(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

(e) *Clarification.* In carrying out its responsibilities under this subpart, an Exchange is not operating on behalf of a QHP.

(f) *Requirements for State Exchanges on the Federal platform.* (1) A State that receives approval or conditional approval to operate a State Exchange on the Federal platform under §155.106(c) may meet its obligations under paragraph (a) of this section by relying on Federal services that the Federal government agrees to provide under a Federal platform agreement.

(2) A State Exchange on the Federal platform must establish and oversee requirements for its issuers that are no less strict than the following requirements that are applied to Federally-facilitated Exchange issuers:

(i) Data submission requirements under §156.122(d)(2) of this subchapter;

(ii)—(iv) [Reserved]

(v) Changes of ownership of issuers requirements under §156.330 of this subchapter;

(vi) QHP issuer compliance and compliance of delegated or downstream entities requirements under §156.340(a)(4) of this subchapter; and

(vii) Casework requirements under §156.1010 of this subchapter.

(3) If a State is not substantially enforcing any requirement listed under §155.200(f)(2) with respect to a QHP issuer or plan in a State-based Exchange on the Federal platform, HHS may enforce that requirement directly against the issuer or plan by means of plan suppression under §156.815 of this subchapter.

(4) A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, for plan years beginning on or after January 1, 2018, must require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under §155.706(b)(6)(i)(A). A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, as set forth in paragraphs (f)(4)(i) through (vii) of this section, for plan years beginning prior to January 1, 2018, must—