

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 156

[CMS–9958–F]

RIN 0938–AR68

Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements certain functions of the Affordable Insurance Exchanges (“Exchanges”). These specific statutory functions include determining eligibility for and granting certificates of exemption from the individual shared responsibility payment described in section 5000A of the Internal Revenue Code. Additionally, this final rule implements the responsibilities of the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage by providing that certain coverage be designated as minimum essential coverage. It also outlines substantive and procedural requirements that other types of individual coverage must fulfill in order to be certified as minimum essential coverage.

DATES: *Effective Date:* These regulations are effective on August 26, 2013.

FOR FURTHER INFORMATION CONTACT: Zachary L. Baron, (301) 492–4478, for provisions related to exemptions from the individual shared responsibility payment. Cam Moultrie Clemmons, (410) 786–1565, for provisions related to minimum essential coverage.

SUPPLEMENTARY INFORMATION:

Executive Summary

To ensure effective and efficient implementation of the insurance market reforms, the Affordable Care Act requires a nonexempt individual to maintain minimum essential coverage or make a shared responsibility payment. The Affordable Care Act specifies the categories of individuals who are eligible to receive exemptions from the individual shared responsibility payment under section 5000A of the Internal Revenue Code (the Code), which provides nonexempt individuals with a choice: maintain minimum essential coverage for themselves and any nonexempt family members or include an additional

payment with their federal income tax return. Some individuals are exempt from the shared responsibility payment, including members of recognized religious sects whose tenets conflict with acceptance of the benefits of private or public insurance and those who do not have an affordable health insurance coverage option available. Section 1311(d)(4)(H) of the Affordable Care Act (42 U.S.C. 18031(d)(4)(H)) directs the new health insurance marketplaces, called Affordable Insurance Exchanges (Exchanges), to issue certifications of exemption from the individual shared responsibility payment to eligible individuals. Section 1411 of the Affordable Care Act (42 U.S.C. 18081) generally provides procedures for determining an individual’s eligibility for various benefits relating to health coverage, including exemptions from the application of section 5000A of the Code.

This final rule sets forth standards and processes under which the Exchange will conduct eligibility determinations for, and grant certificates of exemption from, the individual shared responsibility payment. Furthermore, it supports and complements rulemaking conducted by the Secretary of the Treasury with respect to section 5000A of the Code, as added by section 1501(b) of the Affordable Care Act. The intent of this rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency, or consumer protection reasons.

Under section 5000A(f)(1)(E) of the Code, the Secretary of the Department of Health and Human Services (the Secretary), in coordination with the Secretary of the Treasury, may designate other health benefits coverage as minimum essential coverage. This final rule provides standards for determining whether certain other types of health insurance coverage constitute minimum essential coverage and procedures for plan sponsors to follow for a plan to be identified as minimum essential coverage under section 5000A of the Code. This rule also designates certain types of existing health coverage as minimum essential coverage. Other types of coverage, not statutorily specified and not designated as minimum essential coverage in this regulation, may be recognized as minimum essential coverage if certain substantive and procedural

requirements are met as set forth in this rule. These additional categories of minimum essential coverage, both those designated per se and those that may apply for recognition are neither group health insurance coverage nor individual health insurance. Consumers with types of coverage that are recognized as minimum essential coverage in accordance with this rule would be determined to have minimum essential coverage if the coverage is certified to be substantially compliant with the requirements of title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market.

Table of Contents

Executive Summary

I. Background

- A. Legislative Overview
- B. Stakeholder Consultation and Input
- C. Alignment With Related Rules and Published Information

II. Provisions of the Regulation and Analysis of and Responses to Public Comments

- A. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act
 - 1. Subpart A—General Provisions
 - a. Definitions (§ 155.20)
 - 2. Subpart C—General Functions of an Exchange
 - a. Functions of an Exchange (§ 155.200)
 - 3. Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions
 - a. Definitions and General Requirements (§ 155.600)
 - b. Eligibility Standards for Exemptions (§ 155.605)
 - c. Eligibility Process for Exemptions (§ 155.610)
 - d. Verification Process Related to Eligibility for Exemptions (§ 155.615)
 - e. Eligibility Redeterminations for Exemptions During a Calendar Year (§ 155.620)
 - f. Options for Conducting Eligibility Determinations for Exemptions (§ 155.625)
 - g. Reporting (§ 155.630)
 - h. Right To Appeal (§ 155.635)
 - B. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges
 - a. Definition of Minimum Essential Coverage (§ 156.600)
 - b. Other Types of Coverage That Qualify as Minimum Essential Coverage (§ 156.602)
 - c. Requirements for Recognition as Minimum Essential Coverage for Coverage Not Otherwise Designated Minimum Essential Coverage in the Statute or This Regulation (§ 156.604)
 - d. HHS Audit Authority (§ 156.606)
- III. Provisions of the Final Regulation
- IV. Collection of Information Requirements
- V. Summary of Regulatory Impact Statement
- VI. Regulatory Flexibility Act
- VII. Unfunded Mandates
- VIII. Federalism

IX. Congressional Review Act
Regulation Text

Abbreviations

Affordable Care Act—the Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act (Pub. L. 111–152))

BHP Basic Health Program

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

FPL Federal Poverty Level

HHS Department of Health and Human Services

IRS Internal Revenue Service

NAIC National Association of Insurance Commissioners

QHP Qualified Health Plan

SSA Social Security Administration

SSN Social Security Number

Code Internal Revenue Code of 1986, as Amended

I. Background

A. Legislative Overview

Section 1501(b) of the Affordable Care Act added section 5000A of the Internal Revenue Code (the Code) to a new chapter 48 of subtitle D (Miscellaneous Excise Taxes) of the Code effective for months beginning after December 31, 2013. Section 5000A of the Code, which was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111–159 (124 Stat. 1123) and Public Law 111–173 (124 Stat. 1215), requires that nonexempt individuals either maintain minimum essential coverage or make a shared responsibility payment. It also describes categories of individuals who may qualify for an exemption from the individual shared responsibility payment, and provides the definition of minimum essential coverage.

Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will, subject to section 1411 of the Affordable Care Act, grant certifications of exemption from the individual shared responsibility payment specified in section 5000A of the Code. Section 1311(d)(4)(I)(i) of the Affordable Care Act specifies that the Exchange will transfer to the Secretary of the Treasury a list of the individuals to whom the Exchange provided such a certification. Section 1411(a)(4) of the Affordable Care Act provides that the Secretary of Health and Human Services (the Secretary) will establish a program for determining whether a certification of exemption from the individual shared responsibility requirement and penalty will be issued by an Exchange under section 1311(d)(4)(H) of the Affordable Care Act. We interpret this provision as authorizing the Secretary to determine

“whether,” with respect to the nine exemptions provided for under section 5000A of the Code, Exchanges would perform the role of issuing certifications of exemption under section 1311(d)(4)(H) of the Affordable Care Act, whether eligibility for the exemption would be claimed solely through tax filing, or whether both processes would be available. Under this interpretation, the responsibility under section 1311(d)(4)(H) of the Affordable Care Act to issue certifications of exemption is “subject to” these determinations by the Secretary under section 1411(a)(4) of the Affordable Care Act, and Exchanges are thus only required to issue certifications of exemption with respect to exemptions not exclusively assigned to the Internal Revenue Service (IRS).

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related requirements. Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges and other components of title I of the Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of title I of the Affordable Care Act.

In accordance with our interpretation of these sections of the Affordable Care Act, and the authority provided by, *inter alia*, section 1321(a) of the Affordable Care Act, we specify that under the program established under section 1411(a)(4) of the Affordable Care Act, the Exchange will determine eligibility for and grant certificates of exemption as described below. We also note that consistent with prior guidance, in the State Exchange Implementation Questions and Answers released by HHS on November 29, 2011,¹ and the Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid released by HHS on December 10, 2012,² a state-based Exchange can be approved to operate by the Department of Health and Human Services (HHS) if

¹ State Exchange Implementation Questions and Answers, published November 29, 2011: http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

² Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, published December 10, 2012: <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

it uses a federally-managed service to make eligibility determinations for exemptions.

On March 27, 2012, HHS published the final rule entitled “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers” (77 FR 18309). The provisions of the final rule, herein referred to as the Exchange final rule, encompass the key functions of Exchanges related to eligibility, enrollment, and plan participation and management. In the Exchange final rule, 45 CFR 155.200(b) provided that a minimum function of an Exchange is to grant certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act. This final rule cross-references several provisions in the Exchange final rule, notably the limited situations where eligibility and verification processes used in determining eligibility for enrollment in a qualified health plan (QHP) through the Exchange and for insurance affordability programs can also be used by Exchanges for the purpose of determining whether an individual is eligible for an exemption from the individual shared responsibility payment.

Section 5000A(f) of the Code designates certain types of coverage as minimum essential coverage. The term “minimum essential coverage” includes all of the following under the statute: Government sponsored programs (the Medicare program under part A of title XVIII of the Social Security Act (the Act); the Medicaid program under title XIX of the Act; the Children's Health Insurance Program (CHIP) program under title XXI of the Act; medical coverage under chapter 55 of title 10, United States Code, including the TRICARE program; a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretaries of the Department of Health and Human Services and Treasury; a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or the Nonappropriated Fund Health Benefits Program of the Department of Defense (established under section 349 of the National Defense Authorization Act for Fiscal Year 1995); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; and coverage under a grandfathered health plan. In addition, section 5000A(f)(1)(E) of the Code directs the Secretary, in coordination with the Secretary of

Treasury, to designate other health benefits coverage, such as a state health benefits risk pool, as minimum essential coverage. This final rule designates certain additional types of coverage qualify as minimum essential coverage and also provides a process by which other types of coverage could be recognized as minimum essential coverage.

B. Stakeholder Consultation and Input

On August 3, 2010, HHS published a request for comment (the RFC) inviting the public to provide input regarding the rules that will govern the Exchanges. In particular, HHS asked states, tribal representatives, consumer advocates, employers, insurers, and other interested stakeholders to comment on the standards Exchanges should meet. The comment period closed on October 4, 2010.

The public response to the RFC yielded comment submissions from consumer advocacy organizations, medical and health care professional trade associations and societies, medical and health care professional entities, health insurers, insurance trade associations, members of the general public, and employer organizations. The majority of the comments were related to the general functions and standards for Exchanges, qualified health plans (QHPs), eligibility and enrollment, and coordination with Medicaid. While this final rule does not directly respond to comments from the RFC, the comments received are described, where applicable, in discussing specific regulatory proposals. These comments are not separately identified, but instead are incorporated into each substantive section of this final rule as appropriate.

In addition to the RFC, HHS received comments on the proposed rule titled “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” (78 FR 7348) that are, similarly not separately identified, but incorporated into each substantive section of this final rule. HHS has also consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, and meetings with tribal representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. HHS initiated and hosted a tribal consultation on February 21, 2013, where we allowed federally-recognized tribal leaders and representatives from tribal health organizations the opportunity to discuss

and provide feedback regarding the provisions within the proposed rule. Furthermore, we also received feedback from health care sharing ministries about the process for how individual members can obtain certificates of exemption based on their membership in a health care sharing ministry, and an expression of interest in a process for allowing health care sharing ministries to obtain recognition that they meet the standards under section 5000A(d)(2)(B) of the Code. We also received information from various stakeholder groups regarding types of “other coverage” as described in section 5000A(f)(1)(E) of the Code.

C. Alignment With Related Rules and Published Information

The proposed rule, titled “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” (78 FR 7348), was published in the **Federal Register** on February 1, 2013 in coordination with the Department of Treasury’s proposed rule, “Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage” (78 FR 7314) (hereinafter referred to as “the Treasury proposed rule”). The Department of the Treasury’s proposed rule will be finalized at a later date. Accordingly, in this final rule, we have removed cross-references to the Treasury proposed rule and replaced them with cross-references to the applicable language in the Affordable Care Act. Upon publication of the Treasury final rule, we intend to replace the statutory references with the appropriate regulatory references.

II. Provisions of the Regulation and Analysis of and Responses to Public Comments

On February 1, 2013, we published a proposed rule, titled “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” (78 FR 7348), in which we proposed to add subpart G to 45 CFR part 155, which includes standards for Exchanges related to conducting eligibility determinations for and granting certificates of exemption from the individual shared responsibility payment. We also proposed to amend § 155.200(a) to add a reference to indicate that, consistent with existing language in § 155.200(b), granting certificates of exemption is a minimum function of the Exchange. Furthermore, we proposed to add subpart G to 45 CFR part 156, which set forth standards under which the

Secretary would designate certain types of existing coverage, not specified under section 5000A, as minimum essential coverage. Additionally, under the proposed regulation, other types of coverage that were neither statutorily nor regulatory designated as minimum essential coverage, may be recognized as minimum essential coverage if certain substantive and procedural requirements are met. These types of coverage, both those designated per se and those recognized by application, are neither group health insurance coverage nor individual health insurance. Consumers with coverage recognized as minimum essential coverage in accordance with this regulation would be determined to have minimum essential coverage for purposes of the individual shared responsibility provision.

We received approximately 220 public comments from state agencies, advocacy groups, health care providers, employers, health insurers, health care associations, and others. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding the proposed rules.

Some comments were outside the scope of the proposed rule, and therefore are not addressed in this final rule. In some instances, commenters raised policy or operational issues, such as those related to certified application counselors, authorized representatives, and eligibility appeals, that will be addressed through forthcoming regulatory and subregulatory guidance to be provided subsequent to this final rule; therefore, some, but not all comments are addressed in the preamble to this final rule.

Brief summaries of each proposed provision, a summary of the public comments we received (with the exception of specific comments on the paperwork burden or the regulatory impact analysis), and our responses to the comments are below. Comments related to the paperwork burden are addressed in the “Collection of Information Requirements” and section in this final rule. We did not receive comments related to the impact analysis.

A. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Subpart A—General Provisions

a. Definitions (§ 155.20)

We proposed to make a technical correction to the definitions of “applicant” and “application filer” to note that they do not apply to an

applicant or application filer seeking an exemption pursuant to proposed subpart G. We proposed separate definitions specific to exemptions for these terms in § 155.600.

Comment: Several commenters expressed concerns about HHS' pre-existing definition of "application filer" in § 155.20 based on its cross-reference to the definition of "family" within the Code and the inclusion of this definition as proposed in § 155.600(a). Commenters believed the inclusion of the definition of "family" within the Code would limit the flexibility of an applicant to include people who would have relationships that may otherwise be included on an exemption application. Commenters believed that these cross-references were inconsistent with other provisions, as they noted that subject to state rules, QHP issuers can allow individuals in multiple tax households to enroll in a QHP together, and that HHS has proposed to define "dependent" in 78 FR 4718 for purposes of eligibility for special enrollment periods based on whether a QHP issuer will allow individuals to enroll in a QHP together. As such, they urged HHS to remove the references to the definition of family within the Code and its implementing regulation.

Response: The commenters correctly describe different situations in which recognition of relationships is determined by who can enroll in a QHP together. In proposing to amend the definition of "application filer" in § 155.20 to exclude those individuals seeking eligibility for an exemption pursuant to subpart G, we otherwise maintained the definition from the Exchange final rule regarding the coverage application process at 77 FR 18445 with a few minor technical corrections. Further, we note that comments regarding eligibility for enrollment in a QHP and insurance affordability programs are beyond the scope of this regulation. Since the relevant family unit for the individual shared responsibility provision is the tax filing unit, our proposed language defining "application filer" at § 155.600(a) specific to subpart G cross-references section 5000A(a) of the Code regarding the individual shared responsibility provision. Because the individual shared responsibility provision will be administered by the Internal Revenue Service on a tax-return-by-tax-return basis, we believe it is appropriate to provide that only members of the same tax filing unit may file an exemption application together.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.20 of the proposed rule with a few technical corrections. We clarify that the term "applicant" in this provision excludes those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G. We also clarify that our previous inclusion of an authorized representative in the definition refers to the authorized representative of an applicant. We also cite to the applicable Treasury regulation instead of section 36B of the Code.

2. Subpart C—General Functions of an Exchange

a. Functions of an Exchange (§ 155.200)

In paragraph (a), we proposed to add that the Exchange would also perform the minimum functions described in subpart G of this part related to eligibility determinations for exemptions.

Comment: Commenters generally supported our proposal that the Exchange would also perform the minimum functions described in subpart G of this part related to eligibility determinations for exemptions. Some commenters raised concerns that the HHS proposed rule and the Treasury proposed rule discussed different issues, and wanted to ensure that both agencies were working in close coordination. Other commenters expressed opposition to Exchanges determining eligibility for exemptions based on overarching philosophical complaints regarding this proposed rule and this provision of the Affordable Care Act. One commenter wanted HHS to reduce the number of exemptions available to individuals. Lastly, another commenter believed that HHS was providing too much latitude to states in determining the basic framework for Exchanges, and rather should set more strict guidelines to prevent confusion for Exchanges and consumers.

Response: We continue to coordinate closely with the Department of Treasury and a range of stakeholders to ensure that we provide sufficient guidance to Exchanges, while also ensuring the appropriate level of operational flexibility to allow for effective implementation. We note that the categories of exemptions proposed were based on the definitions provided within the Affordable Care Act, which added section 5000A of the Code. As we discuss further below, the Secretary of HHS has exercised careful discretion in specifying criteria for the hardship

exemption in accordance with section 5000A(e)(5) of the Code, to ensure that a hardship exemption is only available in limited circumstances in which an individual has suffered a hardship with respect to the capability to obtain coverage under a QHP.

Summary of Regulatory Changes

We are finalizing the provision proposed in § 155.200 of the proposed rule without modification.

3. Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

a. Definitions and General Requirements (§ 155.600)

In paragraph (a) of § 155.600, we proposed definitions and sought comments for terms that apply throughout subpart G. First, we proposed to define "applicant" as an individual who is seeking an exemption from the individual shared responsibility payment for him or herself through an application submitted to the Exchange. We proposed to define "application filer" as an applicant; an individual who is liable for the individual shared responsibility payment (in accordance with 26 CFR 1.5000A-1(c) of the Treasury proposed rule) for an applicant; an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant. We noted that we intended to modify the proposed language in § 155.227 (78 FR 4711) and § 155.225 (78 FR 4710) to clarify that authorized representatives and certified application counselors can assist individuals seeking exemptions, and sought comments about how authorized representatives and certified application counselors could best support individuals seeking certificates of exemption from the Exchange.

We proposed to define "exemption" as an exemption from the individual shared responsibility payment, noting that there is no meaningful distinction between individuals exempt from the shared responsibility payment and individuals who are not "applicable individuals" for purposes of the requirement to maintain minimum essential coverage in section 5000A of the Code.

We proposed to define "health care sharing ministry" in the same manner as provided in 26 CFR 1.5000A-3(b) of the Treasury proposed rule.

We proposed to define "required contribution" in the same manner as provided in 26 CFR 1.5000A-3(e) of the Treasury proposed rule.

We proposed to define "Indian tribe" in the same manner as in 26 CFR

1.5000A–3(g) of the Treasury proposed rule, which in turn references the definition in section 45A(c)(6) of the Code.

In paragraph (b), we proposed that for purposes of this subpart, any attestation that an applicant is to provide under this subpart may also be provided by an application filer on behalf of the applicant.

In paragraph (c) of § 155.600, we proposed that for the purposes of this subpart, the Exchange must consider information through electronic data sources, other information provided by the applicant, or other information as available in the records of the Exchange to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility for the relevant exemption or exemptions for which the applicant requested.

We also proposed to add paragraphs (d) and (e) in order to specify that the accessibility and notice requirements in § 155.205(c) and § 155.230, respectively, apply to exemptions as well, given that the definition of applicant in this subpart is otherwise specific to exemptions.

Comment: One commenter raised concerns about health care sharing ministries. The commenter noted that health care sharing ministries are not subject to state insurance laws, and as such, the statutory exemption for members of health care sharing ministries may create circumstances in which an individual who is a member of a health care sharing ministry does not benefit from the Affordable Care Act's broader consumer protections. The commenter believed that this might motivate organizations to seek to establish standing as a health care sharing ministry in order to evade consumer protections and market reforms enacted by the Affordable Care Act. The commenter advised HHS and IRS to carefully monitor applications from entities seeking recognition as a health care sharing ministry for the purpose of exemptions.

Response: The Affordable Care Act defines health care sharing ministry for purposes of an exemption in section 5000A(d)(2)(B) of the Code. We appreciate the concerns raised regarding organizations that may improperly seek standing as a health care sharing ministry. As we discuss further below, we believe that the process discussed in § 155.615(c) will ensure that HHS only provides exemptions based on membership in a health care sharing ministry for individuals who are members of health care sharing ministries that meet the standards in the

statute, which specify that a health care sharing ministry or its predecessor must have been in existence at all times since December 31, 1999.

Comment: Commenters generally supported allowing an application filer to attest for an applicant on the exemptions application. However, one commenter believed that "attestation" was not defined clearly enough in § 155.600(b), and as such recommended that HHS revise this provision to more clearly specify the acceptable form and manner of an attestation.

Response: The proposed language regarding attestations in § 155.600(b) mirrors the language in 45 CFR 155.300(c), which is used in the coverage process. As we believe this definition provides sufficient flexibility and clarity for Exchanges, we do not deviate from the language used in the coverage process to describe an attestation.

Comment: Several commenters requested that HHS ensure that the application process, including eligibility notices, be accessible to individuals with limited English proficiency (LEP) as well as those individuals with disabilities. Commenters also urged HHS to include clearer guidelines regarding the exemption eligibility process in order to ensure that the processes do not discriminate against individuals, particularly LEP individuals. Commenters requested translation of the requisite materials in non-English languages, and suggested that HHS refer to LEP guidance adopted by the HHS Office of Civil Rights.

Response: We appreciate commenters' concerns regarding ensuring that the application process and eligibility notices are accessible to individuals with LEP as well as those individuals with disabilities. In proposed § 155.600(d) and (e), we cross-referenced § 155.205(c) and § 155.230 respectively, which provide standards to ensure the suggested protections are in place. As such, we do not believe that additional standards are necessary in subpart G to ensure the application process and eligibility notices are accessible to individuals with LEP as well as those individuals with disabilities.

Summary of Regulatory Changes

We finalize the provisions proposed in § 155.600 of the proposed rule with one modification and a few non-substantive technical corrections for clarity. We finalize the definition of "Indian tribe" as proposed, but move the definition earlier in paragraph (a). We make a technical correction for the purpose of clarity in finalizing the

definition of "shared responsibility payment" to specify that it means the payment imposed with respect to a non-exempt individual. We also include the definition of "tax filer" in paragraph (a) to specify that it has the same meaning in subpart G as it does in § 155.300(a).

b. Eligibility Standards for Exemptions (§ 155.605)

Under the program established in accordance with section 1411(a)(4) of the Affordable Care Act for determining whether certificates of exemption are to be issued by Exchanges under section 1311(d)(4)(H) of the Affordable Care Act, we proposed that Exchanges would issue certificates of exemption in the categories of religious conscience and hardship. With respect to the other seven exemptions, for reasons set forth below, we proposed that under the program provided for in section 1411(a)(4) of the Affordable Care Act, Exchanges would also issue certificates of exemption with respect to three additional categories (with exemptions also available through the tax filing process) based on membership in a health care sharing ministry, membership in an Indian tribe, and incarceration. In the four remaining exemption categories, however, we proposed that under the program established under section 1411(a)(4) of the Affordable Care Act, certificates would not be issued by Exchanges under section 1311(d)(4)(H) of the Affordable Care Act, and instead individuals would claim an exemption in one of those categories exclusively through the tax return filing process with the IRS.

In paragraph (a) of § 155.605, we proposed that except as specified in paragraph (g), the Exchange would determine an applicant eligible for and grant a certificate of exemption for a month if the Exchange determines that he or she meets the requirements for one of the categories of exemptions described in this section for at least one day in the month, consistent with 26 CFR 1.5000A–3 of the Treasury proposed rule. We noted that depending on the circumstances for each specific proposed hardship exemption category, the certificate may be provided for an entire calendar year or instead for a specific month or period of months, including periods of time that stretch across more than one calendar year.

We noted that an applicant could apply for multiple exemptions simultaneously in case some are denied, and also receive any exemptions for which he or she is eligible. We solicited comments on this approach.

In paragraph (b), we proposed that except as specified, an applicant is required to submit a new application for each year for which an applicant wants to be considered for an exemption through the Exchange, and that an exemption will only be provided for a calendar year in which the applicant submitted an application for an exemption. We provided exceptions for exemptions provided based on membership in an Indian tribe and for religious conscience, in recognition that an individual's qualification for these exemptions is expected to remain the same from year to year. We also specified an exception for hardship, since some categories of hardship will be provided for one or more months and may be provided for periods of time that stretch across more than one calendar year, and some categories of hardship can only be provided after the close of a calendar year. We welcomed comments on this approach and how the Exchange could expedite and streamline the process.

We considered whether to specify that the Exchange send a notice to each individual who had an exemption certificate from the Exchange for a calendar year, in order to remind him or her about the opportunity to apply to for an exemption for the following calendar year, and whether this notice could be sent only at the individual's direction. We solicited comments regarding the use of such a reminder and on a renewal process more generally.

In paragraph (c), we proposed to codify the statutory eligibility standards for the exemption based on religious conscience. In paragraph (c)(1), we proposed that the Exchange would determine an applicant eligible for an exemption for a month if he or she is a member of a recognized religious sect or division described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division for such month, in accordance with 26 CFR 1.5000A-3(a) of the Treasury proposed rule.

In paragraph (c)(2), we proposed eligibility standards regarding the duration of the exemption for religious conscience. In paragraph (c)(2)(i), we proposed that the Exchange grant the exemption for religious conscience to an applicant that meets the standards of paragraph (c)(1) of this section for a month on a continuing basis, until such time that the applicant either reaches the age of 18, or reports that he or she no longer meets the standards provided in (c)(1) of this section.

We proposed to add paragraph (c)(2)(ii) to specify how the Exchange should handle a situation in which an

individual who has a certificate of exemption based on religious conscience that was granted prior to the individual reaching the age of 18. We proposed that the Exchange send such an individual a notice when he or she reaches the age of 18 that informs the individual that he or she needs to submit a new exemption application if he or she would like to maintain the certificate of exemption.

We proposed to add paragraph (c)(3) to specify that the Exchange will grant an exemption in this category prospectively or retrospectively.

In paragraph (d), we proposed that the Exchange determine an applicant eligible for an exemption for a month if the applicant is a member of a health care sharing ministry for such month in accordance with 26 CFR 1.5000A-3(b) of the Treasury proposed rule. We proposed that an applicant who wanted to retain this exemption for an additional calendar year would re-apply for this exemption each calendar year, and that the Exchange may only provide an exemption in this category retrospectively.

In paragraph (e), we proposed the eligibility standards for the exemption based on incarceration. We specified that the Exchange would determine an individual eligible for an exemption for a month that he or she meets the definition specified in 26 CFR 1.5000A-3(d) of the Treasury proposed rule. We proposed that the Exchange would only provide this exemption for months in which an individual was incarcerated, since there is no assurance that an incarcerated individual will be released on the expected date.

In paragraph (f), we proposed eligibility standards for the exemption based on membership in an Indian tribe. In paragraph (f)(1), we proposed to codify that the Exchange would determine an applicant eligible for an exemption for a month if he or she is a member of an Indian tribe for such month, in accordance with 26 CFR 1.5000A-3(g) of the Treasury proposed rule.

In paragraph (f)(2), we proposed eligibility standards regarding the duration of the exemption for membership in an Indian tribe, such that the Exchange would grant the exemption for membership in an Indian tribe to an applicant who meets the standards of paragraph (f)(1) of this section for a month on a continuing basis, until such time that the individual reports that he or she no longer meets the standards provided in (f)(1) of this section.

We proposed to add paragraph (f)(3) to specify that the Exchange will grant

an exemption in this category during the year prospectively or retrospectively.

In paragraph (g), we proposed eligibility standards for the exemption based on hardship, which is defined in section 5000A(e)(5) of the Code as applying to "any applicable individual who for any month is determined by the Secretary under section 1311(d)(4)(H) of the Affordable Care Act to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan." In developing some of these standards, we considered the standards established by the Commonwealth of Massachusetts. We proposed some specific time standards for each category of hardship, but we solicited comments regarding whether these are appropriate, or if we should adopt a more uniform approach across the category.

In paragraph (g)(1) of § 155.605, we proposed that the Exchange provide an exemption for hardship for a month or months in which an applicant experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she has a significant, unexpected increase in essential expenses; the expense of purchasing minimum essential coverage would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or he or she has experienced other factors similar to those described in paragraphs (g)(1)(i) and (ii) of this section that prevented him or her from obtaining minimum essential coverage. We proposed broad language to include a range of personal scenarios that could negatively impact an applicant such that he or she would be eligible for this exemption, and noted that we expected to clarify these criteria in future guidance. We listed expected standards and solicited comments on these criteria, including on whether additional criteria should be established in regulation or guidance. We also solicited comments regarding whether the proposed time standard could be effectively implemented, or whether we should take a different approach.

In paragraph (g)(2), we proposed that the Exchange provide an exemption for hardship for a calendar year if an applicant, or another individual for whom the applicant attests will be included in the applicant's family (as defined in 26 CFR 1.5000A-1(d)(6) of the Treasury proposed rule), is unable to afford coverage for such calendar year in accordance with 26 CFR 1.5000A-3(e) of the Treasury proposed rule, calculated using projected annual household income. We proposed

identical standards to those defined for the lack of affordable coverage exemption in 26 CFR 1.5000A-3(e) of the Treasury proposed rule, except that the Exchange would use projected household income to determine whether coverage is affordable under this exemption, instead of actual household income from the tax return for the year for which the exemption is requested. We solicited comments regarding whether the approach in paragraph (g)(5) of this section regarding the aggregate cost of employer-sponsored coverage for all the employed members of the family should also be applied in determining eligibility for this hardship category.

We proposed that this exemption is not available for an application that is submitted after the last date on which an applicant could enroll in a QHP through the Exchange for a calendar year for which the exemption is requested to ensure that an applicant can obtain the information needed to make a purchasing decision, including for a catastrophic plan, which is not applicable after the last date on which enrollment would be possible.

We proposed in paragraph (g)(3) of § 155.605 that the Exchange provide an exemption for hardship for a calendar year if an individual taxpayer who was not required to file an income tax return for such calendar year because his or her gross income was below the filing threshold, but who nevertheless filed to receive a tax benefit, claimed a dependent who was required to file a tax return, and as a result had household income exceeding the applicable return filing threshold outlined in 26 CFR 1.5000A-3(f)(2) of the Treasury proposed rule.

We proposed to add paragraph (g)(4) to specify that the Exchange provide an exemption for hardship for a calendar year for an individual who has been determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act. We sought comments on whether this exemption should be limited to such individuals who are also not eligible for advance payments of the premium tax credit (that is, with projected household income below 100% of the poverty threshold).

We proposed to add paragraph (g)(5) of § 155.605 to specify that the Exchange provide an exemption for hardship for a calendar year if an applicant and one or more employed members of his or her family, as defined in 26 CFR 1.5000A-1(d)(6) of the Treasury proposed rule, are each determined eligible for self-

only coverage in separate eligible employer-sponsored plans that are affordable, pursuant to 26 CFR 1.5000A-3(e) of the Treasury proposed rule for one or more months during the calendar year, but for whom the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of the household income for that month or those months.

Lastly, as noted above, we proposed under our authority in section 1411(d)(4) of the Affordable Care Act that the Exchange would not issue certifications of exemption with respect to household income below the filing threshold (other than the limited hardship exemption proposed in § 155.605(g)(3) and described above); not being lawfully present; short coverage gaps; and inability to afford coverage (other than the limited hardship exemption proposed in § 155.605(g)(2) and described above). We specified that these exemptions would be available solely through the tax filing process. We solicited comments on this approach and if there were alternative approaches that HHS should consider.

Comment: Multiple commenters expressed support for HHS' proposal to allow an individual to apply for and enable the Exchange to grant multiple exemptions, as well as the provision specifying that an individual eligible for an exemption for at least one day of the month receive the exemption for a full month. Another commenter expressed broad support for the proposed exemptions process, but wanted HHS to maintain its focus on ensuring individuals receive coverage through the Exchange.

Response: In fulfilling the goals of the Affordable Care Act, we are committed to ensuring that all individuals have access to quality, affordable health coverage. Furthermore, as specified in the statute, we are also committed to providing access to exemptions from the shared responsibility payment to those individuals who meet specified standards.

Comment: Commenters expressed differing opinions regarding whether the Exchange should send notices to individuals in possession of certain certificates of exemption at the end of a calendar year to remind them of the need to submit an application for the same exemption for the next calendar year. Several commenters wanted HHS to specify that the Exchange send such a reminder notice that would arrive during open enrollment, to allow an individual to make the appropriate purchasing decision. Another

commenter opposed specifying that the Exchange send such a reminder notice, noting that most exemptions are meant to be temporary, and that the primary goal of the Exchange should be ensuring that individuals have access to coverage.

Response: We will maintain the language as proposed, which does not specify that Exchanges will send an additional reminder notice to an individual at the end of a calendar year. Pursuant to the eligibility standards for exemptions described throughout § 155.605, individuals have broad flexibility in terms of the time periods which Exchanges will grant exemptions, and thus we do not believe the corresponding administrative burden on Exchanges to send an additional notice is outweighed by the benefits of such a notice for individuals. We note that an Exchange also has the flexibility to send such a notice at its discretion.

Comment: Several commenters raised concerns regarding our proposed codification of the eligibility standards for the religious conscience exemption specified in the Affordable Care Act. Some commenters expressed philosophical opposition to the notion that the government would exempt individuals for religious purposes. Other commenters opposed our proposal to allow children of individuals in recognized religious sects or divisions to be exempt in addition to their parents. Commenters believed that as a result, parents would not have to maintain minimum essential coverage for their dependent children, which they feared would permit parents to avoid caring for their children's health.

Response: Section 5000A(d)(2) of the Code, as added by section 1501(b) of the Affordable Care Act, establishes the religious conscience exemption. We note that state laws governing domestic relations allow parents to attest on behalf of minor children, which was the basis of our proposal. We note that we do not intend this provision to modify or supersede any other laws regarding health responsibility for children.

Comment: One commenter suggested the IRS or the Social Security Administration (SSA) is better positioned to determine eligibility for the religious conscience exemption. Furthermore, the commenter expressed concerns about how the Exchange should handle an appeal when a religious sect is not recognized by the SSA. The commenter indicated that it would be more appropriate for an individual to instead appeal to IRS or SSA in this situation as opposed to the Exchange.

Response: As noted above, the statute specifies that the religious conscience

exemption may only be granted by the Exchange. We are working closely with the SSA to define an appropriate process to address religious sects that are not yet recognized, and we clarify in § 155.615(b)(4) that if an applicant attests to membership in a religious sect or division that is not recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code, the Exchange must provide the applicant with information regarding how his or her religious sect or division can pursue recognition under section 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as the Exchange obtains information indicating that the religious sect or division has been approved. We agree with the commenter that the Exchange is not an ideal venue for an appeal of a denial that was based on a finding that a sect or division did not meet the statutory requirements. We intend to provide further guidance on this process in collaboration with the SSA.

Comment: One commenter requested that HHS expand the religious sects and divisions whose members qualify for the religious conscience exemption.

Response: HHS does not have the authority to expand the criteria set in the statute, which reference section 1402(g)(1) of the Code, and so we are finalizing the cross-reference to the statutory criteria as proposed.

Comment: Commenters expressed differing opinions regarding our proposal that when an individual who has a religious conscience exemption turns 18, he or she must re-apply for the exemption in order to maintain it. One commenter opposed specifying that the Exchange send a notice, instead arguing that the individual turning 18 should be responsible for reapplying without a prompt. Another commenter noted that based on the practices of the religious sects and divisions that this exemption covers, HHS should modify this provision such that the age standard is 21.

Response: In response to comments, to align with other Affordable Care Act definitions of children, and to reduce burden on individuals under the age of 21, we are modifying this provision in the final rule to specify that individuals receiving the religious conscience exemption will have to re-apply for the exemption upon turning 21. We will maintain the provision specifying that the Exchange send a notice prompting an individual to reapply upon turning 21, since this notice is needed to notify him or her that his or her exemption will end absent a new application.

Nothing precludes individuals affected by this change from obtaining coverage on their own.

Comment: One commenter suggested that the Exchange should have the flexibility not to grant exemptions based on membership in a health care sharing ministry or incarceration. The commenter noted the limited benefit for individuals in having an Exchange grant such exemptions since the proposed rule specifies that they are only available through the Exchange retrospectively within a calendar year, and are otherwise available through the tax filing process.

Response: We believe that individuals will benefit from the opportunity to receive the exemptions based on membership in a health care sharing ministry or incarceration through the Exchange in addition to through the tax filing process, and as such, are finalizing the provision as proposed.

Comment: One commenter suggested that HHS clarify the language used in § 155.605(c)(3) and (f)(3) such that the text of the regulation appropriately describe the flexibility for Exchanges to grant an exemption in these categories retrospectively or prospectively.

Response: In proposed § 155.605(c)(3) and (f)(3), we specified that the Exchange “must provide an exemption in this category prospectively or retrospectively.” The intent of this provision was not to allow flexibility to the Exchange whether or not to grant the exemption but, rather, to specify that the Exchange will provide an exemption in these categories retrospectively, prospectively, or both, depending on the period of time for which such an exemption is requested and the period of time for which an applicant meets the criteria for such an exemption. Accordingly, we have modified the language in paragraphs (c), (d), (e), (f), and (g) to specify as appropriate when the Exchange must make the various categories of exemptions available prospectively or retrospectively.

Comment: One commenter expressed support for HHS’ proposal that the Exchange grant the exemption based on membership in an Indian tribe as long as individuals still maintained the opportunity to file for this exemption through the tax filing process. Another commenter suggested that Exchanges should not grant exemptions based on membership in an Indian tribe, but that rather such exemption should only be available through the tax filing process. Alternatively, this commenter said that if the Exchange does grant this exemption, it should only do so prospectively.

Response: We believe that individuals will benefit from the opportunity to receive the exemption based on membership in an Indian tribe through the Exchange in addition to through the tax filing process. Furthermore, we do not believe that granting this retrospectively and prospectively will result in significant burden for the Exchange, since no work is necessary to determine eligibility for this exemption retrospectively beyond what would be necessary to determine eligibility for it prospectively. Accordingly, we are finalizing this provision as proposed.

Comment: Some commenters expressed concerns about the definition of Indian tribe proposed in § 155.600(a), which referred to section 45A(c)(6) of the Code. These commenters recommended a broader definition of Indian for purposes of an exemption. Several commenters recommended that HHS add a hardship exemption category for Indians as defined in 42 CFR 447.50, and another commenter suggested that Exchanges add a hardship exemption category for individuals who are eligible to receive services provided by the Indian Health Service (IHS) pursuant to 25 U.S.C. 1680c(a) or (b). A commenter asked HHS to specify that the duration for these hardship exemptions would parallel the duration of the exemption for a member of an Indian tribe.

Response: We have thoroughly reviewed the definitions of the term “Indian” in the Affordable Care Act. HHS does not have the legal authority to modify through regulation the statutory definitions of “Indian” as referenced in the Affordable Care Act. There is no administrative flexibility to align these definitions. Any changes to the definition must be legislative. In response to comments, we added a category of hardship exemption in § 155.605(g)(6) for an individual who is not a member of a federally-recognized tribe, and is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.50, or an individual eligible for services through IHS in accordance with 25 U.S.C. 1680c(a), (b), or (d)(3). We also redesignate proposed § 155.615(f)(3) as § 155.615(f)(4), and add new § 155.615 to specify that the Exchange will use the same verification procedures for this exemption as it will use for the exemption for members of a federally-recognized tribe. We also note that the duration of this exemption mirrors that as provided for members of federally-recognized tribes, such that whether it is granted prospectively or retrospectively, it is granted for a month on a continuing basis until the individuals specified above report a

change in their eligibility status for this exemption. This ensures that the individuals specified above who have access to health care through the IHS, Tribes and Tribal organizations, and urban Indian organizations (I/T/U) are treated in the same manner as members of federally-recognized tribes for purposes of the individual shared responsibility payment.

Comment: Multiple commenters expressed overall support for our proposal in § 155.605(g)(1), whereby the Exchange would determine an individual eligible for a hardship exemption based on circumstances that resulted in an unexpected increase in essential expenses that prevented an individual from obtaining coverage under a qualified health plan. One commenter suggested that HHS should provide further flexibility to allow Exchanges to define additional eligibility criteria for this exemption. Another commenter expressed support for HHS providing minimum standards for hardship. While we mentioned several examples of events that would qualify as hardships in preamble, based on standards used for similar purposes in the Commonwealth of Massachusetts, some commenters wanted HHS to clarify in the final text of the regulation that an applicant who met the circumstances discussed in the preamble as well as other circumstances used in Massachusetts but not specifically mentioned in preamble would qualify for a hardship exemption.

Response: In preamble to the proposed rule, we noted that we expected to clarify detailed hardship criteria in future guidance. Accordingly, to assist Exchanges in determining eligibility for a hardship exemption for an individual who experienced circumstances that prevented him or her from obtaining coverage under a QHP, we are publishing guidance simultaneously with this rule that provides detailed criteria for this exemption.

Comment: One commenter recommended that Exchanges have greater flexibility in determining the duration of a single exemption, particularly due to the many circumstances that could be covered by the hardship exemption. Several commenters recommended that HHS provide Exchanges with clearer guidance regarding the duration of hardship exemptions that could be granted according to § 155.605(g)(1), including events that may span multiple calendar years. Some commenters urged that in particular situations, such as those where victims suffer natural and human-caused disasters, Exchanges

should grant exemptions that last 2 years. Other commenters suggested that any hardship exemption be provided for a minimum of 6 months or a year. One commenter recommended that the Exchange grant a hardship exemption for more than a calendar year if an individual experiences an event that occurs across 2-calendar years. Another commenter requested clarification regarding the language in § 155.605(a) specifying that the Exchange would provide an exemption for a month if the Exchange determines that an individual meets the requirements for an exemption for at least one day of the month, with the exception of § 155.605(g).

Response: In response to comments, we clarify that a hardship exemption granted under § 155.605(g)(1) will at minimum be provided for the month before the hardship, the month or months of the hardship, and the month after the hardship, and that Exchanges have flexibility to provide it for additional months after the hardship, consistent with the circumstances of the hardship. This ensures that such a hardship exemption addresses the time period where an individual actually experienced the hardship, while also providing flexibility for Exchanges to evaluate the particular circumstances of an event that may necessitate an extended duration of an exemption. As such, the hardship exemptions provided under § 155.605(g)(1), which will be provided before and after the occurrence of when the individual actually experienced the hardship, necessitate an exception in regards to the general provision of § 155.605(a).

Comment: Numerous commenters urged HHS to specify additional categories of hardship exemptions outside of those proposed or to expand the scope of certain categories of hardship exemptions as proposed. These suggestions include providing hardship exemptions for: Employees who have an offer of self-only employer-sponsored coverage that costs less than 8 percent of household income, but for whom family coverage costs more than 8 percent of household income; individuals with income less than 150 percent of the FPL; individuals for whom the aggregate cost of employer-sponsored coverage (not only employed members) exceeds 8 percent of household income for that month(s); individuals and families with household income below 250 percent of the FPL that are offered affordable employer-sponsored coverage (less than 8 percent of household income), but the amount that the individual or family would have to pay for the lowest-cost

bronze plan on the Exchange exceeds 8 percent of household income; individuals and their dependents who have an offer of employer-sponsored coverage that is affordable but that does not provide minimum value; individuals participating in special non-minimum essential coverage programs that already require financial determinations by a state; individuals who already receive certain kinds of public assistance benefits; or individuals who in good faith attempted to purchase insurance but were unable to do so based on limited enrollment opportunities.

Response: As specified in guidance published simultaneously with this final rule, we have identified several events that Exchanges can refer to in order to help them in determining eligibility for hardship exemptions. These will also be the detailed criteria used by the Federally-facilitated Exchange. Due to the broad range of circumstances that will qualify an individual for a hardship exemption, we do not believe that further categories of exemptions need to be added to the text of the regulation. However, as discussed further below, we have modified the eligibility standards for the hardship exemption for situations in which coverage is unaffordable based on projected income such that if an individual and his or her dependents have an offer of employer-sponsored coverage that does not meet the minimum value standard, the Exchange will not consider this offer in determining affordability. Rather, in such a situation, the Exchange will consider affordability based on the lowest-cost offer of employer-sponsored coverage that does meet the minimum value standard, and if no such offer exists, on the cost of the applicable lowest cost bronze plan in the relevant rating area of the Exchange, reduced by any available advance payments of the premium tax credit. This is similar to the considerations for eligibility for advance payments of the premium tax credit based on eligibility for coverage in an eligible employer-sponsored plan, which take into account both cost and minimum value.

Comment: One commenter expressed concerns about the burden on Exchanges to handle eligibility determinations for exemptions, including the hardship exemption, as they viewed the eligibility determination process for exemptions as more appropriately handled through the tax filing process, particularly when exemptions are not available prospectively through the Exchange. Some commenters supported the

proposed hardship exemption at § 155.605(g)(3) (related to the tax filing threshold), while another commenter stated that the proposed hardship exemption at § 155.605(g)(3) should not be granted by the Exchange as it concerned tax filing. Other commenters generally supported the hardship exemption proposed at § 155.605(g)(5) (related to affordable self-only coverage), even if suggesting modifications as noted above, for employed members determined eligible for affordable self-only insurance, but for whom the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of household income.

Response: Based on comments received, and in order to minimize burden on Exchanges while ensuring efficient processing of exemptions applications, we will modify § 155.605(g) such that the hardship exemptions proposed at § 155.605(g)(3) and (5) will be provided exclusively through the tax filing process, and not by the Exchange. These exemptions necessitate information that will only be available at the time of tax filing, such that if they were exclusively available through the Exchange, an individual would need to file a tax return, request an exemption from the Exchange, receive a determination from the Exchange, and depending on the determination, potentially amend his or her return. Accordingly, to streamline the process for consumers, we grant limited authority to the IRS to administer these two hardship exemptions. We note that we will continue to consider the administrative feasibility of Exchanges granting the hardship exemption under § 155.605(g)(5) after the conclusion of the first year of operations.

Comment: Commenters expressed broad support for our proposal at § 155.605(g)(4) to provide a hardship exemption for individuals ineligible for Medicaid in states that chose not to expand Medicaid under the Affordable Care Act, but expressed differing opinions regarding whether such a hardship exemption should be limited to those individuals who are not determined eligible for advance payments of the premium tax credit. Some commenters supported the policy as proposed based on affordability concerns even for those individuals eligible for advance payments of the premium tax credit, while others suggested that the individuals who are eligible for advance payments of the premium tax credit should not be eligible to receive a hardship exemption.

Response: We appreciate the concerns raised by commenters arguing both for and against maintaining this hardship exemption as proposed. We continue to believe that it is appropriate that individuals, even those eligible for advance payments of the premium tax credit, to be eligible for this hardship exemption if ineligible for Medicaid solely as a result of a state that chose not to expand Medicaid eligibility under the Affordable Care Act. We expect that these exemptions will be provided through the eligibility process for coverage, and note that notwithstanding receiving a hardship exemption, such individuals may still decide to enroll in a QHP and receive advance payments of the premium tax credit in this situation. We also note that these exemptions will be available retrospectively following the close of a coverage year.

Comment: Several commenters expressed general support for § 155.605(g)(2), which provides a hardship exemption based on projected annual household income. However, some commenters believed that this still did not fully address the consequences of 26 CFR 1.36B-2(c)(3)(v)(A)(2) concerning the affordability of an eligible employer-sponsored plan for a related individual. One commenter requested clarification as to whether this hardship exemption applied to the individual or the entire tax filing unit. Another commenter did not support limiting the availability of this hardship exemption only within open enrollment periods.

Response: We note that while the lack of affordable coverage based on projected income hardship exemption and the lack of affordable coverage exemption described in section 5000A(e)(1) of the Code address certain situations where a related individual is ineligible for advance payments of the premium tax credit based on 26 CFR 1.36B-2(c)(3)(v)(A)(2), these provisions are not intended to provide an exemption in all cases in which an individual may be ineligible for advance payments of the premium tax credit.

We finalize this exemption to generally follow the standards in section 5000A(e)(1) of the Code. As in the proposed rule, we specify in paragraph (g)(2)(i) of the final rule that this exemption differs from the exemption described in section 5000A(e)(1) of the Code in that it relies on projected household income. In order to facilitate implementation of this exemption, we add paragraphs (g)(2)(ii), (iii), and (iv) to clarify the applicable standards. First, in paragraph (g)(2)(ii), we clarify that as described above, the Exchange will only consider the affordability of an eligible

employer-sponsored plan for this exemption if it meets the minimum value standard. Second, in paragraph (g)(2)(iii), we describe how the Exchange will determine the cost of coverage for an individual who is eligible to purchase coverage under an eligible employer-sponsored plan.

We note that, under the Treasury proposed rule, the standards for determining the required contribution for coverage through an eligible employer-sponsored plan vary depending on whether an individual is an employee eligible to purchase coverage under an eligible employer-sponsored plan through the employee's employer, or is eligible to purchase coverage under an eligible employer-sponsored plan because of a relationship to an employee, with respect to eligibility for an exemption. For an individual employee who is eligible through his or her own employer, the affordability calculation is based on the lowest cost option for self-only coverage. For all other individuals eligible to purchase coverage under an eligible employer-sponsored plan, the required contribution is the portion of the annual premium that the employee would pay for the lowest cost option for family coverage that would cover the employee and all individuals who are included in the employee's family and are not otherwise exempt. We note that the Exchange will only know whether an individual within the employee's family has been granted an exemption by that Exchange. Accordingly, we specify in paragraph (g)(2)(iii)(C) that the Exchange will consider the lowest cost family coverage that meets the minimum value standard and would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

We also note that proposed 26 CFR 1.36B-2(c)(3)(v)(A)(4) (78 FR 25914), provides that for purposes of determining eligibility for the premium tax credit, the affordability of coverage in an eligible employer-sponsored plan is determined by assuming that each employee satisfies the requirements of available nondiscriminatory wellness programs related to tobacco use, and does not satisfy the requirements of any available wellness programs that are not related to tobacco use. That is, if a plan includes a nondiscriminatory wellness program for tobacco users, such as smoking cessation classes, the affordability of coverage under that plan will be determined based on the premium that is charged to tobacco

users who complete this program. In the preamble to proposed 26 CFR 1.36B–2(c)(3)(v)(4) (78 FR 25911), Treasury also noted that it expects to specify that this treatment of nondiscriminatory wellness programs will also be used in determining the required contribution for purposes of the lack of affordable coverage exemption under section 5000A(e)(1) of the Code.

Accordingly, in order to ensure that an individual is not liable for the shared responsibility payment if he or she is ineligible for advance payments of the premium tax credit and cost-sharing reductions as a result of a finding by the Exchange that he or she is eligible for qualifying coverage in an eligible employer-sponsored plan based on incorporating the completion of a tobacco-related wellness program, we specify in paragraph (g)(2)(iii)(A) that the Exchange will determine eligibility for the exemption specified in paragraph (g)(2) for an individual who uses tobacco without incorporating any discount resulting from the completion of a wellness program designed to prevent or reduce tobacco use. We also specify in paragraph (g)(2)(iii)(B) that discounts from wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned.

In paragraph (g)(2)(iv), we clarify that in the case of an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, or only eligible to purchase coverage under an eligible employer-sponsored plan that does not meet the minimum value standard, the Exchange will determine the required contribution for coverage in accordance with section 5000A(e)(1)(B)(ii) of the Code, inclusive of all members of the individual's family who have not otherwise been granted an exemption through the Exchange, and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan that meets the minimum value standard. This determination is based on the premium for the single lowest cost bronze plan available, less any credit allowable under section 36B of the Code, in the individual market through the Exchange serving the rating area in which the individual resides.

Furthermore, we clarify that in finalizing this provision, we specify in paragraphs (g)(2)(v) and (g)(2)(vi) that this exemption will be available throughout the calendar year prospectively for a month or months until the last date on which an individual could enroll in a QHP through the calendar year for which the exemption is requested. This refers not

only to the open enrollment period, but to any special enrollment period, notwithstanding special effective dates, for which an individual may potentially be determined eligible during the calendar year under 45 CFR 155.420(b). As such, an individual may be determined eligible for this exemption for the remaining month or months of a calendar year as late as November of that calendar year, as the effective dates for a special enrollment period under § 155.420(b) would still allow such an individual to enroll in a QHP by December of that calendar year. Lastly, in order to reduce administrative burden, we also specify in paragraph (g)(2)(vi) that an exemption in this category will be provided for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

Comment: Some commenters wanted to ensure that Exchanges would provide clear and easily understandable information to explain different exemptions available to individuals, including the steps needed to apply for an exemption.

Response: We recognize the need for consumer information that explains the available exemptions as well as the necessary documentation and steps needed for individuals to apply. We expect to work with states and other stakeholders to ensure that individuals are properly educated about the exemption eligibility process.

Comment: One commenter wanted to ensure that the Exchange would issue a certificate of exemption to any individual who is qualified and not limit the availability of certificates to only those individuals who are seeking coverage through the Exchange.

Response: We agree with the commenter that the Exchange will not limit certificates of exemption to individuals who are seeking coverage through the Exchange. We note that a hardship exemption will allow an individual to enroll in a catastrophic plan, both inside and outside the Exchange, and the Exchange may not limit the availability of an exemption contingent on an individual seeking coverage through the Exchange or elsewhere. Further, while a portion of the eligibility process for the hardship exemption proposed in § 155.605(g)(4) for individuals who are determined ineligible for Medicaid based on a state's choice not to expand Medicaid eligibility under the Affordable Care Act relies on the eligibility process for Medicaid, proposed § 155.610(a) specifies that the Exchange will generally use a separate application for

exemptions. We finalize this provision as proposed.

Comment: One commenter was supportive of HHS' decision not to specify that the Exchange would grant the exemption specified in section 5000A(d)(3) of the Code for individuals who are not lawfully present, but also recommended clear guidance and instructions regarding individuals who nevertheless attempt to apply for this exemption through the Exchange to ensure that the Exchange will follow the appropriate privacy and confidentiality protections, and also to direct individuals to claim this exemption through the tax filing process.

Response: We note that the privacy and confidentiality protections in 45 CFR 155.260 apply to the exemption eligibility process, and are sufficient to address these concerns. Furthermore, we expect that the Exchange will provide clear guidance regarding the exemptions available through the Exchange as well as the exemptions that can be claimed solely through the tax filing process, in order to appropriately direct individuals.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.605 of the proposed rule with the following modifications: We make technical corrections in paragraphs (c) through (g) for the purpose of clarity to specify when the Exchange must make different exemptions available, whether prospectively or retrospectively. In paragraph (c)(2) concerning the duration of the exemption for religious conscience, we specify that an exemption in this category will be provided on a continuing basis until the month after the month of the individual's 21st birthday, and as such if an Exchange granted such an individual an exemption prior to the age of 21, would have to send the applicant a notice at that point to remind him or her to submit a new application to maintain the certificate of exemption. We make revisions throughout paragraph (g) to specify which hardship exemptions must be granted by the Exchange, and which can be claimed only through the tax filing process. We clarify that an Exchange will determine an applicant eligible for an exemption under paragraph (g)(1) of this section for the month before, a month or months during which they experience the circumstances that qualify as a hardship, and the month after. We make a technical correction in paragraph (g)(1)(i) to clarify that the financial or domestic circumstances caused a significant and unexpected increase in

essential expenses that prevented the individual from obtaining coverage under a QHP. We make a technical correction in paragraphs (g)(1)(ii) to replace “minimum essential coverage” with “qualified health plan” to align with the statutory language describing the hardship exemption, and modify paragraph (g)(1)(iii) to clarify that Exchange will determine an individual eligible for a hardship exemption if he or she experienced circumstances that prevented him or her from obtaining coverage under a QHP in accordance with the statute.

We add paragraph (g)(2)(ii) to clarify that the Exchange will only consider the affordability of an eligible employer-sponsored plan for the exemption described in paragraph (g)(2) if the eligible employer-sponsored plan meets the minimum value standard. We add paragraph (g)(2)(iii) to clarify the applicable standards if an individual is eligible for coverage through an eligible employer-sponsored plan that meets the minimum value standard, and note in paragraph (g)(2)(iii)(A) that an individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan, and in paragraph (g)(2)(iii)(B) that discounts from wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned. That is, for purposes of this exemption, the cost of an eligible employer-sponsored plan that includes a premium differential for smokers and non-smokers is calculated using the non-smoker premium for non-smokers, and the smoker premium for smokers, without any discounts that may be available through smoking cessation programs. We outline the appropriate methods to determine the required contribution for coverage through an eligible employer-sponsored plan that meets the minimum value standard in paragraphs (g)(2)(iii)(C) and (D), depending on whether an individual is an employee eligible to purchase coverage under an eligible employer-sponsored plan through the employee's employer, or is eligible to purchase coverage under an eligible employer-sponsored plan by reason of a relationship to an employee. We specify in paragraph (g)(2)(iii)(D) that the Exchange will consider the lowest cost family coverage that meets the minimum value standard that would cover the employee and all other individuals who are included in the employee's family who have not

otherwise been granted an exemption through the Exchange. We specify in paragraph (g)(2)(iv) that the Exchange will determine the required contribution for coverage in the individual market in the case of an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan in accordance with section 5000A(e)(1)(B)(i) of the Code, or eligible only to purchase coverage under an eligible employer-sponsored plan that does not meet the minimum value standard, inclusive of all members of the individual's family who have not otherwise been granted an exemption through the Exchange, or are treated as eligible to purchase coverage under an eligible employer-sponsored plan that meets the minimum value standard. We also clarify in paragraphs (g)(2)(v) and (g)(2)(vi) that this exemption will be available throughout the calendar year prospectively for a month or months until the last date on which an individual could enroll in a QHP through the calendar year for which the exemption is requested, and that the Exchange will provide an exemption in this category for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

We clarify that the Exchange may not grant the hardship exemptions under paragraph (g)(3) and (5) of this section, but rather only the IRS will allow an applicant to claim these exemptions. We add paragraph (g)(6) to provide that an Exchange will determine an applicant eligible for a hardship exemption for any month for which he or she is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.50, or an individual eligible for services through the Indian Health Service in accordance with 25 U.S.C. 1680c(a), (b), or (d)(3). We clarify that the duration for the exemption provided under paragraph (g)(6) of this section is the same as specified in paragraph (f)(2) of this section.

c. Eligibility Process for Exemptions (§ 155.610)

In § 155.610, we proposed the process by which the Exchange would determine an applicant's eligibility for exemptions. In paragraph (a), we proposed to specify that the Exchange would use an application established by HHS in order to collect the information necessary to determine eligibility and grant a certificate of exemption for an applicant, unless the Exchange receives approval to use an alternative application. We also clarified that in cases in which relevant information has already been collected through the

eligibility process for enrollment in a QHP and for insurance affordability programs, the Exchange would use this information for the purpose of eligibility for an exemption to the maximum extent possible.

In paragraph (b), we proposed that the Exchange may seek approval from HHS for an alternative application. We further specified that such alternative application must only request the minimum information necessary for the purposes identified in paragraph (a) of this section.

In noting that there are exemptions that share common data and verifications with the eligibility process for enrollment in a QHP and for insurance affordability programs, in paragraph (c) we proposed that if an individual submits the application in 45 CFR 155.405 and then requests an exemption, the Exchange would use the information collected on the application for coverage and not duplicate any verification processes that share the standards specified in this subpart. We solicited comments on how best to coordinate these processes to ensure maximum administrative simplicity for all involved parties.

In paragraph (d), we proposed the Exchange would accept the application for an exemption from an application filer, and provide tools for the submission of an application. We did not specify particular channels for application acceptance, but we solicited comments regarding whether we should specify some or all of the channels included in 45 CFR 155.405.

In paragraph (e), we proposed that the Exchange would specify that an applicant who has a social security number (SSN) will provide such number to the Exchange in order to coordinate information in the tax filing process and provide the Exchange with additional information with which to ensure program integrity. However, we proposed to clarify in paragraphs (e)(2) and (e)(3) that the Exchange may not require an individual who is not seeking an exemption for him or herself to provide a SSN, except that the Exchange would require an application filer to provide the SSN for a non-applicant tax filer only if the applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized to verify household income and family size for a hardship exemption. We solicited comments on the applicability of this provision in the context of the exemption eligibility process.

In paragraph (f), we proposed that the Exchange would grant a certificate of exemption to any applicant determined

eligible in accordance with the standards for exemptions provided in § 155.605.

In paragraph (g)(1), we proposed that the Exchange determine eligibility for exemptions promptly and without undue delay, which is the same timing threshold used throughout subpart D of this part, including in 45 CFR 155.310(e)(1), with respect to eligibility determinations for enrollment in a QHP and for insurance affordability programs. In paragraph (g)(2), we proposed that the assessment of timeliness of eligibility determinations by the Exchange is based on the period from the date of the application until the date on which the Exchange notifies the applicant of its decision. We solicited comments regarding specific performance standards for the eligibility process described in this subpart, and whether we should define an outer bound in which an eligibility determination will be made.

In paragraph (h), we proposed to clarify that except for the exemptions for religious conscience and membership in an Indian tribe proposed in § 155.605(c) and § 155.605(f), respectively, after December 31 of a given calendar year, the Exchange will not accept an application for an exemption for months for such calendar year. We intended to specify that this provision also apply to the hardship exemption under § 155.605(g), but inadvertently did not include such language in the text of the regulation. We solicited comments regarding this approach, and whether there should be additional categories of exemptions for which the Exchange would grant exemptions after the close of a calendar year.

In paragraph (i), we proposed that the Exchange provide timely written notice to an applicant of any eligibility determination for an exemption made in accordance with this subpart, which could be provided through electronic means, consistent with § 155.230(d).

In paragraph (j), we proposed that an individual who has been certified by an Exchange as qualifying for an exemption retain the records that demonstrate not only receipt of the certificate of exemption but also qualification for the underlying exemption. We noted that to the extent that the Exchange provides a certificate of exemption for which the underlying verification is based in part on the special circumstances exception proposed in § 155.615(h), an individual would retain records that demonstrate receipt of the certificate of exemption, as well as the circumstances that warranted the use of the special circumstances exception.

Comment: Commenters were generally supportive of our proposals throughout this section. One commenter suggested that HHS codify the preamble language specifying that individuals could apply for multiple exemptions simultaneously. Another commenter sought clearer standards regarding the eligibility process for exemptions in order to limit administrative burden.

Response: We believe that the language proposed in this section provides the appropriate amount of detail to guide the Exchange in establishing an efficient process for exemptions, while also allowing for the Exchange to have the necessary flexibility to administer these processes effectively. We clarify that while we believe individuals will benefit from the opportunity to seek multiple exemptions simultaneously, we feel that the existing regulation text is sufficient, and so are finalizing it as proposed.

Comment: One commenter recommended that HHS revise the language in § 155.610(a) to clarify that except as specified, the Exchange must use an application established by HHS to collect only the information that is “strictly” necessary for determining eligibility for an exemption. Another commenter wanted HHS to cross-reference to § 155.260 so that information collected on the exemption application was subject to the appropriate security and privacy protections.

Response: We share the commenter’s concern regarding Exchanges using an exemptions application that minimizes the information individuals must provide to receive an eligibility determination for an exemption, and is subject to robust privacy and security protections. We believe that the comment regarding limiting requests for information to only what is necessary is addressed in proposed § 155.615(j), which limits the ability of the Exchange to require the provision of information by an applicant to support the eligibility process for exemptions to the minimum necessary, and is finalized as proposed. We also note that § 155.260(a) already includes language specifying that the provisions of § 155.260 apply to the exemptions process. Accordingly, we are not including additional language in this final regulation.

Comment: Commenters made several suggestions with the goal of enhancing the efficiency of the coverage and exemptions application processes. Several commenters supported our proposals to re-use information from the coverage application for the purposes of exemptions eligibility determinations when possible in order to prevent

collecting duplicate information. One commenter recommended combining the coverage application and exemptions application in order to streamline the eligibility determination process for both enrollment in a QHP and exemptions, reduce burden on individuals and Exchanges, and inform an applicant of all potential coverage or exemptions options based on his or her particular circumstances.

Response: As noted in our proposed rule, we continue to believe that where possible, individuals who apply for coverage should not have to provide duplicate information to the Exchange if they subsequently decide to apply for an exemption. We also believe that it is important to have separate applications for coverage and exemptions to avoid creating burden on those individuals who are only seeking coverage or exemptions. Accordingly, we are finalizing these provisions as proposed.

Comment: One commenter viewed the language in § 155.610(c) regarding the reuse of information collected through the eligibility process for enrollment in a QHP through the Exchange and for insurance affordability programs as confusing, and recommended the phrase “that adhere to the standards specified in this subpart” be eliminated.

Response: We are modifying this language to clarify that when an Exchange has verified information through the eligibility process for enrollment in a QHP through the Exchange and for insurance affordability programs, and such verifications occur in accordance with the standards specified in this subpart, the Exchange may not repeat the verification for purposes of determining eligibility for an exemption. For example, we note that the verification procedures for the exemption for members of an Indian tribe cross-references the verification procedures in subpart D of this part; accordingly, if the Exchange verified that an individual meets the standards through the eligibility process for enrollment in a QHP and for insurance affordability programs, and such an individual subsequently requests an exemption based on membership in an Indian tribe, the Exchange will not repeat the verification.

Comment: Commenters urged that the Exchange allow individuals to apply for an exemption via the same channels as the coverage application, including online, by telephone, by mail, and in person. One commenter raised particular concerns in terms of allowing individuals to have the full range of options to apply for a religious conscience exemption.

Response: We are committed to providing an efficient and consumer-friendly application process for exemptions. In § 155.610(d)(3), we specify that for applications submitted before October 15, 2014, the Exchange must, at a minimum, accept such applications in paper, via mail. We believe that this will ensure the availability of an effective process within the time constraints that the Exchange is facing for implementation, while allowing for state flexibility to utilize other channels sooner than October 15, 2014. We intend to discuss the availability of applications through other channels beginning on or after October 15, 2014 in a future regulation.

Comment: Several commenters appreciated HHS' proposal in § 155.610(e)(2) that the Exchange may not require an individual who is seeking an exemption on behalf of someone else other than himself or herself to provide a SSN. However, another commenter expressed concerns that the broad language used here would prevent the collection of a SSN who are not seeking an exemption, but rather are applying for enrollment in a QHP.

Response: We appreciate the commenter's concerns, and note that § 155.610(e)(2) only applies to subpart G regarding eligibility determinations for exemptions, whereas 45 CFR 155.310(a)(3) provides the standards for collecting Social Security numbers as part of the eligibility process for enrollment in a QHP through the Exchange and for insurance affordability programs. Accordingly, we are finalizing the language as proposed.

Comment: Several commenters were generally supportive of HHS specifying that Exchanges determine individuals eligible for an exemption "promptly and without undue delay," but also raised concerns about the lack of clear timeliness standards proposed at § 155.605(g). One commenter noted that due to the lack of specificity, an applicant for an exemption should not be considered uninsured for the time it takes to evaluate whether he or she is qualified for an exemption. Other commenters urged HHS to set more clear timeliness standards. Another commenter suggested that HHS specify that Exchanges will grant an exemption in real time when all documentation is available electronically, and where an applicant must submit paper documentation, suggested specific timeliness standards. A commenter recommended that HHS more clearly specify the meaning of the "date of the application" in terms of the procedures that Exchanges will use to log or stamp an application date, and wanted to

ensure that the date of the application would be based on when an individual submitted the application regardless of when it is received by the Exchange. The commenter also wanted to make sure an individual receives the appropriate notice and appeals rights if the Exchange fails to promptly determine eligibility.

Response: We drafted this provision based on the timeliness standards for the coverage process and believe that the current language is appropriate. Accordingly, we are finalizing this provision as proposed. We are also finalizing proposed paragraph (g)(2), which specifies that the Exchange will assess the timeliness of eligibility determinations. As with the coverage process, we intend to work closely with Exchanges to monitor timeliness and identify opportunities to improve performance. We note that HHS does not have authority to determine whether an individual is liable for the shared responsibility payment, as such authority belongs to the Internal Revenue Service. Comments addressing the appeals process will be discussed in a future regulation.

Comment: One commenter noticed a discrepancy between the preamble associated with § 155.610(h) and the corresponding regulation text, whereby the preamble mentioned that after December 31 of a given calendar year, the Exchange will not accept an application for an exemption except for the exemptions described in § 155.605(c) (religious conscience) and (g) (hardship), but the regulation text referenced § 155.605(c) and (f) (membership in an Indian tribe). Another commenter noted that the preamble language associated with this provision only allows an individual to receive an exemption retrospectively through the Exchange until an individual could file an income tax return, and asked whether HHS intended to limit this to the regular tax filing due date or to a potentially later date if a taxpayer applies for an extension or amends a previously filed return. If HHS intended to limit this to the regular tax filing date, the commenter asked that HHS modify this provision to clarify that the Exchange will provide a retrospective exemption for a calendar year up to the extended filing date or amended filing date for such year, should a taxpayer request an extension or amend a return.

Response: We believe that it is appropriate to provide exemptions based on religious conscience and membership in a federally-recognized Indian tribe retrospectively, without a time limit for filing. We note that as a

result of a drafting oversight, we did not include a reference to the hardship exemption in the regulation text to specify that this should also be treated differently than under the general rule, and we correct this in the final regulation. We also provide for further special treatment for hardship exemptions; specifically, that the Exchange will only accept an application for the hardship exemption under paragraph § 155.605(g)(1) for a month or months during a calendar year when the application is filed during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred. We believe that the circumstances of a hardship exemption will motivate an individual to seek such an exemption in a timely manner, and also recognize the need to balance the availability of this exemption for an individual who amends his or her tax return with the administrative burden associated with processing requests for prior years. We further note that section 6511 of the Code provides the period of limitations on filing a claim for refund or credit with the IRS. A taxpayer generally must file an amended tax return by the later of three years from the filing of the original tax return or two years from the time the tax was paid. Taxpayers need to file amended returns within these timeframes to ensure the receipt of a refund of the shared responsibility payment for a prior year through the IRS, even though the Exchange may appropriately grant a hardship exemption anytime during the period specified in § 155.605(g)(1). We maintain the general rule regarding exemptions for incarcerated individuals and individuals who are members of a health care sharing ministry, since these will also be available through the tax filing process, which should facilitate access to these exemptions in the case of amended returns.

Comment: Based on HHS' proposal to allow individuals to apply for multiple exemptions, one commenter worried about the potential that individuals would be confused if receiving multiple notices as a result. The commenter requested that once an exemption is granted for a period, HHS specify that the Exchange would not provide a notice regarding any further exemptions for which an individual applied for the same time period. The commenter suggested that an individual should only receive a denial notice for a month or months where he or she does not already have a certificate of exemption in effect.

Response: We share the commenter's concerns regarding limiting potential

confusion for a consumer who applies for multiple exemptions simultaneously. Accordingly, we clarify that in a situation in which an individual applies for multiple exemptions, we expect the Exchange will provide the appropriate notice regarding each exemption for which an individual applied, as we believe that not providing feedback for all requested exemptions could create additional confusion for consumers. We also expect that if an applicant is approved for an exemption, and then is later denied for a different exemption for the same period of time, the notice describing the denial will clearly state that the applicant's prior exemption remains in effect.

Comment: Regarding the proposed recordkeeping provision at § 155.610(j), commenters expressed concern that an individual might think he or she only needs to retain the exemption certificate, and not records that demonstrate his or her qualification for the underlying exemption, and recommended that HHS specify that the Exchange notify individuals of their obligation to retain the underlying records as well. Another commenter recommended deleting this paragraph from the regulation, as they felt the responsibility should rest on the IRS as opposed to the Exchange.

Response: We agree with the commenters' suggestion to clarify that the Exchange will notify individuals to retain both the certificate of exemption as well as records that demonstrate the underlying qualification for the exemption. We are maintaining this paragraph with that clarification in the final regulation, since the Exchange is providing the certificate of exemption and is thus ideally positioned to notify individuals of this issue.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.610 of the proposed rule with a few slight modifications: We clarify that the Exchange must use information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination to the extent that the Exchange finds that such information is still applicable. In § 155.610(d)(3), we specify that until October 15, 2014, the Exchange must, at a minimum, permit an individual to apply for an exemption via mail, using a paper application. We correct the oversight in paragraph § 155.610(h) by providing that an applicable exemption that is available retrospectively and described in § 155.605(g) can also be

provided for previous tax years based on an application that is submitted after December 31 of a given calendar year, except for § 155.605(g)(1), which may only be provided during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred. Due to the range of hardship exemptions available, we redesignate paragraph (h) as paragraph (h)(1), make a technical correction for clarity in paragraph (h)(1), and add paragraph (h)(2) to specify that the Exchange will only accept an application for a hardship exemption specified in § 155.605(g)(1) for a month or months during a calendar year when the application is filed during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred. We also modify paragraph (j)(1) to specify that an Exchange will also notify an individual who is determined eligible for an exemption to retain the certificate of exemption, and also records demonstrating his or her qualification for the underlying exemption.

d. Verification Process Related to Eligibility For Exemptions (§ 155.615)

In this section, we proposed language regarding the verification process related to eligibility for exemptions. These processes were designed not only to minimize the burden on applicants, but also to serve a valuable program integrity function in order to assure that applicants are only deemed eligible for exemptions if they meet the standards specified in § 155.605.

In paragraph (a), we proposed that unless HHS grants a request for modification under paragraph (i) of this section, the Exchange will verify or obtain information as provided in this section in order to determine that the applicant is eligible for an exemption.

In paragraph (b), we proposed the verification process concerning the exemption for religious conscience. We specified that for any applicant requesting this exemption, the Exchange will verify that he or she meets the standards as outlined in § 155.605(c). First, in paragraph (b)(1), we proposed that except as specified in paragraph (b)(2) of this section, the Exchange will accept a Form 4029 that reflects that an applicant has been approved for an exemption from Social Security and Medicare taxes under section 1402(g)(1) of the Code by the IRS. Second, in paragraph (b)(2), we proposed that except as specified in paragraphs (b)(3) and (4) of this section, the Exchange will accept an applicant's attestation that he or she is a member of a recognized religious sect or division

described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division. Next, the Exchange will verify that the religious sect or division to which the applicant attests membership is recognized by SSA as a religious sect or division under section 1402(g)(1) of the Code.

Third, in paragraph (b)(3), we proposed that if the information provided by an applicant regarding his or her membership in a recognized religious sect or division is not reasonably compatible with other information provided by the individual or the records of the Exchange, the Exchange will follow the procedures specified in paragraph (g) of this section concerning situations in which the Exchange is unable to verify information.

Fourth, in paragraph (b)(4), we proposed that if an applicant attests to membership in a religious sect or division that is not recognized by SSA as a religious sect or division under section 1402(g)(1) of the Code, the Exchange must provide the applicant with information regarding how his or her religious sect or division can pursue recognition under section 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as the Exchange obtains information indicating that the religious sect or division has been approved.

In paragraph (c), we proposed the verification process concerning the exemption for membership in a health care sharing ministry. We specified that for any applicant requesting this exemption, the Exchange will verify whether he or she meets the standards in § 155.605(d). First, in paragraph (c)(1), we proposed that except as specified in paragraphs (c)(2) and (3) of this section, the Exchange will first accept an attestation from an applicant that he or she is a member of a health care sharing ministry. Next, we proposed that the Exchange will verify that the health care sharing ministry to which the applicant attests membership is known to the Exchange as a health care sharing ministry, based on a list that would be developed by HHS based on outreach to health care sharing ministries, which HHS would then make available to Exchanges.

In paragraph (c)(2), we proposed that if the information provided by an applicant regarding his or her membership in a health care sharing ministry is not reasonably compatible with other information provided by the individual or the records of the Exchange, the Exchange will follow the procedures specified in paragraph (g) of

this section concerning situations in which the Exchange is unable to verify information.

In paragraph (c)(3), we proposed that if an applicant attests to membership in a health care sharing ministry that is unknown to the Exchange as a health care sharing ministry according to the standards in § 155.605(d), the Exchange will then notify HHS and not determine an applicant eligible or ineligible for this exemption until HHS informs the Exchange regarding the attested health care sharing ministry's status with respect to the standards specified in 26 CFR 1.5000A-3(b) of the Treasury proposed rule.

In paragraph (d), we proposed the verification process concerning the exemption for incarceration. We specified that for any applicant requesting this exemption, the Exchange will verify, through the process described in 45 CFR 155.315(e), that he or she was incarcerated. In paragraph (d)(2), we proposed that if the Exchange is unable to verify an applicant's incarceration status through the verification process outlined, the Exchange will follow the procedures in paragraph (g) of this section concerning situations in which the Exchange is unable to verify information.

In paragraph (e), we proposed the verification process concerning the exemption for members of Indian tribes. We specified in paragraph (e)(1) that for any applicant requesting this exemption, the Exchange will verify his or her membership in an Indian tribe through the process outlined in 45 CFR 155.350(c). In paragraph (e)(2), we also proposed that the Exchange follow the procedures specified in paragraph (g) of this section if it is unable to verify an applicant's tribal membership.

In paragraph (f), we proposed the verification process concerning exemptions for hardship. In paragraph (f)(2), we proposed that for an applicant applying for a hardship exemption prospectively based on an inability to afford coverage, as described in § 155.605(g)(2), the Exchange use procedures established under subpart D of this part to verify the availability of affordable coverage through the Exchange based on projected income and eligibility for advance payments of the premium tax credit, as specified in subpart D of this part, which involves verifying several attestations by the applicant, including an attestation related to citizenship, as well as the procedures described in § 155.320(e) to verify eligibility for qualifying coverage in an eligible employer-sponsored plan. We solicited comments regarding appropriate verification procedures for

other categories of hardship that will ensure a high degree of program integrity while minimizing administrative burden.

In paragraph (g), we proposed procedures for the Exchange to follow in the event the Exchange is unable to verify information necessary to make an eligibility determination for an exemption, including situations in which an applicant's attestation is not reasonably compatible with information in electronic data sources or other information in the records of the Exchange, or when electronic data are required but unavailable. These procedures mirror those provided in § 155.315(f), with modifications to preclude eligibility pending the outcome of the verification process, made in accordance with the Secretary's authority under section 1411 of the Affordable Care Act.

First, under paragraph (g)(1), we proposed that the Exchange will make a reasonable effort to identify and address the causes of the issue, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer. Second, in paragraph (g)(2)(i), we proposed that if the Exchange is unable to resolve the issue, the Exchange will notify the applicant of the issue. After providing this notice, in paragraph (g)(2)(ii), we proposed that the Exchange will provide 30 days from the date on which the notice is sent for the applicant to present satisfactory documentary evidence via the channels available for the submission of an application, except by telephone, or otherwise resolve the issues. In paragraph (g)(3), we proposed that the Exchange may extend the period for an applicant to resolve the issue if the applicant can provide evidence that a good faith effort has been made to obtain the necessary documentation. And in paragraph (g)(4), we proposed that the Exchange will not grant a certificate of exemption during this period based on the information that is the subject of the request under this paragraph.

In paragraph (g)(5), we proposed that, if after the conclusion of the period described in paragraph (g)(2)(ii) of this section, the Exchange is unable to verify the applicant's attestation, the Exchange will determine the applicant's eligibility based on the information available from the data sources specified in this subpart, as applicable, unless such applicant qualifies for the exception provided under paragraph (h) of this section, and notify the applicant in accordance with the procedures

described under § 155.610(i), including the inability to verify the applicant's attestation.

In paragraph (h), we proposed a provision under which the Exchange would provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available to account for situations in which documentation cannot be obtained.

In paragraph (i), we proposed that HHS have the flexibility to approve an Exchange Blueprint or a significant change to an Exchange Blueprint to modify the methods for the collection and verification of information as described in this subpart, as well as the specific information to be collected, based on a finding by HHS that the requested modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that any applicable requirements under 45 CFR 155.260, 45 CFR 155.270, paragraph (j) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

In paragraph (j), we proposed that the Exchange will not require an applicant to provide information beyond what is necessary to support the process of the Exchange for eligibility determinations for exemptions, including the process for resolving inconsistencies described in paragraph (g) of this section.

Comment: One commenter raised broad concerns about potential challenges for consumers regarding verification, and requested that HHS specify a 1-year transition period during which the Exchange would rely primarily on self-attestation, using a form signed under penalty of perjury, or auditing a portion of applications submitted by individuals.

Response: We share the commenter's desire for a good consumer experience for those individuals who are seeking an exemption. However, we believe that statutory and program integrity concerns argue in favor of the Exchange applying a more comprehensive verification process than self-attestation. We expect to learn from the initial months and years of operations, and to work with states to achieve continuous improvement, with a particular focus on the consumer experience.

Comment: One commenter recommended that a taxpayer who already has an approved IRS Form 4029 should not have to request an exemption through the Exchange, and instead should be able to write "Exempt Form 4029" on his or her tax return.

Response: We strive to establish an Exchange exemption process that minimizes the burden on individuals to the extent possible. We note that section 5000A(d)(2) of the Code specifies that the religious conscience exemption is available only through the Exchange. However, we note that we are finalizing proposed § 155.615(b)(1), which specifies that the verification process for this exemption will include the Exchange accepting an approved IRS Form 4029 for any individual who has one.

Comment: One commenter recommended that in situations in which the health care sharing ministry to which an individual attests membership is not included on the list provided to the Exchange by HHS, HHS should issue the eligibility determination notice denying the exemption as opposed to the Exchange.

Response: If an Exchange accepts the original exemption application from an individual, we continue to believe that it is appropriate for the Exchange to issue the corresponding eligibility determination notice in order to prevent confusion that individuals may experience if receiving a separate notice from HHS. We note that nothing precludes an Exchange from notifying such an individual that the determination is based on a list provided by HHS.

Comment: One commenter requested further specificity about the process and standards HHS will use in developing the list of health care sharing ministries that meet the standards specified in the statute.

Response: We recognize the importance of providing a clear process for establishing the list of health care sharing ministries that meet the statutory standards. Accordingly, we are renumbering proposed § 155.615(c) as § 155.615(c)(1)(i) through (iii), and adding § 155.615(c)(2) to specify a process that is substantially similar to the approach discussed in § 155.604(c) regarding how HHS will determine that certain types of coverage meet the substantive and procedural requirements for consideration as minimum essential coverage. Specifically, we note that to be considered a health care sharing ministry for the purposes of this subpart, an organization will submit information to HHS that substantiates the organization's compliance with the standards specified in section 5000A(d)(2)(B)(ii) of the Code. We also note that if at any time HHS determines that an organization previously considered a health care sharing ministry for the purposes of this subpart

no longer meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code, HHS may revoke its earlier decision. This revocation refers to the status of the health care sharing ministry, and not to the status of an individual's exemption related to membership in a health care sharing ministry. As such, while the Exchange would not grant an exemption to an individual attesting membership in such a health care sharing ministry after revoking its status, the Exchange would not revoke a prior exemption granted to an individual based on the status of a health care sharing ministry. We discuss this information collection in the Information Collection Requirements section of this final rule.

We also clarify in paragraph (c)(1)(iii) that if an applicant attests to membership in a health care sharing ministry that is not known to the Exchange as a health care sharing ministry based on information provided by HHS, the Exchange must provide the applicant with information regarding how an organization can pursue recognition under § 155.615(c)(2), and determine the applicant ineligible for this exemption until such time as HHS notifies the Exchange that the health care sharing ministry's meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code. We note that individual members cannot seek recognition under § 155.615(c)(2) on behalf of their health care sharing ministry, as HHS will only review information submitted by the health care sharing ministry itself.

Comment: One commenter urged HHS to remove the reference to reasonable compatibility as part of verifying membership in a health care sharing ministry, or to clarify that an individual could still receive an exemption based on membership in a health care sharing ministry if he or she had been enrolled in health insurance in the past or was currently enrolled in health insurance.

Response: In response to the commenter, we will clarify that the Exchange will not consider an individual's current or previous health coverage as reasonably incompatible with membership in a health care sharing ministry, since nothing in the statute limits the availability of such an exemption to an individual who was or is uninsured.

Comment: One commenter suggested that for purposes of the Federally-Facilitated Exchange, HHS work with local tribes and the Bureau of Indian Affairs to contract for the verification of membership in an Indian tribe.

Response: We appreciate this comment, and are committed to creating

an efficient eligibility process for all applicants. In proposed § 155.615(e), we specified that the Exchange would use the same verification process that is used for the verification of Indian status for purposes of special cost-sharing provisions and special enrollment periods for enrollment in a QHP through the Exchange. The cross-referenced section allows an Exchange to rely on any electronic data sources that have been approved by HHS for this purpose, including electronic data acquired from tribes. Based on the short timeline for implementation, for October 1, 2013, the Federally-facilitated Exchange will be unable to collect data from individual tribes, and so will rely on a paper documentation process. State-based Exchanges may have additional opportunities for October 1, 2013.

Comment: One commenter recommended that HHS should specify that an individual renew an exemption based on membership in an Indian tribe on an annual basis. Other commenters urged HHS to use electronic data matching with the Indian Health Service (IHS) as one tool to verify membership in an Indian tribe as well as the suggested hardship exemptions discussed above. Commenters asked HHS to specify that the Exchange first consult all available electronic data sources; second, if electronic data sources do not support an applicant's attestation, seek paper documentation; and third, if individuals lack the appropriate documentation, call the listed tribe's Contract Health Services Officer or tribal enrollment office.

Response: We modeled the verification process for the exemption based on an individual's membership in an Indian tribe on the verification process that will be used for individuals seeking coverage at 45 CFR 155.350(c). We appreciate the suggestions from commenters, as they generally follow our approach in 45 CFR 155.350(c). Specifically, in 45 CFR 155.350(c), we specify that the Exchange will first use any approved electronic data sources, and only request paper documentation when electronic data sources are unavailable or do not support an applicant's attestation. 45 CFR 155.350(c) does not specify that the Exchange will contact a tribe's Contract Health Services Officer or tribal enrollment office when documentation is unavailable. Rather, in § 155.615(h), we proposed that when documentation does not exist or is not reasonably available, the Exchange will provide an exception on a case-by-case basis and accept an applicant's attestation. We also note that Exchanges have flexibility to work with local tribes to gain

information that could be used on an electronic basis.

Comment: One commenter worried that the proposed verifications process placed too much burden on individuals as opposed to the Exchange, and urged HHS to shift this burden in the future.

Response: We have attempted to limit burden on individuals as much as possible in the proposed and final regulations. We intend to work with all relevant stakeholders in the future to identify opportunities to increase the efficiency and integrity of the verification process.

Comment: Commenters expressed concerns regarding proposed § 155.615(g) and situations where the Exchange is unable to verify the necessary information to determine eligibility for an exemption. Some commenters requested greater clarification to limit any possible confusion about when attestations should be accepted, when attestations must be verified, when documents must be provided, and what type of documents would be sufficient. Additionally commenters expressed concerns about the 30-day time period for individuals to present satisfactory documentary evidence to the Exchange in order to resolve an inconsistency, and urged extending this time period, or providing flexibility for the Exchange to ensure that individuals have a “reasonable opportunity” to submit documentation.

Response: In response to comments, we will modify proposed § 155.615(g)(2)(ii) to allow an individual 90 days to present satisfactory documentary evidence to the Exchange, which is the time period used in the eligibility process for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. We will maintain the proposed language specifying that an individual is not eligible for an exemption during this time period. As the language from paragraph (g) is modeled after the inconsistency process from § 155.315(f), we believe that this provision already describes the process concerning an Exchange’s inability to verify necessary information with sufficient clarity to limit confusion. The notices that the Exchange provides to an individual for whom the Exchange is unable to verify necessary information will specify the documentation that such an individual can submit to resolve an inconsistency.

Comment: Multiple commenters expressed support for our proposal at § 155.615(h) to provide an exception on a case-by-case basis for individuals who lack certain documentation, although some sought further clarification to

prevent confusion. One commenter suggested that paragraph (h) of this section should extend not only to circumstances when the Exchange has information that is inconsistent with an individual’s attestation but also to circumstances when the attestation itself cannot be verified through other data sources.

Response: As this exception for special circumstances mirrors similar language used in regards to the coverage process at § 155.315(g), we maintain the language as proposed. We clarify that this provision is designed to address any situation in which documentation is needed, but does not exist or is not reasonably available.

Comment: One commenter expressed support for § 155.615(j), which limits the collection of application information to the minimum amount necessary, while also recommending that HHS amend this provision to ensure alignment with section 1411(g) of the Affordable Care Act.

Response: We affirm that the Exchange should collect only the minimum information necessary to support the eligibility process for exemptions. The proposed language mirrors that used in 45 CFR 155.315(i), which is designed to implement section 1411(g)(1) of the Affordable Care Act. We also note that the overarching privacy and security protections specified in 45 CFR 155.260 apply to the exemptions process. Together, we believe that these sections already appropriately address the commenter’s concerns regarding information collection and privacy.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.615 of the proposed rule with several modifications, as follows. First, we make a technical correction in paragraph (b)(1) to specify that the Exchange must accept a form that reflects he or she is exempt from Social Security and Medicare taxes under section 1402(g)(1) of the Code. Second, we clarify that if an applicant attests to membership in a religious sect or division that is not recognized by the SSA as an approved religious sect or division under section 1402(g)(1) of the Code, the Exchange will provide the applicant with information regarding how his or her religious sect or division can pursue recognition under section 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as the Exchange obtains information indicating that the religious sect or division has been approved. Third, we renumber proposed § 155.615(c), move the

language from previous paragraph (c)(1) into paragraph (c), redesignating paragraphs (c)(2) and (c)(3) as paragraphs (c)(1)(i) and (ii), and add § 155.615(c)(2) to specify a process for establishing the list of health care sharing ministries that meet the statutory standards that is substantially similar to the approach discussed in § 155.604(c) regarding how HHS will determine that certain types of coverage meet the substantive and procedural requirements for consideration as minimum essential coverage. We also specify in paragraph (c)(1)(i) that the Exchange may not consider an applicant’s prior or current enrollment in health coverage as not reasonably compatible with an applicant’s attestation of membership in a health care sharing ministry, and we specify in paragraph (c)(1)(ii) that if an applicant attests to membership in a health care sharing ministry that is not known to the Exchange as a health care sharing ministry based on information provided by HHS, the Exchange will provide the applicant with information regarding how an organization can pursue recognition under § 155.615(c)(2), and determine the applicant ineligible for this exemption until such time as HHS notifies the Exchange that the health care sharing ministry’s meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code.

We specify in paragraph (f)(1) that the Exchange will not verify whether an applicant experienced a hardship under § 155.605(g)(3) or (5); rather, these exemptions will be claimed directly with the IRS at tax filing. We redesignate paragraph (f)(2) as paragraph (f)(2)(i), make a technical correction in redesignated paragraph (f)(2)(i) to clarify that the procedures used to determine eligibility for advance payments of the premium tax credit in subpart D include § 155.315(c)(1). We note that at 78 FR 4638, we proposed to consolidate § 155.320(d) and (e) into § 155.320(d). To the extent that we finalize this redesignation, we intend to make a simultaneous technical correction to this cross-reference. We add new paragraph (f)(2)(ii) to clarify that in determining eligibility for the lack of affordable coverage based on projected income hardship exemption, the Exchange will accept an application filer’s attestation for an applicant regarding eligibility for minimum essential coverage other than through an eligible employer-sponsored plan. We redesignate paragraph (f)(3) as paragraph (f)(4), and add new paragraph (f)(3) to specify that the Exchange will use the same verification procedures for

the exemption for an individual who is eligible for services through an Indian health care provider as it will use for the exemption for members of a federally-recognized tribe.

In 78 FR 4636, we proposed to modify § 155.315(f) to specify that the Exchange would trigger an inconsistency when electronic data is required but not reasonably expected to be available within 2 days. To ensure alignment across the eligibility process for enrollment in a QHP through the Exchange and insurance affordability programs with the eligibility process for exemptions, we make a technical correction to specify that the Exchange will trigger the process under § 155.615(g) when electronic data is required but not reasonably expected to be available within the time period specified as § 155.315(f). We modify § 155.615(g)(2)(ii) to allow an applicant 90 days to present satisfactory documentary evidence to resolve an inconsistency. Lastly, we add paragraph (k) to mirror the Exchange's requirement regarding the validation of a Social Security number for an individual applying for an exemption from the shared responsibility payment with the same validation process for purposes of individual seeking coverage as described in § 155.315(b).

e. Eligibility Redeterminations for Exemptions During a Calendar Year (§ 155.620)

In § 155.620, we proposed in paragraph (a) to implement section 1411(f) of the Affordable Care Act by providing that the Exchange will redetermine an individual's eligibility for an exemption if the Exchange receives and verifies new information as reported by an individual. In paragraph (b)(1), we proposed that the Exchange will require an individual with a certificate of exemption to report any changes related to the eligibility standards described in § 155.605. We solicited comments as to whether we should provide flexibility such that the Exchange may establish a reasonable threshold for changes in income, such that an individual who experiences a change in income that is below the threshold is not required to report such change.

In paragraph (b)(2), we proposed that the Exchange would allow an individual to report changes through the channels acceptable for the submission of an exemption application.

In paragraph (c), we proposed that the Exchange use the verification processes used at the point of initial application, as described in § 155.615, in order to verify any changes reported by an

individual prior to using the self-reported information in an eligibility determination for an exemption. In paragraph (c)(2), we proposed that the Exchange notify an individual in accordance with § 155.610(i) after re-determining his or her eligibility based on a reported change. Lastly, in paragraph (c)(3), we proposed that the Exchange provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption and who has elected to receive electronic notifications, unless he or she has declined to receive such notifications. We noted that unlike § 155.330, we did not propose that the Exchange conduct periodic data matching regarding an individual's eligibility for an exemption. We solicited comments as to whether we should establish similar data matching provisions, and if so, whether we should specify that the Exchange should handle changes identified through the matching process in a similar manner as to that specified in § 155.330, or take a different approach.

Also unlike the eligibility process for enrollment in a QHP and for insurance affordability programs, we did not propose an annual Exchange redetermination process for exemptions. We solicited comments regarding how the Exchange could expedite and streamline the process for individuals with a certificate of exemption that is not approved indefinitely who wish to maintain the exemption for a subsequent year.

Comment: One commenter stated that individuals should not have to report changes in religious status or their status as a member of an Indian tribe, but rather the religious sect or tribe should report such a change in status to the Exchange or HHS in order to prevent fraud.

Response: We share the commenter's program integrity concerns, but continue to believe that the responsibility to report changes remains appropriately on the individual who has received an exemption. As Exchanges start to grant exemptions, we will work with states to monitor the process and determine whether changes would be appropriate.

Comment: One commenter sought clarification as to whether redeterminations only occur when an individual reports a change or whether the Exchange has the authority to cancel an exemption it previously granted on its own.

Response: We clarify that redeterminations under this section can

only occur when an individual reports a change that impacts his or her eligibility determination for an exemption.

Comment: Several commenters expressed concerns regarding the burden involved in requiring an individual to report changes that would impact his or her eligibility for an exemption. One commenter inquired about how HHS would enforce the regulatory reporting requirements.

Response: The proposed approach is identical to the approach taken in § 155.330(b), and we believe that it is generally appropriate for eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, and exemptions. With that said, as noted above, we have modified the eligibility standards, in order to reduce administrative burden, for the hardship exemption specified in § 155.605(g)(2), which covers situations in which an individual lacks affordable coverage based on projected household income, such that the Exchange will provide this exemption for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

Accordingly, we modify paragraphs (a), (b), and (c)(3) to conform to this change by clarifying that the Exchange will not conduct mid-year redeterminations for this exemption, will not require individuals receiving this exemption to report changes, and will not send periodic reminders to report changes to individuals who have this exemption. As Exchanges start to grant exemptions, we will work with states to monitor the process and determine whether other changes would be appropriate.

Comment: Commenters raised concerns about requiring individuals to report changes, and suggested that if HHS maintains these requirements, they should provide a special enrollment period for an individual who loses their exemption in the middle of a calendar year as a result of a redetermination and who has no opportunity to enroll in coverage, which would leave them potentially liable for the shared responsibility payment.

Response: We do not want to create an incentive for an individual who has an exemption to not report changes in their eligibility. We also do not want to create a situation in which an individual who has followed procedures and wants to enroll in health coverage is instead liable for the shared responsibility payment. We are adding paragraph (d) to clarify that the Exchange will implement a change resulting from a redetermination under

this section for the month or months after the month in which the redetermination occurs such that a certificate that was provided for the month in which the redetermination occurs, and for prior months, remains effective. We address the ability of an individual who loses eligibility for an exemption following a redetermination to enroll in a QHP in the guidance published simultaneously with this final regulation.

Comment: One commenter suggested that the Exchange provide periodic electronic notifications regarding reporting changes to individuals only if they decide to receive such notifications as opposed to providing individuals periodic electronic notifications regarding reporting changes unless they affirmatively decline to receive such notifications.

Response: As we proposed this provision to mirror a similar provision concerning the coverage process at § 155.330(c)(2), we maintain the provision as proposed, with the modification discussed above to eliminate this notification for individuals who have the exemption specified in § 155.605(g)(2).

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.620 of the proposed rule with a few slight modifications. We clarify in paragraph (a) that the Exchange only must redetermine the eligibility of an individual with an exemption granted by the Exchange, and that it will not conduct redeterminations for the exemption described in § 155.605(g)(2). In paragraph (b), we specify that the Exchange will not require an individual who has an exemption under § 155.605(g)(2) to report changes with respect to his or her eligibility for this exemption; accordingly, in paragraph (c)(3), we clarify that the Exchange will not provide periodic reminders to report changes to this group of individuals. We also add paragraph (d) to specify that the Exchange will implement a change resulting from a redetermination under this section for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months, remains effective.

f. Options for Conducting Eligibility Determinations for Exemptions (§ 155.625)

In § 155.625, we proposed that a state-based Exchange can satisfy the requirements of subpart G if it uses a

federally-managed service to make eligibility determinations for exemptions, and we solicited comments regarding the specific configuration of a service that would be useful for states and also feasible within the time remaining for implementation.

First, in paragraph (a), we proposed that the Exchange may satisfy the requirements of this subpart by either executing all eligibility functions, directly or through contracting arrangements described in 45 CFR 155.110(a), or through the use of a federally-managed service described in paragraph (b) of § 155.625.

Second, in paragraph (b), we proposed that the Exchange may implement an eligibility determination for an exemption made by HHS, provided that the Exchange accepts the application, as specified in § 155.610(d), and issues the eligibility notice, as specified in § 155.610(i), and that verifications and other activities required in connection with eligibility determinations for exemptions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (b)(4) of this section. We also proposed that under this option, the Exchange will transmit all applicant information and other information obtained by the Exchange to HHS, and adhere to HHS' determination. Lastly, in paragraph (b)(4), we proposed that the Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for exemptions.

In paragraph (c), we proposed the standards to which the Exchange will adhere when eligibility determinations are made in accordance with paragraph (b) of this section. Such standards included that the arrangement does not increase administrative costs and burdens on individuals, or increase delay, and that applicable requirements under § 155.260, § 155.270, and § 155.315(i), and section 6103 of the Code are met with respect to the confidentiality, disclosure, maintenance or use of information.

Comment: Commenters expressed general support for the proposals in § 155.625 in regards to the ability for a state-based Exchange to satisfy the requirements of this subpart by either executing all eligibility functions directly, through contracting arrangements, or through the use of a federally-managed service described in paragraph (b). Commenters urged HHS to further help reduce the burden on

Exchanges developing the operational capacity needed to conduct eligibility determinations for exemptions. Another commenter wanted to clarify that an Exchange relying on HHS to make an eligibility determination for an exemption could also rely on HHS to administer the exemptions appeals process.

Response: In response to comments seeking to limit the burden on Exchanges, and based on the operational capacity of the Exchange and HHS being able to comply with the statutory requirements to accept exemptions applications and issue eligibility determination notices for the first year of operations, we are modifying the proposed language regarding how the Exchange may rely on the use of an HHS service.

We specify that for an application submitted prior to October 15, 2014, the Exchange may rely on HHS to process exemptions applications, complete the necessary verifications, determine eligibility, and issue notices, including any certificates of exemption. Exchanges will still assist individuals seeking a lack of affordable coverage based on projected income hardship exemption by providing an individual with the resulting cost of his or her lowest-cost bronze plan that incorporates any advance payments of the premium tax credit allowable under section 36B of the Code. Additionally, the Exchange call center and Internet Web site as specified in 45 CFR 155.205(a) and (b) respectively, must be responsible for providing information to consumers regarding the exemption eligibility process.

For an application submitted on or after October 15, 2014, the Exchange may adopt an exemption eligibility determination made by HHS provided that the Exchange accepts the application and issues the eligibility notice in the same manner as discussed in the proposed rule. As a result of clarifying the flexibility for Exchanges prior to October 15, 2014, we accordingly remove paragraph (c).

We also note that comments regarding the appeals process for exemptions will be addressed in a future regulation. We expect that future rulemaking will clarify that if an Exchange relies on HHS to make an eligibility determination for an exemption, the Exchange may also rely on HHS to administer the exemptions appeals process as well, provided that any underlying decisions made by the Exchange are addressed through the appropriate Exchange appeals process.

Summary of Regulatory Changes

We are modifying the provisions proposed in § 155.625 to eliminate proposed paragraph (c). We redesignate paragraphs (b)(1) through (b)(5) as (b)(2)(i) through (b)(2)(v) to clarify that the standards discussed therein apply to an Exchange seeking to rely on an exemption eligibility determination made by HHS on or after October 15, 2014. We add (b)(1) to reflect that HHS will administer the entire eligibility process for exemptions for Exchanges that decide to rely on HHS to conduct eligibility determinations for an application submitted before October 15, 2014, provided that the Exchange adheres to the eligibility determination made by HHS furnishes any information available through the Exchange that is necessary for an applicant to utilize the process administered by HHS, and the Exchange call center and Internet Web site provide information to assist consumers regarding the exemption eligibility process.

g. Reporting (§ 155.630)

In § 155.630, we proposed to codify the provisions specified in section 1311(d)(4)(I)(i) of the Affordable Care Act regarding reporting by the Exchange to IRS regarding eligibility determinations for exemptions. If the Exchange grants an individual a certificate of exemption in accordance with § 155.610(i), we proposed that the Exchange will transmit to IRS the individual's name and SSN, exemption certificate number, and any additional information specified in additional guidance published by IRS in accordance with 26 CFR 601.601(d)(2). We solicited comments as to how this interaction could work as smoothly as possible.

Comment: One commenter raised concerns about the lack of an IRS interface to report exemptions, and wanted HHS to ensure that Exchanges will be provided sufficient time to implement such an interface.

Response: We recognize the commenter's concerns regarding the reporting process for exemptions. HHS continues to work closely with the IRS to ensure an efficient interface to report exemptions, and anticipates releasing technical guidance on this shortly. We also anticipate that this reporting will be accomplished through a monthly file, which will be sent to IRS for the first time in February, 2014, and will also incorporate information regarding enrollment in a QHP through the Exchange and advance payments of the premium tax credit, based on other provisions.

Comment: One commenter recommended that HHS provide Exchanges flexibility to obtain and report taxpayer identification numbers, if relevant, rather than only SSNs as proposed. The commenter also wanted to ensure that this provision explicitly specifies that Exchanges will comply with existing confidentiality protections for individual tax information under the Affordable Care Act and section 6103 of the Code.

Response: We maintain the language of the proposed regulation. We also note that in response to this comment, in order to limit the administrative burden on Exchanges associated with reporting to IRS, we have clarified in § 155.615(k) that similar to the coverage process, the Exchange will validate application SSNs that are included on an exemptions application. Similar to eligibility for enrollment in a QHP, having a SSN is not a requirement to receiving an exemption, and as such the inability to validate a SSN will not preclude an eligibility determination for an exemption. However, the successful validation of a SSN will help in the efficient administration of the tax filing process. Furthermore, we note that 45 CFR 155.260 specifies that tax information will be protected in accordance with section 6103 of the Code.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.630 of the proposed rule without modification.

h. Right To Appeal (§ 155.635)

In § 155.635, we proposed that the Exchange will include notice of the right to appeal and instructions for how to appeal in any notification issued in accordance with § 155.610(i) and § 155.625(b)(1). We proposed that an individual may appeal any eligibility determination or redetermination made by the Exchange in relation to an exemption. Additional detail about the appeal process is described in subpart F of the proposed rule titled, "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing" (78 FR 4719).

Comment: One commenter expressed concerns about individuals with access to eligible employer-sponsored coverage that would prevent an individual from receiving advance payments of the

premium tax credit, while still leaving them subject to the shared responsibility payment. The commenter wanted the Exchange to have discretion through the appeals process to consider the totality of an applicant's circumstances. Another commenter urged HHS to specify that translation services are available for LEP individuals to ensure they have appropriate access to the appeals process, including the content of notices and requests for hearings.

Response: Comments concerning the appeals process for exemptions will be addressed in future rulemaking.

Summary of Regulatory Changes

We are finalizing the provisions proposed in § 155.635 of the proposed rule with three modifications. First, we are deleting the reference to § 155.625(b)(1), as we are modifying proposed § 155.625 to specify that an Exchange that relies on HHS to make eligibility determinations for exemptions will not issue the eligibility notice. Second, we also make a technical correction in paragraph (b) to replace the reference to the Commissioner of the IRS with the Secretary of the Treasury. Third, we make a technical correction to remove the introductory text, which is not substantive.

B. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

a. Definition of Minimum Essential Coverage (§ 156.600)

The proposed rule cross referenced the Treasury regulation under section 5000A of the Code for the definition of minimum essential coverage.

Summary of Regulatory Changes

We made minor changes to the provisions of § 156.600 to clarify the meaning of the final rule.

b. Other Types of Coverage That Qualify as Minimum Essential Coverage (§ 156.602)

The proposed rule specifically designated the following types of coverage as minimum essential coverage for purposes of the Code: Self-funded student health insurance plans; foreign health coverage; Refugee Medical Assistance supported by the Administration for Children and Families (45 CFR Part 400 Subpart G); Medicare advantage plans; AmeriCorps coverage (45 CFR 2522.10 through 2522.950), and state high risk pools (as defined in § 2744 of the Public Health Service Act (PHS Act)). We solicited comments on these types of coverage

and whether there are other existing categories of coverage that should be recognized as minimum essential coverage. We also solicited comments regarding whether self-funded student health coverage should be limited to institutions of higher education, as defined by the Higher Education Act of 1965, or if coverage offered by other institutions, such as primary or secondary educational institution, or unaccredited educational institutions, should be included. Lastly, we solicited comments on the inclusion of AmeriCorps coverage in the designated list.

Under the proposed rule, state high risk pools were designated as minimum essential coverage for a period of time to be determined by the Secretary. We reserved the right to review and monitor the extent and quality of coverage, and in the future to reassess whether they should be designated minimum essential coverage or should be required to go through the process outlined in § 156.604 of this proposed rule. We solicited comments on whether state high risk pools should automatically be designated as minimum essential coverage or whether they should be required to follow the process outlined in § 156.604 of this proposed rule.

The comments and our responses are set forth below.

Comment: Many commenters were concerned that the unregulated status of self-funded student health coverage may leave students unable to benefit from the protections of the Affordable Care Act, and that students who are offered a self-funded plan through their college or university may find it difficult or impossible to obtain coverage through the Exchanges and to access the Affordable Care Act premium and cost-sharing subsidies. These commenters conceded that some self-funded student health coverage is good coverage, but other plans do not provide adequate coverage. These commenters specifically cited annual and lifetime limits, prescription drug limits, pre-existing condition exclusions and rescissions as reasons that some self-funded student health coverage is not satisfactory coverage for many students. In contrast, other commenters stated their support for designating self-funded student health coverage as minimum essential coverage, citing the ACHA guidelines document, *Standards for Student Health Insurance/Benefits Programs*, which will “encourage provision of benefits in self-funded plans that are consistent with Affordable Care Act requirements that have been established for student insured plans.”

Response: After reviewing the comments regarding designating self-funded student health plans as minimum essential coverage for purposes of the Code, we agree that because self-funded student health plans can be varied in the types of benefits being provided, these plans should not be permanently designated as minimum essential coverage. In this final rule we designate self-funded student health coverage 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 plans may apply to be recognized as minimum essential coverage through the process outlined in § 156.604 of the final rule. In addition, the Department of the Treasury intends to publish guidance under section 36B of the Code about whether individuals who are eligible to enroll in self-funded student health plans will be treated as eligible for qualified health plan coverage subsidized by the premium tax credit.

In the proposed rule we designated state high risk pools as minimum essential coverage for a transition period and solicited comments on whether state high risk pools should be recognized as minimum essential coverage. We did not receive any comments on state high risk pools and we are finalizing the proposed rule. To be consistent with the treatment of self-funded student health plans which under the final rule are designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014, we are applying the same one-year transitional period to state high risk pools. For coverage beginning after December 31, 2014, sponsors of state high risk pools may apply to be recognized as minimum essential coverage through the process outlined in § 156.604 of the final rule. In addition, the Department of the Treasury intends to publish guidance under section 36B of the Code about whether individuals who are eligible to enroll in state high risk pools will be treated as eligible for qualified health plan coverage subsidized by the premium tax credit.

Comment: Some commenters supported the designation of foreign health coverage as minimum essential coverage because foreign health coverage provides meaningful health care benefits to, legally admitted, non-citizens temporarily working in the United States. Other commenters expressed concern that foreign health coverage, which is generally provided to non-citizens by a foreign home country

or through foreign commercial health coverage, provides limited or no out-of-country benefits to such persons while legally in the United States.

Response: We agree that the health care benefits provided by foreign governments or through foreign insurance for legally admitted non-citizens of the United States vary from country to country and may create a barrier to care if health care providers in the United States do not accept payment from such coverage. Therefore, foreign health coverage is not designated as minimum essential coverage in this final rule. However, sponsors of foreign health coverage may apply for their coverage to be recognized as minimum essential coverage in the process outlined in § 156.604 of this final rule.

Comment: Some commenters supported the designation of coverage provided by AmeriCorps programs to their AmeriCorps members as minimum essential coverage. They stated that the lack of an employer/employee relationship creates difficulties for programs seeking insurance on their own through traditional group insurance markets. Further, coverage provided by AmeriCorps programs to their AmeriCorps members has produced economies of scale and a solution to the accessibility challenges particular to smaller programs. Commenters also stated that the demographics and full funding of premiums by the program has led to stable claims experience.

Other commenters opposed designating the coverage provided by AmeriCorps programs to AmeriCorps volunteers as minimum essential coverage because some of the provided benefits fall below the minimal coverage requirements required by the Affordable Care Act. In addition, commenters noted that stipends for most volunteers are between 100–200 percent FPL, meaning that they may either qualify for a premium assistance program or a hardship exemption.

Response: In response to these comments concerning consumer protections, the final rule does not automatically designate coverage provided by AmeriCorps programs to AmeriCorps volunteers as minimum essential coverage. However, AmeriCorps coverage provided to volunteers may be recognized as minimum essential coverage through the certification process outlined in § 156.604 of this final rule.

Comment: Several commenters urged HHS to recognize multi-share plans as minimum essential coverage. These commenters also requested that if multi-share plans were not designated as

minimum essential coverage, that they be eligible to apply for recognition as minimum essential coverage. These commenters described the unique structure of multi-share plans, stating that these programs already meet the community needs of affordable health insurance; multi-share programs often focus on specific geographic areas or populations; and that multi-share plans are community funded, receive no federal subsidies and are a demonstrated alternative to traditional health insurance. Multi-share plans are designed to be coverage of last resort for low-income small businesses, students and individuals when other programs are unavailable.

Response: While multi-share plans are not designated as minimum essential coverage in this final rule, HHS invites all multi-share organizations to apply for their coverage to be recognized as minimum essential coverage in the process outlined in § 156.604 of this final rule.

Summary of Regulatory Changes

As proposed in the proposed rule, in § 156.602 we designate Medicare Advantage, and Refugee Medical Assistance supported by the Administration for Children and Families (45 CFR Subpart G), as minimum essential coverage. We also designate self-funded student health plans and state high risk pools 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 plans and state high risk pools may apply to be recognized as minimum essential coverage through the process outlined in § 156.604 of the final rule. Section 156.602 no longer specifically designates foreign health coverage or coverage provided by AmeriCorps programs to AmeriCorps volunteers as minimum essential coverage. However, plans that provide coverage to AmeriCorps volunteers as well as coverage provided by foreign governments may receive designation as minimum essential coverage by following the process for recognition explained in § 156.604.

c. Requirements for Recognition as Minimum Essential Coverage for Types of Coverage Not Otherwise Designated Minimum Essential Coverage in the Statute or This Regulation (§ 156.604)

The proposed rule outlined a process by which other types of coverage could seek to be recognized as minimum essential coverage. Coverage recognized as minimum essential coverage through

this process would need to offer substantially the same consumer protections as those enumerated in the Title I of Affordable Care Act relating to non-grandfathered, individual coverage to ensure consumers are receiving the protections of the Affordable Care Act. We solicited comments on the proposed “substantially comply” standard as it applies to other types of individual coverage. We also solicited comments on the process for recognizing other coverage as minimum essential coverage.

In the proposed regulation, sponsors of minimum essential coverage must also meet other criteria specified by the Secretary. We solicited comments on the types of criteria the Secretary should consider in this process as well as whether they should be added to the final rule. We proposed that sponsors of a plan that seeks to have such coverage recognized as minimum essential coverage adhere to certain procedures. Sponsors would submit to HHS electronically the following information: (1) Name of the organization sponsoring the plan; (2) name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization; (3) address of the individual named above; (4) phone number of the individual named above; (5) number of enrollees; (6) eligibility criteria; (7) cost sharing requirements, including deductible and out-of-pocket maximum; (8) essential health benefits covered (as defined in § 1302(b) of the Affordable Care Act and its implementing regulations); and (9) a certification that the plan substantially complies with the provisions of Title I of the Affordable Care Act as applicable to non-grandfathered individual health insurance coverage. If at any time HHS determines that a type of coverage previously recognized as minimum essential coverage no longer meets the coverage requirements, HHS may revoke the recognition of such coverage. We solicited comments on whether there should be an appeal process for sponsors of coverage that had the minimum essential coverage status revoked by the Secretary. We also solicited comment on whether this appeal process should be available to sponsors whose initial request for recognition of minimal essential coverage status for their coverage was denied by HHS.

The comment and our response are set forth below.

Comment: A commenter suggested that the process for designating coverage not otherwise designated as minimum essential coverage should include definitive timelines for the submission

and consideration of each plan applying to be designated as minimum essential coverage, opportunities for such plans to exchange ideas with HHS, and an appeals process for plans that are denied.

Response: We appreciate the commenter’s suggestions regarding this process and we will take them under further consideration while developing this administrative process.

As previously stated, we solicited comments on the types of criteria that the Secretary should require a sponsor to meet in order for HHS to recognize the coverage of the organization as minimum essential coverage and indicated that we might specify criteria for sponsoring organizations. We did not get any comments specifically addressing this issue, and we have decided that the focus of the CMS review of applications for health coverage to be recognized as minimum essential coverage will not be on the type of organization providing coverage but on the extent of the coverage itself and the protections provided in the coverage. We made minor changes to certification requirement to clarify that the organization must certify that the coverage substantially complies with the requirements of title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market and the organization must submit any plan documentation or other information that demonstrate that the coverage substantially comply with these requirements.

Summary of Regulatory Changes

We made minor changes to the provisions of § 156.604 to clarify that, in addition to the organization certifying that the coverage substantially complies with the requirements of title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market, the organization must submit any plan documentation or other information that demonstrates that the coverage substantially complies with these requirements.

d. HHS Audit Authority (§ 156.606)

Under this proposed rule, HHS would have the ability to audit plans to ensure the accuracy of the certification either randomly or when triggered by certain information. We solicited comments on the proposed procedures and if and when audits should be conducted. We also solicited comments on whether sponsors of the types of coverage that have been designated as minimum essential coverage in the proposed rule should also submit the above information required to HHS.

Under the proposed rule, once recognized as minimum essential coverage, a plan would have to provide notice to its enrollees, specifying that the plan has been recognized as minimum essential coverage for the purposes of the individual shared responsibility provision. The sponsor of any plan recognized as minimum essential coverage would also be required to provide the annual information reporting to the IRS specified in section 6055 of the Code and implementing regulations and furnish statements to individuals enrolled in such coverage to assist them in establishing that they are not liable for the shared responsibility payment under section 5000A of the Code. We requested comments on whether all plans and programs designated as minimum essential coverage under this regulation must provide notice to enrollees, or only plans recognized through the process in § 156.604 of this regulation.

Comment: A commenter suggested that the process for designating coverage not otherwise designated as minimum essential coverage should include definitive timelines for the submission and consideration of each plan applying to be designated at minimum essential coverage, opportunities for such plans to exchange ideas with HHS, and an appeals process for plans that are denied.

Response: We appreciate the commenter's suggestions regarding this process and we will take them under further consideration while developing this administrative process.

Summary of Regulatory Changes

We made minor changes to the provisions of section 156.606 to clarify the meaning of the final regulation.

III. Provisions of the Final Regulation

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ substantively from the proposed rule are as follows:

Changes to § 155.605

- Modifies eligibility standards for the religious conscience exemption such that if an exemption is provided to an individual under the age of 21, an exemption will be provided on a continuing basis until the month after the individual's 21st birthday, which triggers a corresponding notice and opportunity for the individual turning 21 to file another application to maintain this exemption.
- Clarifies which hardship exemptions must be granted by the

Exchange and which are available solely through the tax filing process.

- Clarifies that hardship exemption under paragraph (g)(1) of this section must be granted for the month before, the month or months during which an individual experiences the circumstances that qualify as a hardship preventing him or her from purchasing a qualified health plan, and the month after.

- Clarifies that an eligible employer-sponsored plan is only considered for the lack of affordable coverage based on projected income hardship exemption if it meets the minimum value standard.

- Specifies how the Exchange will determine the required contribution to purchase coverage under an eligible employer-sponsored plan or in the individual market for the lack of affordable coverage based on projected income hardship exemption, including clarifying that in determining the required contribution for an eligible employer-sponsored plan, an individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan, and wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned.

- Clarifies that the lack of affordable coverage based on projected income hardship exemption is only available prospectively for the month or months of a calendar year after which the exemption is requested, and that it will be provided for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

- Adds a hardship exemption for any month in which an individual is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.50, or an individual eligible for services through the Indian Health Service in accordance with 25 USC 1680c(a), (b), or (d)(3), and specifies that the duration of this exemption is the same as that for a member of an Indian tribe.

Changes to § 155.610

- Clarifies that the Exchange must use information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination to the extent that the Exchange finds that such information is still applicable.

- Specifies that at a minimum, the Exchange must provide a paper

application process for applications submitted prior to October 15, 2014.

- Clarifies that hardship exemptions can also be provided for previous tax years after December 31 of a given calendar year, noting that the Exchange will only accept an application for an exemption described in § 155.605(g)(1) during one of the 3-calendar years after the month or months during which the applicant attests that the hardship occurred.

- Clarifies that the Exchange will notify an individual to retain records that demonstrate the receipt of a certificate of exemption, as well as records demonstrating his or her qualification for the underlying exemption.

Changes to § 155.615

- Clarifies how the Exchange will address a situation in which an applicant attests to membership in a religious sect or division that is not recognized under section 1402(g)(1) of the Code.

- Clarifies how the Exchange will address a situation in which an applicant attests to membership in an organization that is not known to the Exchange as a health care sharing ministry based on information provided by HHS.

- Provides a process for establishing the list of health care sharing ministries that meet the statutory standards.

- Clarifies that the Exchange will not find that an applicant's previous or current enrollment in health coverage is not reasonably compatible with his or her attestation of membership in a health care sharing ministry.

- Clarifies that the Secretary of the Treasury will administer the exemptions specified in § 155.605(g)(3) and (5).

- Clarifies the applicability of verification procedures specified in 45 CFR subpart D to the lack of affordable coverage based on projected income hardship exemption.

- Specifies that the Exchange will use the same verification procedures for the exemption for an individual who is eligible for services through an Indian health care provider as it will use for the exemption for members of a federally-recognized tribe.

- Clarifies when an inconsistency process should be triggered when certain data sources are not reasonably expected to be available.

- Allows an applicant 90 days to present satisfactory documentary evidence to resolve an inconsistency.

- Specifies how an Exchange must validate a Social Security number for an individual seeking an exemption.

Changes to § 155.620

- Specifies that the Exchange will not conduct mid-year redeterminations for the hardship exemption for an individual who has a lack of affordable coverage based on projected household income, will not require individuals receiving this exemption to report changes, and will not send periodic reminders to report changes to individuals who have this exemption.

- Specifies that the Exchange will implement a change resulting from a redetermination under this section for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months remains effective.

Changes to § 155.625

- Specifies that for applications submitted before October 15, 2014, a state-based Exchange can be approved if relying on HHS to administer the entire eligibility process for exemptions, provided that the Exchange furnishes any information available through the Exchange that is necessary for an applicant to utilize the process administered by HHS, and the Exchange call center and Internet Web site assist consumers seeking exemptions.

Changes to § 155.635

- Clarifies that an Exchange relying on HHS to make eligibility determinations for exemptions will not issue the eligibility notice for applications submitted prior to October 15, 2014.

Changes to § 156.600

- Makes minor changes to the provisions of 45 CFR § 156.600 to clarify the meaning of the regulation.

Changes to § 156.602

- Designates self-funded student health plans and state high risk pools as minimum essential coverage for a one year transitional period, and allows self-funded student health plans and state high risk pools to apply to be recognized as minimum essential coverage through the process outlined in § 156.604 of the final rule after January 1, 2015.

- Removes the designation of foreign health coverage and AmeriCorps as minimum essential coverage. In order to be recognized as minimum essential coverage, foreign health coverage and coverage for AmeriCorps must follow the process for recognition explained in § 156.604.

Changes to § 156.604

- Makes minor changes to the provisions of § 156.604 to clarify the meaning of the regulation.

Changes to § 156.606

- Makes minor changes to the provisions of 45 CFR § 156.606 to clarify the meaning of the regulation.

IV. Collection of Information Requirements

The final rule entitled “Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions” finalizes standards with regard to the minimum function of an Exchange to perform eligibility determinations and issue certificates of exemption from the individual shared responsibility payment. The rule also finalizes standards related to eligibility for exemptions, including the verification and eligibility determination process, eligibility redeterminations, options for conducting eligibility determinations, and reporting related to exemptions. In addition, the rule finalizes rules designating certain types of coverage as minimum essential coverage and outlining substantive and procedural requirements that other types of coverage must fulfill in order to be recognized as minimum essential coverage under section 5000A(f)(5) of the Code.

This section outlines the information collection requirements in the proposed regulation on which we solicited public comment in the exemptions proposed rule. We used data from the Bureau of Labor Statistics to derive average costs for all estimates of salary in establishing the information collection requirements. Salary estimates included the cost of fringe benefits, calculated at 30.4 percent of salary, which is based on the June 2012 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics. Additionally, we used estimates from the Congressional Budget Office to derive estimates of the number of exemption applications we anticipate Exchanges to receive, and the number of exemption eligibility determination notifications we anticipate Exchanges to generate.

Finally, this final rule describes an information collection requirement for which we did not solicit public comment in the exemptions proposed rule. The information collection requirement related to Health Care Sharing Ministries will be addressed through a separate notice and comment process under the Paperwork Reduction Act (PRA).

1. Exemption Application (§ 155.610)

Throughout this subpart, we specify that the Exchange will collect attestations from applicants for a certificate of exemption. These attestations will be collected using the application described in § 155.610(a). In § 155.610(a), we provide that the Exchange use an application created by HHS to collect the information necessary for determining eligibility for and granting certificates of exemption from the individual shared responsibility payment. The burden associated with this requirement is the time and effort estimated for an applicant to complete an application. The exemption application may be available in both paper and electronic formats. An electronic application process would vary depending on each applicant’s circumstances and which exemption an applicant is applying for, such that an applicant is only presented with questions relevant to the exemption for which he or she is applying. The goal is to solicit sufficient information so that in most cases no further inquiry will be needed. We estimate that on average, it will take .27 hours (16 minutes) for an application filer to complete an application, which is based on the estimates created for the single, streamlined application for enrollment in a QHP³, with a 90 percent electronic/10 percent paper mix (noting that no specific application channel is specified in this proposed rule). While the Congressional Budget Office⁴ estimates that 24 million individuals would be exempt from the individual shared responsibility payment in 2016, it is unclear how many individuals will seek these exemptions from an Exchange. Some of these individuals will claim an exemption through the tax filing process, others will be exempt but not need to file for an exemption (for example those below the filing threshold), while others will apply for and receive an exemption through the Exchange. Therefore, of the 24 million individuals, we conservatively anticipate that up to half will apply for an exemption through the Exchange. We specifically sought comment on this assumption. Accordingly, we estimate that approximately 12 million

³ The estimates may be found in the information collection request entitled, “Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children’s Health Insurance Program Agencies.”

⁴ Congressional Budget Office, “Payments of Penalties for Being Uninsured Under the Affordable Care Act,” September 2012 http://cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf.

applications for exemptions will be submitted to the Exchange for calendar year 2016, for a total of 3.2 million burden hours. We note, however, that the Commonwealth of Massachusetts saw a very small number of individuals apply for exemptions from a similar individual shared responsibility payment⁵. We also note that some individuals will apply for an exemption but be determined ineligible for an exemption, but it is difficult for us to estimate this number, and that in an unknown number of cases, multiple individuals in a single household may submit a single application.

We do not estimate any cost to the Exchanges of evaluating the exemption applications. For the purposes of this estimate, we expect all applications to be submitted electronically and processed through the system, which would result in no additional labor costs to evaluate and review the exemption applications. We requested comment on this assumption.

We estimate that the cost to develop the exemption application will be significantly less than the estimated cost of developing the coverage application because the coverage application takes into account additional factors necessary in order to perform eligibility determinations for insurance affordability programs. We also note that as with the coverage application, HHS will be releasing a model application for use by Exchanges, which will significantly decrease the burden associated with the implementation of the application. On average, we estimate that the implementation of the exemption application will take approximately 1,059 hours of software development at a labor cost of \$98.50 per hour, for a total cost of \$104,312 per Exchange and a total cost of \$1,877,607 for 18 state-based Exchanges.

2. Notices (§§ 155.610, 155.615, 155.620)

Several provisions in subpart G outline specific notices that the Exchange will send to individuals during the exemption eligibility determination process, including the notice of eligibility determination described in § 155.610(i). The purpose of these notices is to alert an applicant of his or her eligibility determination for an exemption and related actions taken by the Exchange. To the extent that an applicant is determined eligible for an exemption, the notice of eligibility

determination described in § 155.610(i) will serve as the certificate of exemption. Accordingly, we do not provide a separate burden estimate for the certificates of exemption described throughout this subpart. When possible, we anticipate that the Exchange will consolidate notices when multiple members of a household are applying together and receive an eligibility determination at the same time.

Consistent with 45 CFR 155.230(d), the notice may be in paper or electronic format, based on the election of an individual, will be in writing, and will be sent after an eligibility determination has been made by the Exchange; these are the same standards that are used for eligibility notices for enrollment in a QHP through the Exchange and for insurance affordability programs, as described in 45 CFR 155.310(g). It is difficult to estimate the number of applicants that will opt for electronic versus paper notices, although we anticipate that a large volume of applicants will request electronic notification. We estimated the associated mailing costs for the time and effort needed to mail notices in bulk to applicants who request paper notices.

We expect that the exemption eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application throughout the eligibility determination process. A health policy analyst, senior manager, and an attorney would review the notice. HHS is currently developing model notices, which will decrease the burden on Exchanges associated with developing such notices. If a state opts to use the model notices provided by HHS, we estimate that the Exchange effort related to the development and implementation of the exemption eligibility determination notice will necessitate 44 hours from a health policy analyst at an hourly cost of \$49.35 to learn exemptions rules and draft notice text; 20 hours from an attorney at an hourly cost of \$90.14, and four hours from a senior manager at an hourly cost of \$79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of \$52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each Exchange, at a cost of approximately \$5,971 per Exchange and a total cost of \$107,469 for 18 state-based Exchanges. For most notices outlined in subpart G of this proposed rule, we estimate that the notice development as outlined in the paragraph above, including the systems programming, would take each

Exchange an estimated 100 hours to complete in the first year.

We expect that the burden on the Exchange to maintain this notice will be significantly lower than to develop it. We estimate that it will take each professional approximately a quarter of the time to maintain the notice as compared to developing the notice. Accordingly, we estimate the maintenance of the eligibility determination notice in subsequent years will necessitate 11 hours from a health policy analyst at an hourly cost of \$49.35; 5 hours from an attorney at an hourly cost of \$90.14; one hour from a senior manager at an hourly cost of \$79.08 and eight hours from a computer programmer at an hourly cost of \$52.50. In total, we estimate that this will take a total of 25 hours for each Exchange, at a cost of approximately \$1,492 per Exchange and a total cost of \$26,856 for 18 state-based Exchanges.

Pursuant to section 5000A of the Code, the IRS must collect the necessary data from QHP issuers to determine the national average bronze monthly premiums in order to assist in the computation of the shared responsibility payment. To assist the IRS, HHS must request the monthly premium for all bronze level QHP's through all 51 Exchanges from QHP issuers. The burden associated on states and QHP issuers is already included in the information collection request entitled, "Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations," and as such, we do not include a separate burden estimate here. As this information is already being collected for another purpose, there will be no additional burden on QHP issuers or states.

3. Electronic Transmissions (§§ 155.615, 155.630)

Section 155.615 specifies that the Exchange will utilize applicable procedures established under subpart D of the Exchange final rule in order to obtain data through electronic data sources for purposes of determining eligibility for and granting certificates of exemption. This involves the electronic transmission of data through procedures established under subpart D in order to verify an applicant's incarceration status, to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, and to determine eligibility for advance payments of the premium tax credit. Section 155.615 also includes additional electronic transmissions that are specific to the eligibility process for exemptions, including those related to health care

⁵Massachusetts Health Connector and Department of Revenue, "Data on the Individual Mandate, Tax Year 2010", June, 2012. Retrieved from <http://www.mahealthconnector.org>.

sharing ministries and religious conscience. In section 155.630, we proposed that the Exchange will provide relevant information to IRS regarding certificates of exemption for the purposes of tax administration, such as the name and other identifying information for the individual who received the exemption. As we expect that these transmissions of information will all be electronic, and through the same channels used for reporting to IRS established in § 155.340, we do not anticipate for there to be any additional burden other than that which is required to design the overall eligibility and enrollment system. We do not provide a burden estimate for the electronic transmissions, as the cost is incorporated into the development of the IT system for the Exchange eligibility and enrollment system.

4. Verification and Change Reporting (§§ 155.615, 155.620)

The Exchange will use the same verification processes for new applications and for changes that are reported during the year. This includes the process for situations in which the Exchange is unable to verify the information necessary to determine an applicant's eligibility, which is described in section 155.615(g). It is not possible at this time to provide estimates for the number of applicants for whom additional information will be required to complete an eligibility determination, but we anticipate that this number will decrease as applicants become more familiar with the eligibility process for exemptions and as more data become available electronically. As such, for now, we estimate the burden associated with the processing of documentation for one submission from an applicant. We note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff at an hourly cost of \$28.66 to review the documentation, for a total cost of \$6 per document submission.

5. ICRs Regarding Health Care Sharing Ministries (§ 155.615)

In order to facilitate the provision of an exemption for membership in a health care sharing ministry to the members of such ministry, we specify in § 155.615(c)(2) that an organization that believes that it meets the statutory standards to be considered a health care sharing ministry will submit certain information to HHS. We are aware of four organizations that have made public statements regarding their status as a health care sharing ministry. We

note that we will account for the additional burden associated with healthcare sharing ministries in a future information collection request that will go through the requisite notice and comment period and subsequent OMB review and approval process.

6. ICRs Regarding Agreements (§ 155.625)

These provisions specify that an Exchange that decides to utilize the HHS service for making eligibility determinations for exemptions for application submitted on or after October 15, 2014, will enter into a written agreement with HHS. These agreements are necessary to ensure that the use of the service will minimize burden on individuals, ensure prompt determinations of eligibility without undue delay, and provide for secure, timely transfers of application information.

The burden associated with these provisions is the time and effort necessary for the Exchange to establish an agreement with HHS. We estimate that the creation of the necessary agreement will necessitate 35 hours from a health policy analyst at an hourly cost of \$49.35, and 35 hours from an operations analyst at an hourly cost of \$54.45 to develop the agreement; and 30 hours from an attorney at an hourly cost of \$90.14 and five hours from a senior manager at an hourly cost of \$79.14 to review the agreement. For the purpose of this estimate, we assume that the 18 state-based Exchanges will utilize the HHS service for exemptions. Accordingly, the total burden on the Exchange associated with the creation of the necessary agreement will be approximately 105 hours and \$6,733 per Exchange, for a total cost of \$121,194 for 18 Exchanges.

7. ICRs Regarding Minimum Essential Coverage (§§ 156.604(a)(3), 156.604(d))

Organizations that currently provide health coverage that are not statutorily specified and not designated as minimum essential coverage in this regulation may submit a request to CMS that their coverage be recognized as minimum essential coverage. As described in § 156.604(a)(3), sponsoring organizations would have to electronically submit to CMS information regarding their plans and certify that their plans meet substantially all of the requirements in the Title I of Affordable Care Act, as applicable to non-grandfathered, individual coverage. Some commenters suggested that organizations submitting such requests provide more information regarding their plans rather than simply

certifying that their plans meet substantially all of the requirements in the Title I of Affordable Care Act. We have revised the certification to request plan documentation or other information that demonstrate that the coverage sponsored by the organization substantially complies with the provisions of Title I of the Affordable Care Act applicable to non-grandfathered individual health insurance coverage.

We sought comments on how many organizations are likely to submit such requests but did not receive any information that would allow us to estimate the number of requests. We assume that at least 10 organizations will submit such a request. The burden associated with this certification includes the time needed to collect and input the necessary plan information, and maintain a copy for recordkeeping by clerical staff and for a manager and legal counsel to review it and for a senior executive to review and sign it. The certification and attachments will be submitted to CMS electronically at minimal cost. We estimate that it will take a combined total of 5.25 hours (4 hours for clerical staff at an hourly cost of \$30.64, 0.5 hours for a manager at an hourly cost of \$55.22, 0.5 hours for legal counsel at an hourly cost of \$83.10 and 0.25 hours for a senior executive at an hourly cost of \$112.43) to prepare and submit the information and certification to CMS and to retain a copy for recordkeeping purposes. The total cost for one organization is estimated to be approximately \$220. Therefore, the total burden for 10 organizations will be 52.5 hours, with an equivalent cost of \$2,200.

Section 156.604(d) specifies that sponsoring organizations whose health coverage are recognized as minimum essential coverage will have to provide a notice to enrollees informing them that the plan has been recognized as minimum essential coverage for the purposes of the Code. The notice requirement may be satisfied by inserting a statement into existing plan documents. Plan documents are usually reviewed and updated annually before a new plan year begins. Sponsoring organizations may insert the statement in their plan documents at that time at minimal cost. Once the notice is included in the plan documents the first year, no additional cost will be incurred in future years. Therefore this notice is not subject to the Paperwork Reduction Act of 1995. Commenters suggested that a sponsoring organization should be required to provide a notice to enrollees if its request is denied and its plan is not recognized as minimum essential coverage. To minimize the burden on

sponsoring organizations, we are not requiring such a notice.
 The sponsor of any type of coverage recognized as minimum essential coverage is also required to provide the annual information reporting to the IRS

specified in section 6055 of the Code and furnish statements to individuals enrolled in such coverage to assist them in establishing that they are not liable for the shared responsibility payment under section 5000A of the Code. The

Department of Treasury plans to publish for public comment, in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the required ICRs in the near future.

TABLE 1—ANNUAL INFORMATION COLLECTION REQUIREMENTS

Regulation section(s)	Description	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)
§ 155.610	Application Development	18	18	1,059	19,062
§ 155.610	Application Completion	12,000,000	12,000,000	0.27	3,200,000
§§ 155.610, 155.620	Notice Development and Maintenance	18	18	125	2,250
§ 155.620	Change Reporting	1	1	0.2	0.2
§ 155.625	Agreements	18	18	105	1,890
§§ 156.604(a)(3)	Minimum Essential Coverage Certification.	10	10	5.25	52.5
Total	3,223,255

C. Submission of PRA-Related Comments

We have submitted a copy of this final rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the CMS Web site at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>, or call the Reports Clearance Office at 410-786-1326.

V. Summary of Regulatory Impact Statement

A. Summary

As stated earlier in this preamble, this final rule implements certain functions of the Exchanges. These specific statutory functions include determining eligibility for and granting certificates of exemption from the individual shared responsibility payment described in section 5000A of the Internal Revenue Code. Additionally, this final rule implements the responsibility of the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage by designating certain coverage as minimum essential coverage. It also outlines substantive and procedural requirements that other types of individual coverage must fulfill in order to be recognized as minimum essential coverage under the Internal Revenue Code.

HHS has crafted this rule to implement the protections intended by Congress in an economically efficient manner. We have examined the effects of this rule as required by Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). In accordance with OMB Circular A-4, CMS has quantified the benefits, costs and transfers where possible, and has also provided a qualitative discussion of some of the benefits, costs and transfers that may stem from this final rule.

B. Executive Orders 13563 and 12866

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a final rule—(1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition,

jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year), and a "significant" regulatory action is subject to review by the OMB. This rule has been designated a "significant regulatory action" under Executive Order 12866. Accordingly, OMB has reviewed this final regulation pursuant to the Executive Order.

1. Need for Regulatory Action

This final rule sets forth standards and processes under which the Exchange will conduct eligibility determinations for and grant certificates of exemption from the individual shared responsibility payment. Furthermore, it supports and complements rulemaking conducted by the Secretary of the Treasury with respect to section 5000A of the Code, as added by section 1501(b) of the Affordable Care Act. The intent of this rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where

there are compelling practical, efficiency, or consumer protection reasons. In addition, this final rule provides standards for determining whether certain other types of health insurance coverage constitute minimum essential coverage and procedures for sponsors to follow for a plan to be identified as minimum essential coverage under section 5000A of the Code. This rule also designates certain types of existing health coverage as minimum essential coverage. Other types of coverage, not statutorily specified and not designated as minimum essential coverage in this regulation, may be recognized as minimum essential coverage if certain substantive and procedural requirements are met as set forth in this rule.

2. Summary of Impacts

In developing this final rule, HHS carefully considered its potential effects including costs and benefits. Because of data limitations, HHS did not attempt to quantify the benefits, costs and transfers resulting from this final rule. Nonetheless, HHS was able to identify several potential impacts which are discussed qualitatively below.

The exemption provisions of this final rule set forth how and what exemptions can be received through the Exchange. Given the statute, these rules would generate exemption request activity; the final rules could also potentially affect the amount of shared responsibility payments made in a given year and the number of individuals who would enroll in health insurance plans to avoid shared responsibility payments. The impact of the minimum essential coverage provisions would be similar; individuals whose coverage would be designated minimum essential coverage, under the authority of the Secretary of Health and Human Services to designate other health benefit coverage as minimum essential coverage, would, in the absence of the rule, pay shared responsibility payments or switch health insurance coverage so as not to incur those penalties.

As noted in our discussion, above, of information collection requirements, while CBO estimates that 24 million individuals would be exempt from the penalty in 2016, it is unclear how many individuals will seek these exemptions from an Exchange. These submissions would be associated with a variety of effects, including: costs to Exchanges to review the exemption requests; costs to applicants to request exemptions and retain documents; potential effects on enrollment in health coverage and its benefits; and a transfer from the federal

government to individuals receiving exemptions in cases in which there is a foregone shared responsibility payment.

We note that the cost to an applicant of submitting a request and retaining documents is bounded by the expected shared responsibility payment; otherwise, he or she would not necessarily apply for the exemption. Though we lack data to precisely characterize the effects of these provisions, we note that the potential number of individuals seeking exemptions through the Exchange could place the overall impact of the final rule over the \$100 million threshold for economic significance, even at a low economic cost per individual.

The minimum essential coverage provisions included in this final rule could lead to transfers from the federal government to affected individuals (in this case, individuals whose coverage is designated to be minimum essential coverage) and have effects on health coverage enrollment (for example, decreased switching between plans). Decreased switching between plans would entail time savings for affected individuals and uncertain effects on premium payments and use of medical services and products. We currently lack data to estimate the number of individuals whose coverage would be designated minimum essential coverage by this rule.

C. Alternatives Considered

Under the Executive Order, HHS is required to consider alternatives to issuing rules and alternative regulatory approaches. HHS considered the regulatory alternatives below:

1. Grant Certificates for All Categories of Exemptions

Section 155.605 provides the eligibility standards for exemptions that will be granted by the Exchange. The preamble to this section notes that Exchanges will not grant certificates of exemption in four categories: (1) Lack of affordable coverage; (2) household income below the filing threshold; (3) not lawfully present; and (4) short coverage gaps. Also, Exchanges will not grant certificates of exemptions for certain hardship exemptions, specifically § 155.605(g)(3) and (5). These exemptions instead are solely available during the tax filing process, as we believe that the IRS is in a better position to issue these exemptions.

The alternative model would specify that the Exchange would provide certificates of exemption in all nine categories described in section 5000A of the Code. This alternative model was not selected for practical and

administrative reasons; the specific reasons for taking this approach are discussed in the preamble associated with this section of the final regulation. For example, for certain categories of exemptions, the information needed will only be available on a retrospective basis, and is most efficiently available through the tax filing process. Thus, we believe that the least burdensome approach for individuals and Exchanges is to make these exemptions available only through the tax filing process.

2. Designation of State High Risk Pools, Self-Funded Student Health Plans and AmeriCorps as Minimum Essential Coverage

We considered designating state high risk pools, self-funded student health plans, foreign health coverage and AmeriCorps as minimum essential coverage in section 156.602. After careful review of comments received, state high risk pools and self-funded student health plans will be designated as minimum essential coverage for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, self-funded student health plans and state high risk pools may apply to be recognized as minimum essential coverage. HHS hopes that during this transitional year, such plans will voluntarily adopt Affordable Care Act consumer protections to ensure their qualification as minimum essential coverage. We also considered automatically designating AmeriCorps and foreign health coverage as minimum essential coverage but did not adopt that policy in this final rule. These types of coverage may be recognized as minimum essential coverage through the certification process outlined in § 156.604 of this final rule. We believe that the options adopted in this final rule provide the best balance between allowing individuals to retain their current coverage and ensuring that they receive the consumer protections in the Affordable Care Act.

VI. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-

profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. As the burden for this final regulation falls on either Exchanges or individuals, the finalized regulations will not have a significant economic impact on a substantial number of small entities, and therefore, a regulatory flexibility analysis is not required.

VII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2013, that threshold is approximately \$141 million. This final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of \$141 million. The majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 2012 Medicaid eligibility rule. Furthermore, this final rule does not set any mandate on states to set up an Exchange.

VIII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. We note again that the impact of changes related to implementation of the Affordable Care Act was described in the RIA associated with the Exchange final rule. As discussed in the Exchange final rule RIA, we have consulted with states to receive input on how the various Affordable Care Act provisions codified in this proposed rule would affect states.

Because states have flexibility in designing their Exchange, state decisions will ultimately influence both administrative expenses and overall premiums. However, because states are not required to create an Exchange, these costs are not mandatory. For states electing to create an Exchange, the initial costs of the creation of the Exchange will be funded by Exchange

Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources left to the discretion of the state. In the Department’s view, while this proposed rule does not impose substantial direct costs on state and local governments, it has federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each state electing to establish a state-based Exchange must adopt the federal standards contained in the Affordable Care Act and in this proposed rule, or have in effect a state law or regulation that implements these federal standards. However, the Department anticipates that the federalism implications (if any) are substantially mitigated because states have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require states to establish an Exchange; but if a state elects not to establish an Exchange or the state’s Exchange is not approved, HHS, will establish and operate an Exchange in that state. Additionally, states will have the opportunity to participate in state Partnership Exchanges that would allow states to leverage work done by other states and the federal government, and will be able to leverage a federally-managed service for eligibility determination for exemptions.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, the Department has engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state officials on an individual basis.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached final regulation in a meaningful and timely manner.

IX. Congressional Review Act

This rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that

before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to the Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below:

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

- 1. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

- 2. Amend § 155.20 by revising the introductory text to paragraph (1) for the definition of “Applicant” and revising the definition of “Application filer” to read as follows:

§ 155.20 Definitions.

* * * * *

Applicant means:

(1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

* * * * *

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in 26 CFR 1.36B-1(d), an authorized representative of an applicant, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part.

* * * * *

■ 3. In § 155.200, revise paragraph (a) to read as follows:

§ 155.200 Functions of an Exchange.

(a) **General requirements.** The Exchange must perform the minimum functions described in this subpart and in subparts D, E, G, H, and K of this part.

* * * * *

■ 4. Add subpart G to part 155 to read as follows:

Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions.

Sec.

155.600 Definitions and general requirements.

155.605 Eligibility standards for exemptions.

155.610 Eligibility process for exemptions.

155.615 Verification process related to eligibility for exemptions.

155.620 Eligibility redeterminations for exemptions during a calendar year.

155.625 Options for conducting eligibility determinations for exemptions.

155.630 Reporting.

155.635 Right to appeal.

Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions**§ 155.600 Definitions and general requirements.**

(a) **Definitions.** For purposes of this subpart, the following terms have the following meaning:

Applicant means an individual who is seeking an exemption for him or herself

through an application submitted to the Exchange.

Application filer means an applicant, an individual who is liable for the shared responsibility payment in accordance with section 5000A of the Code for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

Exemption means an exemption from the shared responsibility payment.

Health care sharing ministry has the same meaning as it does in section 5000A(d)(2)(B)(ii) of the Code.

Indian tribe has the same meaning as it does in section 45A(c)(6) of the Code.

Required contribution has the same meaning as it does in section 5000A(e)(1)(B) of the Code.

Shared responsibility payment means the payment imposed with respect to a non-exempt individual who does not maintain minimum essential coverage in accordance with section 5000A(b) of the Code.

Tax filer has the same meaning as it does in § 155.300(a).

(b) **Attestation.** For the purposes of this subpart, any attestation that an applicant is to provide under this subpart may be made by the application filer on behalf of the applicant.

(c) **Reasonably compatible.** For purposes of this subpart, the Exchange must consider information through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant for the exemption or exemptions for which he or she applied.

(d) **Accessibility.** Information, including notices, forms, and applications, must be provided to applicants in accordance with the standards specified in § 155.205(c).

(e) **Notices.** Any notice required to be sent by the Exchange to an individual in accordance with this subpart must be provided in accordance with the standards specified in § 155.230.

§ 155.605 Eligibility standards for exemptions.

(a) **Eligibility for an exemption through the Exchange.** Except as specified in paragraph (g) of this section, the Exchange must determine an applicant eligible for and issue a certificate of exemption for any month if the Exchange determines that he or she meets the requirements for one or more of the categories of exemptions described in this section for at least one day of the month.

(b) **Duration of single exemption.** Except as specified in paragraphs (c)(2), (f)(2), and (g) of this section, the Exchange may provide a certificate of exemption only for the calendar year in which an applicant submitted an application for such exemption.

(c) **Religious conscience.** (1) The Exchange must determine an applicant eligible for an exemption for any month if the applicant is a member of a recognized religious sect or division described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division, for such month in accordance with section 5000A(d)(2)(A) of the Code.

(2) **Duration of exemption for religious conscience.** (i) The Exchange must grant the certificate of exemption specified in this paragraph to an applicant who meets the standards provided in paragraph (c)(1) of this section for a month on a continuing basis, until the month after the month of the individual's 21st birthday, or until such time that an individual reports that he or she no longer meets the standards provided in paragraph (c)(1) of this section.

(ii) If the Exchange granted a certificate of exemption in this category to an applicant prior to his or her reaching the age of 21, the Exchange must send the applicant a notice upon reaching the age of 21 informing the applicant that he or she must submit a new exemption application to maintain the certificate of exemption.

(3) The Exchange must make an exemption in this category available prospectively or retrospectively.

(d) **Membership in a health care sharing ministry.** (1) The Exchange must determine an applicant eligible for an exemption for a month if for such month the applicant is a member of a health care sharing ministry as defined in section 5000A(d)(2)(B)(ii) of the Code.

(2) The Exchange must make an exemption in this category available only retrospectively.

(e) **Incarceration.** (1) The Exchange must determine an applicant eligible for an exemption for a month if he or she meets the standards in section 5000A(d)(4) of the Code for such month.

(2) The Exchange must make an exemption in this category available only retrospectively.

(f) **Membership in an Indian tribe.** (1) The Exchange must determine an applicant eligible for an exemption for any month if he or she is a member of an Indian tribe, as defined in section 45A(c)(6) of the Code, for such month, as provided in section 5000A(e)(3) of the Code.

(2) *Duration of exemption for membership in an Indian tribe.* The Exchange must grant the exemption specified in this paragraph to an applicant who meets the standards specified in paragraph (f)(1) of this section for a month on a continuing basis, until such time that the applicant reports that he or she no longer meets the standards provided in paragraph (f)(1) of this section.

(3) The Exchange must make an exemption available in this category prospectively or retrospectively.

(g) *Hardship*—(1) *General.* The Exchange must grant a hardship exemption to an applicant eligible for an exemption for at least the month before, a month or months during which, and the month after, if the Exchange determines that—

(i) He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan;

(ii) The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or

(iii) He or she has experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan.

(2) *Lack of affordable coverage based on projected income.* The Exchange must determine an applicant eligible for an exemption for a month or months during which he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.36B-1(d), is unable to afford coverage in accordance with the standards specified in section 5000A(e)(1) of the Code, provided that—

(i) Eligibility for this exemption is based on projected annual household income;

(ii) An eligible employer-sponsored plan is only considered under paragraphs (g)(2)(iii) and (iv) of this section if it meets the minimum value standard described in § 156.145 of this subchapter.

(iii) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage such that—

(A) An individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan;

(B) Wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned;

(C) In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

(D) In the case of an individual who is eligible to purchase coverage under an eligible employer-sponsored plan as a member of the employee's family, as defined in 26 CFR 1.36B-1(d), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

(iv) For an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage in accordance with section 5000A(e)(1)(B)(ii) of the Code, inclusive of all members of the family, as defined in 26 CFR 1.36B-1(d), who have not otherwise been granted an exemption through the Exchange and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan, in accordance with paragraph (g)(2)(ii) of this section; and

(v) The applicant applies for this exemption prior to the last date on which he or she could enroll in a QHP through the Exchange for the month or months of a calendar year for which the exemption is requested.

(vi) The Exchange must make an exemption in this category available prospectively, and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

(3) *Filing threshold.* The IRS may allow an applicant to claim an exemption for a calendar year if he or she was not required to file an income tax return for such calendar year because his or her gross income was below the filing threshold, but who nevertheless filed, claimed a dependent with a filing requirement, and as a result, had household income exceeding the applicable return filing threshold described in section 5000A(e)(2) of the Code;

(4) *Ineligible for Medicaid based on a state's decision not to expand.* The Exchange must determine an applicant eligible for an exemption for a calendar year if he or she has been determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act;

(5) *Self-only coverage in an eligible employer-sponsored plan.* The IRS may allow an applicant to claim an exemption for a calendar year if he or she, as well as one or more employed members of his or her family, as defined in 26 CFR 1.36B-1(d), has been determined eligible for affordable self-only employer-sponsored coverage pursuant to section 5000A(e)(1) of the Code through their respective employers for one or more months during the calendar year, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of household income for that calendar year; or

(6) *Eligible for services through an Indian health care provider.* (i) The Exchange must determine an applicant eligible for an exemption for any month if he or she is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.50 and not otherwise eligible for an exemption under paragraph (f) of this section, or an individual eligible for services through the Indian Health Service in accordance with 25 USC 1680c(a), (b), or (d)(3).

(ii) The Exchange must grant the exemption specified in paragraph (g)(6) of this section to an applicant who meets the standards specified in paragraph (g)(6) of this section for a month on a continuing basis, until such time that the applicant reports that he or she no longer meets the standards provided in paragraph (g)(6) of this section.

§ 155.610 Eligibility process for exemptions.

(a) *Application.* Except as specified in paragraphs (b) and (c) of this section, the Exchange must use an application established by HHS to collect information necessary for determining eligibility for and granting certificates of exemption as described in § 155.605.

(b) *Alternative application.* If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

(c) *Exemptions through the eligibility process for coverage.* If an individual

submits the application described in § 155.405 and then requests an exemption, the Exchange must use information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination, and must not request duplicate information or conduct repeat verifications to the extent that the Exchange finds that such information is still applicable, where the standards for such verifications adhere to the standards specified in this subpart.

(d) *Filing the exemption application.* The Exchange must—

(1) Accept the application from an application filer; and

(2) Provide the tools to file an application.

(3) For applications submitted before October 15, 2014, the Exchange must, at a minimum, accept the application by mail.

(e) *Collection of Social Security Numbers.* (1) The Exchange must require an applicant who has a Social Security number to provide such number to the Exchange.

(2) The Exchange may not require an individual who is not seeking an exemption for himself or herself to provide a Social Security number, except as specified in paragraph (e)(3) of this section.

(3) The Exchange must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size for an exemption under § 155.605(g)(2) that requires such verification.

(f) *Determination of eligibility; granting of certificates.* The Exchange must determine an applicant's eligibility for an exemption in accordance with the standards specified in § 155.605, and grant a certificate of exemption to any applicant determined eligible.

(g) *Timeliness standards.* (1) The Exchange must determine eligibility for exemption promptly and without undue delay.

(2) The Exchange must assess the timeliness of eligibility determinations made under this subpart based on the period from the date of application to the date the Exchange notifies the applicant of its decision.

(h) *Exemptions for previous tax years.* (1) Except for the exemptions described in § 155.605(c), (f), and (g), after December 31 of a given calendar year, the Exchange will not accept an

application for an exemption that is available retrospectively for months for such calendar year, and must provide information to individuals regarding how to claim an exemption through the tax filing process.

(2) The Exchange will only accept an application for an exemption described in § 155.605(g)(1) during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred.

(i) *Notification of eligibility determination for exemptions.* The Exchange must provide timely written notice to an applicant of any eligibility determination made in accordance with this subpart. In the case of a determination that an applicant is eligible for an exemption, this notification must include the exemption certificate number for the purposes of tax administration.

(j) *Retention of records for tax compliance.* (1) An Exchange must notify an individual to retain the records that demonstrate receipt of the certificate of exemption and qualification for the underlying exemption.

(2) In the case of any factor of eligibility that is verified through use of the special circumstances exception described in § 155.615(h), the records that demonstrate qualification for the underlying exemption are the information submitted to the Exchange regarding the circumstances that warranted the use of the exception, as well as records of the Exchange decision to allow such exception.

§ 155.615 Verification process related to eligibility for exemptions.

(a) *General rule.* Unless a request for modification is granted under paragraph (i) of this section, the Exchange must verify or obtain information as provided in this section in order to determine that an applicant is eligible for an exemption.

(b) *Verification related to exemption for religious conscience.* For any applicant who requests an exemption based on religious conscience, the Exchange must verify that he or she meets the standards specified in § 155.605(c) by—

(1) Except as specified in paragraph (b)(2) of this section, accepting a form that reflects that he or she is exempt from Social Security and Medicare taxes under section 1402(g)(1) of the Code;

(2) Except as specified in paragraphs (b)(3) and (4) of this section, accepting his or her attestation of membership in a religious sect or division, and verifying that the religious sect or division to which the applicant attests

membership is recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code.

(3) If information provided by an applicant regarding his or her membership in a religious sect or division is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must follow the procedures specified in paragraph (g) of this section.

(4) If an applicant attests to membership in a religious sect or division that is not recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code, the Exchange must provide the applicant with information regarding how his or her religious sect or division can pursue recognition under section 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as the Exchange obtains information indicating that the religious sect or division has been approved.

(c) *Verification related to exemption for membership in a health care sharing ministry.* (1) For any applicant who requests an exemption based on membership in a health care sharing ministry, the Exchange must verify that the applicant meets the standards specified in § 155.605(d) by, except as provided in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, accepting his or her attestation; and verifying that the health care sharing ministry to which the applicant attests membership is known to the Exchange as a valid health care sharing ministry based on data provided by HHS—

(i) If information provided by an applicant regarding his or her membership in a health care sharing ministry is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must follow the procedures specified in paragraph (g) of this section. The Exchange may not consider an applicant's prior or current enrollment in health coverage as not reasonably compatible with an applicant's attestation of membership in a health care sharing ministry.

(ii) If an applicant attests to membership in a health care sharing ministry that is not known to the Exchange as a health care sharing ministry based on information provided by HHS, the Exchange must provide the applicant with information regarding how an organization can pursue recognition under § 155.615(c)(2), and determine the applicant ineligible for this exemption until such time as HHS

notifies the Exchange that the health care sharing ministry's meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code.

(2) To be considered a health care sharing ministry for the purposes of this subpart, an organization must submit information to HHS that substantiates the organization's compliance with the standards specified in section 5000A(d)(2)(B)(ii) of the Code. If at any time HHS determines that an organization previously considered a health care sharing ministry for the purposes of this subpart no longer meets the standards specified in section 5000A(d)(2)(B)(ii) of the Code, HHS may revoke its earlier decision regarding the status of the health care sharing ministry.

(d) *Verification related to exemption for incarceration.* (1) For any applicant who provides information attesting that he or she was incarcerated for a given month in accordance with the standards specified in § 155.605(e), the Exchange must verify his or her attestation through the same process as described in § 155.315(e).

(2) To the extent that the Exchange is unable to verify an applicant's attestation that he or she was incarcerated for a given month in accordance with the standards specified in § 155.605(e) through the process described in § 155.315(e), the Exchange must follow the procedures specified in paragraph (g) of this section.

(e) *Verification related to exemption for members of Indian tribes.* (1) For any applicant who provides information attesting that he or she is a member of an Indian tribe, the Exchange must use the process outlined in § 155.350(c) to verify that the applicant is a member of an Indian tribe.

(2) To the extent that the Exchange is unable to verify an applicant's status as a member of an Indian tribe through the process described in § 155.350(c), the Exchange must follow the procedures specified in paragraph (g) of this section.

(f) *Verification related to exemption for hardship—(1) In general.* For any applicant who requests an exemption based on hardship, except for the hardship exemptions described in § 155.605(g)(3) and (5), the Exchange must verify whether he or she has experienced the hardship to which he or she is attesting.

(2) *Lack of affordable coverage based on projected income.* (i) For any applicant who requests an exemption based on the hardship described in § 155.605(g)(2), the Exchange must verify the unavailability of affordable coverage through the procedures used to

determine eligibility for advance payments of the premium tax credit, as specified in subpart D of this part, including the procedures described in § 155.315(c)(1), and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in § 155.320(e), except as specified in § 155.615(f)(2)(ii).

(ii) The Exchange must accept an application filer's attestation for an applicant regarding eligibility for minimum essential coverage other than through an eligible employer-sponsored plan, instead of following the procedures specified in § 155.320(b).

(3) *Eligible for services through an Indian health care provider.* For any applicant who requests an exemption based on the hardship described in § 155.605(g)(6), the Exchange must verify whether he or she meets the standards specified in § 155.605(g)(6) through the same process described in § 155.615(e).

(4) To the extent that the Exchange is unable to verify any of the information needed to determine an applicant's eligibility for an exemption based on hardship, the Exchange must follow the procedures specified in paragraph (g) of this section.

(g) *Inability to verify necessary information.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for an exemption, including but not limited to when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination for an exemption are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within the time period as specified in § 155.315(f), the Exchange—

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in paragraph (g)(1) of this section, must—

(i) Provide notice to the applicant regarding the inconsistency; and

(ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (g)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels

available for the submission of an application, as described in § 155.610(d), except for by telephone, or otherwise to resolve the inconsistency.

(3) May extend the period described in paragraph (g)(2)(ii) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

(4) During the period described in paragraph (g)(1) and (g)(2)(ii) of this section, must not grant a certificate of exemption based on the information subject to this paragraph.

(5) If, after the period described in paragraph (g)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility for an exemption based on any information available from the data sources used in accordance with this subpart, if applicable, unless such applicant qualifies for the exception provided under paragraph (h) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.610(i), including notice that the Exchange is unable to verify the attestation.

(h) *Exception for special circumstances.* For an applicant who does not have documentation with which to resolve the inconsistency through the process described in paragraph (g)(2) of this section because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, the Exchange must provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.

(i) *Flexibility in information collection and verification.* HHS may approve an Exchange Blueprint in accordance with § 155.105(d) or a significant change to the Exchange Blueprint in accordance with § 155.105(e) to modify the methods to be used for collection of information and verification as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements under §§ 155.260, 155.270, and paragraph (j) of this section, and section 6103 of the Code with respect to the confidentiality,

disclosure, maintenance, or use of such information will be met.

(j) *Applicant information.* The Exchange may not require an applicant to provide information beyond the minimum necessary to support the eligibility process for exemptions as described in this subpart.

(k) *Validation of Social Security number.* (1) For any individual who provides his or her Social Security number to the Exchange, the Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (g) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (g)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

§ 155.620 Eligibility redeterminations for exemptions during a calendar year.

(a) *General requirement.* The Exchange must redetermine the eligibility of an individual with an exemption granted by the Exchange if it receives and verifies new information reported by such an individual, except for the exemption described in § 155.605(g)(2).

(b) *Requirement for individuals to report changes.* (1) Except as specified in paragraph (b)(2) of this section, the Exchange must require an individual who has a certificate of exemption from the Exchange to report any change with respect to the eligibility standards for the exemption as specified in § 155.605, except for the exemption described in § 155.605(g)(2), within 30 days of such change.

(2) The Exchange must allow an individual with a certificate of exemption to report changes via the channels available for the submission of an application, as described in § 155.610(d).

(c) *Verification of reported changes.* The Exchange must—

(1) Verify any information reported by an individual with a certificate of exemption in accordance with the processes specified in § 155.615 prior to using such information in an eligibility redetermination.

(2) Notify an individual in accordance with § 155.610(i) after redetermining his or her eligibility based on a reported change.

(3) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption for which changes must be reported in accordance with § 155.620(b) and who has elected to receive electronic notifications, unless he or she has declined to receive such notifications.

(d) *Effective date of changes.* The Exchange must implement a change resulting from a redetermination under this section for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months remains effective.

§ 155.625 Options for conducting eligibility determinations for exemptions.

(a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—

(1) Directly or through contracting arrangements in accordance with § 155.110(a); or (2) Through the approach described in paragraph (b) of this section.

(b) *Use of HHS service.* Notwithstanding the requirements of this subpart—

(1) For an application submitted before October 15, 2014, the Exchange may adopt an exemption eligibility determination made by HHS, provided that—

(i) The Exchange adheres to the eligibility determination made by HHS;

(ii) The Exchange furnishes to HHS any information available through the Exchange that is necessary for an applicant to utilize the process administered by HHS; and

(iii) The Exchange call center and Internet Web site specified in § 155.205(a) and (b), respectively, provide information to consumers regarding the exemption eligibility process.

(2) For an application submitted on or after October 15, 2014, the Exchange may adopt an exemption eligibility determination made by HHS, provided that—

(i) The Exchange accepts the application, as specified in § 155.610(c), and issues the eligibility notice, as specified in § 155.610(i);

(ii) Verifications and other activities required in connection with eligibility determinations for exemptions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (b)(2)(v) of this section;

(iii) The Exchange transmits to HHS promptly and without undue delay and via secure electronic interface, all information provided as a part of the application or update that initiated the eligibility determination, and any information obtained or verified by the Exchange;

(iv) The Exchange adheres to the eligibility determination made by HHS; and

(v) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for exemptions.

§ 155.630 Reporting.

Requirement to provide information related to tax administration. If the Exchange grants an individual a certificate of exemption in accordance with § 155.610(i), the Exchange must transmit to the IRS at such time and in such manner as the IRS may specify—

(a) The individual's name, Social Security number, and exemption certificate number;

(b) Any other information required in guidance published by the Secretary of the Treasury in accordance with 26 CFR 601.601(d)(2).

§ 155.635 Right to appeal.

(a) For an application submitted before October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 155.610(i).

(b) For an application submitted on or after October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 155.610(i) and § 155.625(b)(2)(i).

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 5. The authority citation for part 156 is revised to read as follows:

Authority: Title I of the Affordable Care Act, Sections 1301–1304, 1311–1312, 1321, 1322, 1324, 1334, 1341–1343, and 1401–1402, 1501, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18042).

■ 6. Add subpart G to part 156 to read as follows:

Subpart G—Minimum Essential Coverage

Sec.

156.600 The definition of minimum essential coverage.

156.602 Other coverage that qualifies as minimum essential coverage.

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.

156.606 HHS audit authority.

Subpart G—Minimum Essential Coverage

§ 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 complies 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).

Dated: June 7, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services

Approved: June 11, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–15530 Filed 6–26–13; 11:15 am]

BILLING CODE 4120–01–P