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and the same premium rate standards described at 45 CFR 156.255.

(d) *Allocation standards for stand-alone dental plans.* The issuer must ensure that the dollar allocation described in paragraph (b) of this section is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

(e) *Disclosure of attribution and allocation methods.* An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange must submit to the Exchange annually for approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

(f) *Multi-State plans.* Issuers of multi-State plans, as defined in §155.1000(a) of this subchapter, must submit the allocations and actuarial memorandum described in this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

[78 FR 15535, Mar. 11, 2013, as amended at 79 FR 13840, Mar. 11, 2014]

### §156.480 Oversight of the administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs.

(a) *Maintenance of records.* An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in §156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.

(b) *Annual reporting requirements.* For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under §§156.410(a) through (d), 156.425(a) through (b), and 156.460(a) through (c) of this part.

(c) *Audits and compliance reviews.* HHS or its designee may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements of this subpart and 45 CFR 156.50. Compliance reviews conducted under this section will follow the standards set forth in §156.715.

(1) *Notice of audit.* HHS will provide at least 30 calendar days advance notice of its intent to conduct an audit of an issuer under this section.

(i) *Conferences.* All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed.

(ii) [Reserved]

(2) *Compliance with audit activities.* To comply with an audit under this section, the issuer must:

(i) Ensure that its relevant employees, agents, contractors, subcontractors, downstream entities, and delegated entities cooperate with any audit or compliance review under this section;

(ii) Submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial audit response deadline established by HHS at the entrance conference described under paragraph (c)(1)(i) of this section for the applicable benefit year;

(iii) Respond to all audit notices, letters, and inquiries, including requests for supplemental or supporting information, as requested by HHS, no later than 15 calendar days after the date of the notice, letter, request, or inquiry; and

(iv) In circumstances in which an issuer cannot provide the requested data or response to HHS within the timeframes under paragraph (c)(2)(ii)



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or (iii) of this section, as applicable, the issuer may make a written request for an extension to HHS. The extension request must be submitted within the timeframe established under paragraph (c)(2)(ii) or (iii), as applicable, and must detail the reason for the extension request and the good cause in support of the request. If the extension is granted, the issuer must respond within the timeframe specified in HHS's notice granting the extension of time.

(3) *Preliminary audit findings.* HHS will share its preliminary audit findings with the issuer, who will then have 30 calendar days to respond to such findings in the format and manner specified by HHS.

(i) If the issuer does not dispute or otherwise respond to the preliminary findings, the audit findings will become final.

(ii) If the issuer responds and disputes the preliminary findings, HHS will review and consider such response and finalize the audit findings after such review.

(4) *Final audit findings.* If an audit results in the inclusion of a finding in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following:

(i) Within 45 calendar days of the issuance of the final audit or compliance review report, provide a written corrective action plan to HHS for approval.

(ii) Implement that plan.

(iii) Provide to HHS written documentation of the corrective actions once taken.

(5) *Failure to comply with audit activities.* If an issuer fails to comply with the audit activities set forth in this section in the manner and timeframes specified by HHS:

(i) HHS will notify the issuer of payments received under this subpart that the issuer has not adequately substantiated; and

(ii) HHS will notify the issuer that HHS may recoup any payments identified in paragraph (c)(5)(i) of this section.

(6) *Circumstances requiring HHS enforcement.* If HHS determines that the State Exchange or State-based Exchange on the Federal platform is not enforcing or fails to substantially enforce the requirements of this subpart or § 156.50, then HHS may do so and may pursue the imposition of civil money penalties as specified in § 156.805 for non-compliance by QHP issuers participating in the State Exchange or State Exchange on the Federal platform.

[78 FR 65100, Oct. 30, 2013, as amended at 86 FR 24292, May 5, 2021]

## Subpart F—Consumer Operated and Oriented Plan Program

### § 156.500 Basis and scope.

This subpart implements section 1322 of the Affordable Care Act by establishing the Consumer Operated and Oriented Plan (CO–OP) program to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, known as ''CO–OPs.'' Under this program, loans are awarded to encourage the development of CO–OPs. Applicants that meet the eligibility standards of the CO–OP program may apply to receive loans to help fund start-up costs and meet the solvency requirements of States in which the applicant seeks to be licensed to issue CO–OP qualified health plans. This subpart sets forth the eligibility and governance requirements for the CO–OP program, CO–OP standards, and the terms for loans awarded under the CO–OP program.

### § 156.505 Definitions.

The following definitions apply to this subpart:

*Applicant* means an entity eligible to apply for a loan described in § 156.520 of this subpart.

*Consumer operated and oriented plan (CO–OP)* means a loan recipient that satisfies the standards in section 1322(c) of the Affordable Care Act and § 156.515 of this subpart within the timeframes specified in this subpart.

*CO–OP qualified health plan* means a health plan that has in effect a certification that it meets the standards described in subpart C of this part, except that the plan can be deemed certified



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