(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange would begin open enrollment as a State Exchange;

(4) Develop a plan jointly with HHS to facilitate the transition to a State Exchange; and

(5) If the open enrollment period for the year the State intends to begin operating an SBE has not been established, this deadline must be calculated based on the date open enrollment began or will begin in the year in which the State is submitting the Blueprint application.

(b) *Transition process for State Exchanges that cease operations.* If a State intends to cease operation of its Exchange, HHS will operate the Exchange on behalf of the State. Therefore, a State that intends to cease operations of its Exchange must:

(1) Notify HHS that it will no longer operate an Exchange at least 12 months prior to ceasing operations; and

(2) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

(c) *Process for State Exchanges that seek to utilize the Federal platform for select functions.* States may seek approval to operate a State Exchange utilizing the Federal platform for only the individual market. A State seeking approval to operate a State Exchange utilizing the Federal platform for the individual market to support select functions through a Federal platform agreement under §155.200(f) must:

(1) If the State Exchange does not have a conditionally approved Exchange Blueprint application, submit one for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(2) If the State Exchange has a conditionally approved Exchange Blueprint application, submit any significant changes to that application for HHS approval, in accordance with §155.105(e), at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange proposes to begin open enrollment as a State-based Exchanges on the Federal platform (SBE–FP), in accordance with HHS rules in this chapter, as a State Exchange utilizing the Federal platform;

(4) Prior to approval, or conditional approval, of the Exchange Blueprint, execute a Federal platform agreement for utilizing the Federal platform for select functions; and

(5) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

[77 FR 18444, Mar. 27, 2012, as amended at 79 FR 13837, Mar. 11, 2014; 81 FR 12336, Mar. 8, 2016; 83 FR 17060, Apr. 17, 2018; 88 FR 25917, Apr. 27, 2023]

§155.110 Entities eligible to carry out Exchange functions.

(a) *Eligible contracting entities.* The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are:

(1) An entity:

(i) Incorporated under, and subject to the laws of, one or more States;

(ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

(b) *Responsibility.* To the extent that an Exchange establishes such agreements, the Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met.

(c) *Governing board structure.* If the Exchange is an independent State

agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:

(1) Is administered under a formal, publicly-adopted operating charter or by-laws;

(2) Holds regular public governing board meetings that are announced in advance;

(3) Represents consumer interests by ensuring that overall governing board membership:

(i) Includes at least one voting member who is a consumer representative;

(ii) Is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(d) *Governance principles.* (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

(e) *SHOP independent governance.* (1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

(f) *HHS review.* HHS may periodically review the accountability structure and governance principles of a State Exchange.

§ 155.120 Non-interference with Federal law and non-discrimination standards.

(a) *Non-interference with Federal law.* An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) *Non-interference with State law.* Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.

(c) *Non-discrimination.* (1) In carrying out the requirements of this part, the State and the Exchange must:

(i) Comply with applicable non-discrimination statutes; and

(ii) Not discriminate based on race, color, national origin, disability, age, or sex.

(2) Notwithstanding the provisions of paragraph (c)(1)(ii) of this section, an organization that receives Federal funds to provide services to a defined population under the terms of Federal legal authorities that participates in the certified application counselor program under §155.225 may limit its provision of certified application counselor services to the same defined population, but must comply with paragraph (c)(1)(ii) of this section with respect to the provision of certified application counselor services to that defined population. If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other Exchange-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with paragraph (c)(1)(ii) of this section.

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