§155.410(e)(2) of the applicable calendar year.

[77 FR 18467, Mar. 27, 2012, as amended at 80 FR 10870, Feb. 27, 2015]

§ 155.1080 Decertification of QHPs.

(a) *Definition.* The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) *Decertification process.* Except with respect to multi-State plans and CO–OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.

(c) *Decertification by the Exchange.* The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in §155.1000(c).

(d) *Appeal of decertification.* The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) *Notice of decertification.* Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420;

(3) HHS; and

(4) The State department of insurance.

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

§ 155.1090 Request for reconsideration.

(a) *Request for reconsideration of denial of certification specific to a Federally-facilitated Exchange*—(1) *Request for reconsideration.* The Federally-facilitated Exchanges will permit an issuer that has submitted a complete application to a Federally-facilitated Exchange for certification of a health plan as a QHP and is denied certification to request reconsideration of such action.

(2) *Form and manner of request.* An issuer submitting a request for reconsideration under paragraph (a)(1) of this section must submit a written request for reconsideration to HHS, in the form and manner specified by HHS, within 7 calendar days of the date of the written notice of denial of certification. The issuer must include any and all documentation the issuer wishes to provide in support of its request with its request for reconsideration.

(3) *HHS reconsideration decision.* HHS will provide the issuer with a written notice of the reconsideration decision. The decision will constitute HHS's final determination.

(b) [Reserved]

[81 FR 94180, Dec. 22, 2016]

Subpart L [Reserved]

Subpart M—Oversight and Program Integrity Standards for State Exchanges

SOURCE: 78 FR 65095, Oct. 30, 2013, unless otherwise noted.

§ 155.1200 General program integrity and oversight requirements.

(a) *General requirement.* A State Exchange must:

(1) Keep an accurate accounting of Exchange receipts and expenditures in accordance with generally accepted accounting principles (GAAP).

(2) Monitor and report to HHS on Exchange related activities.

(3) Collect and report to HHS performance monitoring data.

(b) *Reporting.* The State Exchange must, at least annually, provide to HHS, in a manner specified by HHS and by applicable deadlines specified by HHS, the following data and information:

(1) A financial statement presented in accordance with GAAP,

(2) Information showing compliance with Exchange requirements under this part 155 through submission of annual reports,

(3) Performance monitoring data, and

(4) If the Exchange is collecting premiums under §155.240, a report on instances in which it did not reduce an enrollee's premium by the amount of the advance payment of the premium tax credit in accordance with §155.340(g)(1) and (2).

(c) *External audits.* The State Exchange must engage an independent

qualified auditing entity which follows generally accepted government auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review. The State Exchange must:

(1) Provide to HHS the results of the annual external audit; and

(2) Inform HHS of any material weakness or significant deficiency identified in the audit and must develop and inform HHS of a corrective action plan for such material weakness or significant deficiency;

(3) Make public a summary of the results of the external audit.

(d) *External audit standard.* The State Exchange must ensure that independent audits of State Exchange financial statements and program activities in paragraph (c) of this section address:

(1) Compliance with paragraph (a)(1) of this section;

(2) Compliance with subparts D and E of this part 155, or other requirements under this part 155 as specified by HHS;

(3) Processes and procedures designed to prevent improper eligibility determinations and enrollment transactions, as applicable;

(4) Compliance with eligibility and enrollment standards through sampling, testing, or other equivalent auditing procedures that demonstrate the accuracy of eligibility determinations and enrollment transactions; and

(5) Identification of errors that have resulted in incorrect eligibility determinations, as applicable.

[78 FR 65095, Oct. 30, 2013, as amended at 84 FR 71710, Dec. 27, 2019]

§ 155.1210 Maintenance of records.

(a) *General.* The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following:

(1) Accommodate periodic auditing of the State Exchange's financial records; and

(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards.

(b) *Records.* The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:

(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;

(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;

(3) Any financial reports filed with other Federal programs or State authorities;

(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and

(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information.

(c) *Availability.* A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

Subpart N—State Flexibility

§ 155.1300 Basis and purpose.

(a) *Statutory basis.* This subpart implements provisions of section 1332 of the Affordable Care Act, relating to Waivers for State Innovation, which the Secretary may authorize for plan years beginning on or after January 1, 2017. Section 1332 of the Affordable Care Act requires the Secretary to issue regulations that provide for all of the following:

(1) A process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input.

(2) A process for the submission of an application that ensures the disclosure of all of the following: