State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6900, 6901, 6902, 6903, 6904, 6905, 6906, 6907, 6908
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF CERTIFICATE OF COMPLIANCE

Government Code Sections 11349.1 and 11349.6(d)

OAL Matter Number: 2020-0205-01

OAL Matter Type: Certificate of Compliance (C)

This rulemaking action makes permanent the emergency regulations regarding the application processes to become a Certified Medi-Cal Managed Care Plan, or a Certified Medi-Cal Managed Care Plan Enroller, for purposes of providing health plan enrollment assistance to individuals and regarding fingerprinting and criminal record checks of applicants. The action also adopts regulations concerning training requirements, roles and responsibilities, conflicts of interest for certified plans and certified enrollers, and necessary definitions, as well as provisions governing the suspension and revocation of certification of plans and enrollers.

OAL approves this regulatory action pursuant to section 11349.6(d) of the Government Code.

Date: March 12, 2020

Dale P. Mentink
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Peter Lee, Executive Director
Copy: Faviola Ramirez-Adams

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION CERT

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2019-0827-09	2020-0205-01C	

For use by Office of Administrative Law (OAL) only

2020 FEB -5 A 11:45

OFFICE OF ADMINISTRATIVE LAW

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
MAR 12 2020
1:35 PM

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
Medi-Cal Managed Care Plan Enrollment Assistance	10	6900	9/6/19

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
[X] Notice re Proposed Regulatory Action [ ] Other	Faviola Adams	916-228-8668	

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	[ ] Approved as Submitted [ ] Approved as Modified [ ] Disapproved/ Withdrawn	2019 36-Z	9/6/2019

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Medi-Cal Managed Care Plan Enrollment Assistance

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2017-0913-02 EE

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	
	ADOPT: Regular Rulemaking: 6900, 6901, 6905, 6906, 6907, 6908 / Cert. of Compliance: 6902, 6903, 6904
	AMEND:
TITLE(S): 10	REPEAL:

3. TYPE OF FILING

- [X] Regular Rulemaking (Gov. Code §11346)
- [ ] Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- [ ] Emergency (Gov. Code, §11346.1(b))
- [X] Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- [ ] Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- [ ] Emergency Readopt (Gov. Code, §11346.1(h))
- [ ] File & Print
- [ ] Other (Specify) _____
- [ ] Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- [ ] Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- [ ] Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- [X] Effective on filing with Secretary of State
- [ ] §100 Changes Without Regulatory Effect
- [ ] Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- [X] Department of Finance (Form STD. 399) (SAM §6660)
- [ ] Fair Political Practices Commission
- [ ] State Fire Marshal
- [ ] Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Faviola Adams	(916) 228-8668		faviola.ramirezadams@covered.ca

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: [signature] DATE: 2/3/20

TYPED NAME AND TITLE OF SIGNATORY: Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
MAR 12 2020
Office of Administrative Law

Title 10. Investment

Chapter 12. California Health Benefit Exchange

Article 12. Medi-Cal Managed Care Plan Enrollment Assistance

§ 6900. Definitions.

(a) For purposes of this Article, the following terms shall have the following associated meanings:

(1) Authorized Contact: The individual appointed by the Certified Medi-Cal Managed Care Plan entity to manage the agreement executed with the Exchange pursuant to this Article.

(2) Certified Medi-Cal Managed Care Plan: a Medi-Cal Managed Care Plan who has been certified pursuant to this Article.

(3) Certified Medi-Cal Managed Care Plan Enroller or Enroller: An individual that is an employee or contractor of a Certified Medi-Cal Managed Care Plan who provides enrollment assistance pursuant to this Article.

(4) Consumer Assistance: The programs and activities created under 45 C.F.R. § 155.205(d) (December 22, 2016), hereby incorporated by reference, to provide enrollment assistance to consumers.

(5) Medi-Cal Managed Care Plan: An entity contracting with the Department of Health Care Services (DHCS) to provide health care services to enrolled Medi-Cal beneficiaries under Chapter 7, commencing with section 14000, or Chapter 8, commencing with section 14200, of Division 9, Part 3, of the Welfare and Institutions Code.

(6) Primary Contact: The individual appointed by the Certified Medi-Cal Managed Care Plan to be the liaison with the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 C.F.R Section 155.205.

§ 6901. Eligibility.

(a) All California Medi-Cal Managed Care Plans as defined in section 6900 are eligible to apply to become a Certified Medi-Cal Managed Care Plan with the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6902. Application.

(a) A Medi-Cal Managed Care Plan may apply to register as a Certified Medi-Cal Managed Care Plan according to the following process:

(1) The entity shall submit an application containing all information, documentation, and declarations required in subdivision (b) of this section.

(2) The application shall demonstrate that the entity is capable of carrying out at least those duties described in section 6906 and has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a Qualified Health Plan (QHP) or an insurance affordability program.

(3) The Exchange shall review the application and, if applicable, request any additional or missing information necessary to determine eligibility.

(4) Entities who have submitted a completed application and demonstrated ability to meet the above requirements shall:

(A) Submit the following:

1. An executed agreement conforming to the Roles and Responsibilities defined in section 6906; and

2. Proof of general liability insurance with coverage of not less than $1,000,000 per occurrence with the Exchange named as an additional insured, and workers' compensation insurance.

(5) Entities who are eligible based on their completed application and whose designee completes and passes the training requirements established pursuant to

section 6905 shall be registered as a Certified Medi-Cal Managed Care Plan by the Exchange and assigned a Certified Medi-Cal Managed Care Plan Number. If the designee fails to complete the training requirements set forth in section 6905 within 30 calendar days of completing the requirements in (a)(4)(A) of this section, the applicant shall be deregistered.

(b) A Certified Medi-Cal Managed Care Plan application shall contain the following information:

(1) Full name;

(2) Legal name;

(3) Primary e-mail address;

(4) Primary phone number;

(5) Secondary phone number;

(6) Federal Employment Identification Number;

(7) State Tax Identification Number;

(8) Identification of applicant's status as a Medi-Cal Managed Care Plan and a copy of supporting documentation;

(9) Identification of the type of organization and, if applicable, a copy of the license or other certification;

(10) A certification that the applicant and all of its employees who will be acting pursuant to this Article comply with section 6907;

(11) An attestation that the entity will serve families of mixed immigration status;

(12) An attestation that the entity will serve individuals with disabilities.

(13) For the primary site and each sub-site, the following information:

(A) Site Location Address;

(B) Mailing Address;

(C) County;

(D) Primary Contact name;

(E) Primary e-mail address;

(F) Primary phone number;

(G) Secondary phone number; and

(H) Hours of operation.

(14) A certification by the Authorized Contact that the information presented is true and correct to the best of the signer's knowledge;

(15) For each Enroller to be affiliated with the applicant:

(A) All information required by section 6903 that is not already included elsewhere in the application required by this section; and

(B) An indication of whether he or she is certified by the Exchange and, if applicable, the certification number.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6903. Certified Medi-Cal Managed Care Plan Enroller Application.

(a) An individual may become a Certified Medi-Cal Managed Care Plan Enroller according to the following process:

(1) The individual shall:

(A) Submit the following:

1. All information, documentation, and declarations required in subdivision (b) of this section; and

2. An executed agreement conforming to the Roles and Responsibilities defined in section 6906.

(B) Within 90 calendar days of completing the requirements in (a)(1)(A) of this section:

1. Submit fingerprinting images in accordance with section 6904 (a);

2. Disclose to the Exchange all criminal convictions and administrative actions taken against the applicant;

3. Complete the required training established in section 6905; and

4. Pass the required certification exam pursuant to section 6660(d) of Article 8.

(2) Individuals who complete the above requirements and pass the Certified Medi-Cal Managed Care Plan Enroller Fingerprinting and Criminal Record Check described in section 6904 shall be certified as a Certified Medi-Cal Managed Care Plan Enroller by the Exchange.

(b) An individual's application to become a Certified Medi-Cal Managed Care Plan Enroller shall contain the following information:

(1) Name, e-mail address, primary and secondary phone number;

(2) Driver's License Number or Identification Number issued by the California Department of Motor Vehicles. If neither is available, the applicant may provide any other unique identifier found on an identification card issued by a federal, state, or local government agency or entity;

(3) Languages that the Certified Medi-Cal Managed Care Plan Enroller can speak;

(4) Languages that the Certified Medi-Cal Managed Care Plan Enroller can write;

(5) Disclosure of all criminal convictions and administrative actions taken against the individual;

(6) A certification by the individual that:

(A) The individual complies with the agreement required by section 6903(a)(1)(A)2. as well as all requirements as set forth in this Article, including but not limited to Section 6907;

(B) The individual is a natural person of not less than 18 years of age; and

(C) The statements made in the application are true, correct, and complete to the best of his or her knowledge and belief;

(D) The individual will abide by all applicable privacy and security requirements, including but not limited to those set forth in the agreement between the Medi-Cal Managed Care Plan and the Exchange; and

(E) The individual will adhere to all applicable State and Federal laws and regulations.

(7) For the individual applying to become a Certified Medi-Cal Managed Care Plan Enroller, signature and date signed; and

(8) For the Authorized Contact from the Certified Medi-Cal Managed Care Plan that the individual will be affiliated with, name, signature, and date signed.

(c) A Certified Medi-Cal Managed Care Plan shall notify the Exchange of every individual to be added or removed as an affiliated Certified Medi-Cal Managed Care Plan Enroller. Such notification shall include:

(1) Name of the Certified Medi-Cal Managed Care Plan and the Certified Medi-Cal Managed Care Plan Number;

(2) Name and signature of the Authorized Contact from the Certified Medi-Cal Managed Care Plan;

(3) Name, e-mail, and primary phone number of the individual to be added or removed;

(4) Effective date for the addition or removal of the individual; and

(5) An indication of whether the individual is certified as a Certified Medi-Cal Managed Care Plan Enroller.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6904. Fingerprinting and Criminal Record Checks.

(a) Subdivisions 6658 (a)-(c) of Article 8 apply to individuals seeking certification pursuant to this Article.

(b) Background check costs for individuals seeking certification under this Article shall be paid by the Certified Medi-Cal Managed Care Plan.

(c) Following the receipt of a final determination pursuant to section 6658(c) that an individual is disqualified from certification, the individual shall not reapply for certification for two years.

Note: Authority cited: Sections 1043 and 100504, Government Code. Reference: Section 100502, Government Code; and Section 11105, Penal Code.

§ 6905. Training Requirements.

(a) All individuals who carry out functions pursuant to this Article shall complete training as outlined in section 6660 of Article 8.

(b) Certified Medi-Cal Managed Care Plans shall ensure that any affiliated Certified Medi-Cal Managed Care Plan Enrollers do not perform any consumer assistance functions if more than twelve months have passed since the Medi-Cal Managed Care Plan Enroller passed the certification exam in section 6660(d) of Article 8.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

§ 6906. Roles & Responsibilities.

(a) Certified Medi-Cal Managed Care Plans and Certified Medi-Cal Managed Care Plan Enrollers shall perform the following functions:

(1) Maintain expertise in eligibility, enrollment, and Exchange program specifications;

(2) Provide information and services in a fair, accurate, and impartial manner, which includes: providing information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process. Such information must acknowledge the existence of other health programs (i.e., Medi-Cal and Children's Health Insurance Programs);

(3) Facilitate selection of a QHP and/or insurance affordability programs;

(4) Provide referrals to any applicable office of health insurance Consumer Assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg-93, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(5) Comply with the privacy and security requirements in 45 C.F.R. § 155.260 (September 6, 2016), hereby incorporated by reference;

(6) Ensure that voter registration assistance is available in compliance with section 6462 of Article 4 of this Chapter; and

(7) Comply with any applicable federal or state laws and regulations.

(b) To ensure that information provided as part of any Consumer Assistance is culturally and linguistically appropriate to the needs of the population being served, including individuals with limited English proficiency, a Certified Medi-Cal Managed Care Plan and its affiliated Certified Medi-Cal Managed Care Plan Enrollers shall comply with the requirements of section 6664(b)(1) through (b)(6) of Article 8.

(c) To ensure that Consumer Assistance is accessible to people with disabilities, Certified Medi-Cal Managed Care Plans and affiliated Certified Medi-Cal Managed Care Plan Enrollers shall comply with the requirements of section 6664(c)(1) through (c)(5) of Article 8.

(d) To ensure that no consumer is discriminated against, Certified Medi-Cal Managed Care Plans and Certified Medi-Cal Managed Care Plan Enrollers shall provide the same level of service to all individuals regardless of age, disability, culture, sexual orientation, or gender identity and seek advice of experts when needed.

(e) Certified Medi-Cal Managed Care Plan Enrollers shall complete the Certified Enrollment Counselor section of a consumer's application to the Exchange, including the following:

(1) Name and certification number of the Certified Medi-Cal Managed Care Plan Enroller;

(2) Name of the Certified Medi-Cal Managed Care Plan and the Certified Medi-Cal Managed Care Plan Number; and

(3) Signature and date of signature by the Certified Medi-Cal Managed Care Plan Enroller.

(f) If any of the information listed in subdivision (e) of this section is not included on the consumer's original application, it shall not be added at a later time.

(g) Certified Medi-Cal Managed Care Plan Enrollers shall wear the badge issued by the Exchange at all times when providing assistance pursuant to this Article.

(h) The Certified Medi-Cal Managed Care Plan and Certified Medi-Cal Managed Care Plan Enroller shall never:

(1) Have a conflict of interest as defined in section 6907;

(2) Mail the paper application for the consumer;

(3) Coach the consumer to provide inaccurate information on the application regarding income, residency, immigration status and other eligibility rules;

(4) Coach or recommend one plan or provider over another;

(5) Accept any premium payments from the consumer;

(6) Input any premium payment information on behalf of the consumer;

(7) Pay any part of the premium or any other type of consideration to or on behalf of the consumer;

(8) Induce or accept any type of direct or indirect remuneration from the consumer;

(9) Intentionally create multiple applications from the same household, as defined in 42 C.F.R. § 435.603(f) (November 30, 2016), hereby incorporated by reference;

(10) Invite, influence, or arrange for an individual whose existing coverage through an eligible employer-sponsored plan is affordable and provides minimum value, as described in 26 USC § 36B(c)(2)(C)) and in 26 C.F.R. § 1.36B-2(c)(3)(v) and (vi)

(July 26, 2017), hereby incorporated by reference, to separate from employer-based group health coverage;

(11) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact, unless the consumer has a pre-existing relationship with the individual Certified Medi-Cal Managed Care Plan Enroller or Certified Medi-Cal Managed Care Plan and other applicable State and Federal laws are otherwise complied with; or

(12) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Certified Medi-Cal Managed Care Plan Enroller or Certified Medi-Cal Managed Care Plan has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

(i) Certified Medi-Cal Managed Care Plan Enrollers shall report to the Exchange any subsequent arrests for which they have been released on bail or personal recognizance and criminal convictions, in accordance with section 6456 (c) of Article 4, and administrative actions taken by any other agency, within 30 calendar days of the date of the arrest or final administrative action order.

(j) Certified Medi-Cal Managed Care Plans shall notify the Exchange of any change in Contact information for the Certified Medi-Cal Managed Care Plan or its Certified Medi-Cal Managed Care Plan Enrollers.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 C.F.R Section 1.36B-2; 45 C.F.R Section 155.260.

§ 6907. Conflict of Interest.

(a) Certified Medi-Cal Managed Care Plans and Certified Medi-Cal Managed Care Plan Enrollers shall:

(1) Comply with applicable State law related to the sale, solicitation, and negotiation of insurance products, including applicable State law related to agent, broker, and producer licensure;

(2) Create a written plan to remain free of conflicts of interest while carrying out functions under this Article;

(3) Provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible;

(4) Disclose to each consumer who receives application assistance from the entity or individual:

(A) Any lines of insurance business which the entity or individual intends to sell while carrying out the Consumer Assistance functions;

(B) Any existing employment relationships, or any former employment relationships within the last five years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(C) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(b) Medi-Cal Managed Care Plan Enrollers who are licensed insurance agents with the California Department of Insurance shall:

(1) Comply with 45 C.F.R. section 155.220, (December 22, 2016), hereby incorporated by reference;

(2) Execute an agreement with the Exchange that complies with 45 C.F.R. section 155.220;

(3) While a Certified Medi-Cal Managed Care Plan Enroller, not receive any direct or indirect consideration from any health insurance issuer or stop loss insurance issuer, other than compensation on a salary or contractual basis from the Certified Medi-Cal Managed Care Plan, in connection with the enrollment of any individuals in a QHP or non-QHP;

(4) Not be concurrently certified as a certified insurance agent by the Exchange.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; and 45 C.F.R. § 155.220.

§ 6908. Suspension and Revocation.

(a) Each of the following shall be justification for the Exchange to suspend or revoke the certification of any Certified Medi-Cal Managed Care Plan or Certified Medi-Cal Managed Care Plan Enroller:

(1) Failure to comply with all applicable federal or state laws or regulations; and

(2) A potentially disqualifying administrative action or criminal record which is substantially related to the qualifications, functions, or duties of the specific position of the entity or individual, under sections 6903 and 6904.

(b) Following the receipt of a determination pursuant to this section that disqualifies an individual or entity from certification, the entity or individual is not eligible to reapply for certification for two years.

Note: Authority cited: Sections 100502 and 100504, Government Code. Reference: Sections 100502 and 100503, Government Code.

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of September 6, 2018

Title 26 → Chapter I → Subchapter A → Part 1 → §1.36b-2

Title 26: Internal Revenue
PART 1—INCOME TAXES

§1.36B-2 Eligibility for premium tax credit.

(a) *In general.* An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family (the applicable taxpayer or the applicable taxpayer's spouse or dependent)—

(1) Is enrolled in one or more qualified health plans through an Exchange; and

(2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(b) *Applicable taxpayer*—(1) *In general.* Except as otherwise provided in this paragraph (b), an applicable taxpayer is a taxpayer whose household income is at least 100 percent but not more than 400 percent of the Federal poverty line for the taxpayer's family size for the taxable year.

(2) *Married taxpayers must file joint return*—(i) *In general.* Except as provided in paragraph (b)(2)(ii) of this section, a taxpayer who is married (within the meaning of section 7703) at the close of the taxable year is an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(ii) *Victims of domestic abuse and abandonment.* Except as provided in paragraph (b)(2)(v) of this section, a married taxpayer satisfies the joint filing requirement of paragraph (b)(2)(i) of this section if the taxpayer files a tax return using a filing status of married filing separately and the taxpayer—

(A) Is living apart from the taxpayer's spouse at the time the taxpayer files the tax return;

(B) Is unable to file a joint return because the taxpayer is a victim of domestic abuse, as described in paragraph (b)(2)(iii) of this section, or spousal abandonment, as described in paragraph (b)(2)(iv) of this section; and

(C) Certifies on the return, in accordance with the relevant instructions, that the taxpayer meets the criteria of this paragraph (b)(2)(ii).

(iii) *Domestic abuse.* For purposes of paragraph (b)(2)(ii) of this section, domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(iv) *Abandonment.* For purposes of paragraph (b)(2)(ii) of this section, a taxpayer is a victim of spousal abandonment for a taxable year if, taking into account all facts and circumstances, the taxpayer is unable to locate his or her spouse after reasonable diligence.

(v) *Three-year rule.* Paragraph (b)(2)(ii) of this section does not apply if the taxpayer met the requirements of paragraph (b)(2)(ii) of this section for each of the three preceding taxable years.

(3) *Dependents.* An individual is not an applicable taxpayer if another taxpayer may claim a deduction under section 151 for the individual for a taxable year beginning in the calendar year in which the individual's taxable year begins.

(4) *Individuals not lawfully present or incarcerated.* An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) is not eligible to enroll in a qualified health plan through an Exchange. However, the individual may be an applicable taxpayer if a family member is eligible to enroll in a qualified health plan. See sections 1312(f)(1)(B) and 1312(f)(3) of the Affordable Care Act (42 U.S.C. 18032(f)(1)(B) and (f)(3)) and §1.36B-3(b)(2).

(5) *Individuals lawfully present.* If a taxpayer's household income is less than 100 percent of the Federal poverty line for the taxpayer's family size and the taxpayer or a member of the taxpayer's family is an alien lawfully present in the United States, the taxpayer is treated as an applicable taxpayer if—

(i) The lawfully present taxpayer or family member is not eligible for the Medicaid program; and

(ii) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the Federal poverty line for the taxpayer's family size.

(6) *Special rule for taxpayers with household income below 100 percent of the Federal poverty line for the taxable year*—(i) *In general.* A taxpayer (other than a taxpayer described in paragraph (b)(5) of this section) whose household income for a taxable year is less than 100 percent of the Federal poverty line for the taxpayer's family size is treated as an applicable taxpayer for the taxable year if—

(A) The taxpayer or a family member enrolls in a qualified health plan through an Exchange for one or more months during the taxable year;

(B) An Exchange estimates at the time of enrollment that the taxpayer's household income will be at least 100 percent but not more than 400 percent of the Federal poverty line for the taxable year;

(C) Advance credit payments are authorized and paid for one or more months during the taxable year; and

(D) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was at least 100 but not more than 400 percent of the Federal poverty line for the taxpayer's family size.

(ii) *Exceptions.* This paragraph (b)(6) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows the information provided to the Exchange is inaccurate.

(iii) Advance credit payments are authorized and paid for one or more months during the taxable year; and

(iv) The taxpayer would be an applicable taxpayer if the taxpayer's household income for the taxable year was between 100 and 400 percent of the Federal poverty line for the taxpayer's family size.

(7) *Computation of premium assistance amounts for taxpayers with household income below 100 percent of the Federal poverty line.* If a taxpayer is treated as an applicable taxpayer under paragraph (b)(5) or (b)(6) of this section, the taxpayer's actual household income for the taxable year is used to compute the premium assistance amounts under §1.36B-3(d).

(c) *Minimum essential coverage*—(1) *In general.* Minimum essential coverage is defined in section 5000A(f) and regulations issued under that section. As described in section 5000A(f), government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage.

(2) *Government-sponsored minimum essential coverage*—(i) *In general.* An individual is eligible for government-sponsored minimum essential coverage if the individual meets the criteria for coverage under a government-sponsored program described in section 5000A(f)(1)(A) as of the first day of the first full month the individual may receive benefits under the program, subject to the limitation in paragraph (c)(2)(ii) of this section. The Commissioner may define eligibility for specific government-sponsored programs further in additional published guidance, see §601.601(d)(2) of this chapter.

(ii) *Obligation to complete administrative requirements to obtain coverage.* An individual who meets the criteria for eligibility for government-sponsored minimum essential coverage must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under paragraph (c)(2)(i) of this section to complete the requirements to obtain government-sponsored minimum essential coverage (other than a veteran's health care program) is treated as eligible for government-sponsored minimum essential coverage as of the first day of the fourth calendar month following the event that establishes eligibility.

(iii) *Special rule for coverage for veterans and other individuals under chapter 17 or 18 of title 38, U.S.C.* An individual is eligible for minimum essential coverage under a health care program under chapter 17 or 18 of title 38, U.S.C. only if the individual is enrolled in a health care program under chapter 17 or 18 of title 38, U.S.C. identified as minimum essential coverage in regulations issued under section 5000A.

(iv) *Retroactive effect of eligibility determination.* If an individual receiving advance credit payments is determined to be eligible for government-sponsored minimum essential coverage that is effective retroactively (such as Medicaid), the individual

is treated as eligible for minimum essential coverage under that program no earlier than the first day of the first calendar month beginning after the approval.

(v) *Determination of Medicaid or Children's Health Insurance Program (CHIP) ineligibility.* An individual is treated as not eligible for Medicaid, CHIP, or a similar program for a period of coverage under a qualified health plan if, when the individual enrolls in the qualified health plan, an Exchange determines or considers (within the meaning of 45 CFR 155.302(b)) the individual to be not eligible for Medicaid or CHIP. This paragraph (c)(2)(v) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange for the year of coverage. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that information provided to the Exchange is inaccurate.

(vi) *Examples.* The following examples illustrate the provisions of this paragraph (c)(2):

Example 1. Delay in coverage effectiveness. On April 10, 2015, Taxpayer D applies for coverage under a government-sponsored health care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (c)(2)(i) of this section, D is eligible for government-sponsored minimum essential coverage on September 1, 2015.

Example 2. Time of eligibility. Taxpayer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under section 5000A(f)(1)(A)(i), Medicare is minimum essential coverage. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (c)(2)(i) and (c)(2)(ii) of this section E is eligible for government-sponsored minimum essential coverage on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in *Example 2,* except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored minimum essential coverage under paragraph (c)(2)(ii) of this section as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

Example 4. Retroactive effect of eligibility. In November 2014, Taxpayer F enrolls in a qualified health plan for 2015 and receives advance credit payments. F loses her part-time employment and on April 10, 2015 applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (c)(2)(iv) of this section, F is eligible for government-sponsored minimum essential coverage on June 1, 2015, the first day of the first calendar month after approval.

Example 5. Determination of Medicaid ineligibility. In November 2014, Taxpayer G applies through the Exchange to enroll in health coverage for 2015. The Exchange determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the Federal poverty line for G's family size for purposes of determining advance credit payments. G enrolls in a qualified health plan and begins receiving advance credit payments. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the Federal poverty line (within the Medicaid income threshold). However, under paragraph (c)(2)(v) of this section, G is treated as not eligible for Medicaid for 2015.

Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in *Example 5,* except that G returns to the Exchange in July 2015 and the Exchange determines that G is eligible for Medicaid. Medicaid approves G for coverage and the Exchange discontinues G's advance credit payments effective August 1. Under paragraphs (c)(2)(iv) and (c)(2)(v) of this section, G is treated as not eligible for Medicaid for the months when G is covered by a qualified health plan. G is eligible for government-sponsored minimum essential coverage for the months after G is approved for Medicaid and can receive benefits, August through December 2015.

(3) *Employer-sponsored minimum essential coverage*—(i) *In general.* For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2) and the regulations under that section) that is minimum essential coverage, and an individual who may enroll in the plan because of a relationship to the employee (a related individual), are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Except for 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 (Public Law 103-337; 10 U.S.C. 1587 note), government-sponsored minimum essential coverage is not an eligible employer-sponsored plan. The Nonappropriated Fund Health Benefits Program of the Department of Defense is considered eligible employer-sponsored coverage, but not government-sponsored coverage, for purposes of determining if an individual is eligible for minimum essential coverage under this section.

(ii) *Plan year.* For purposes of this paragraph (c)(3), a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(iii) *Eligibility for months during a plan year*—(A) *Failure to enroll in plan.* An employee or related individual may be eligible for minimum essential coverage under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph (c)(3)(iii)(A) applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(B) *Waiting periods.* An employee or related individual is not eligible for minimum essential coverage under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(C) *Example.* The following example illustrates the provisions of this paragraph (c)(3)(iii):

Example. (i) Taxpayer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)(ii) of this section) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a qualified health plan through an Exchange for calendar year 2015.

(ii) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for minimum essential coverage under X's plan for the months that B is enrolled in the qualified health plan during X's plan year (January through September 2015).

(iv) *Post-employment coverage.* A former employee (including a retiree), or an individual related (within the meaning of paragraph (c)(3)(i) of this section) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under Federal law or a State law that provides comparable continuation coverage is eligible for minimum essential coverage under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(v) *Affordable coverage*—(A) *In general*—(*1*) *Affordability for employee.* Except as provided in paragraph (c)(3)(v)(A)(*3*) of this section, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)(3)(v)(C) of this section) of the applicable taxpayer's household income for the taxable year.

(*2*) *Affordability for related individual.* Except as provided in paragraph (c)(3)(v)(A)(*3*) of this section, an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage, as described in paragraph (c)(3)(v)(A)(*1*) of this section.

(*3*) *Employee safe harbor.* An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a qualified health plan for a period coinciding with the plan year (in whole or in part), an Exchange determines that the eligible employer-sponsored plan is not affordable for that plan year. This paragraph (c)(3)(v)(A)(*3*) does not apply to a determination made as part of the redetermination process described in 45 CFR 155.335 unless the individual receiving an Exchange redetermination notification affirmatively responds and provides current information on affordability. This paragraph (c)(3)(v)(A)(*3*) does not apply for an individual who, with intentional or reckless disregard for the facts, provides incorrect information to an Exchange concerning the portion of the annual premium for coverage for the employee or related individual under the plan. A reckless disregard of the facts occurs if the taxpayer makes little or no effort to determine whether the information provided to the Exchange is accurate under circumstances that demonstrate a substantial deviation from the standard of conduct a reasonable person would observe. A disregard of the facts is intentional if the taxpayer knows that the information provided to the Exchange is inaccurate.

(*4*) *Wellness program incentives.* Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this section, the term *wellness program incentive* has the same meaning as the term *reward* in §54.9802-1(f)(1)(i) of this chapter.

(*5*) *Employer contributions to health reimbursement arrangements.* Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in Notice 2013-54 (2013-40 IRB 287) (see §601.601(d) of this chapter), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(*6*) *Employer contributions to cafeteria plans.* Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, reduce an employee's or a related individual's required contribution if—

(*i*) The employee may not opt to receive the amount as a taxable benefit;

(*ii*) The employee may use the amount to pay for minimum essential coverage; and

(*iii*) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213.

(*7*) *Opt-out arrangements.* [Reserved]

(B) *Affordability for part-year period.* Affordability under paragraph (c)(3)(v)(A) of this section is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different taxable years of an applicable taxpayer (a part-year period). An eligible employer-sponsored plan is affordable for a part-year period if the employee's annualized required contribution for self-only coverage under the plan for the part-year period does not exceed the required contribution percentage of the applicable taxpayer's household income for the taxable year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable taxpayer's taxable year. Only full calendar months are included in the computation under this paragraph (c)(3)(v)(B).

(C) *Required contribution percentage.* The required contribution percentage is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under published guidance, see §601.601(d)(2) of this chapter. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(D) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(v). Unless stated otherwise, in each example the taxpayer is single and has no dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other minimum essential coverage, and the taxpayer, related individual, and employer-sponsored plan have a calendar taxable year:

Example 1. Basic determination of affordability. In 2014 Taxpayer C has household income of $47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute $3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution for self-only coverage does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(*1*) of this section, X's plan is affordable for C, and C is eligible for minimum essential coverage for all months in 2014.

Example 2. Basic determination of affordability for a related individual. The facts are the same as in *Example 1,* except that C is married to J and X's plan requires C to contribute $5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage ($3,450) does not exceed 9.5 percent of household income, under paragraph (c)(3)(v)(A)(*2*) of this section, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.

Example 3. Determination of unaffordability at enrollment. (i) Taxpayer D is an employee of Employer X. In November 2013 the Exchange for D's rating area projects that D's 2014 household income will be $37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be $3,700 (10 percent of household income). Consequently, the Exchange determines that X's plan is unaffordable. D enrolls in a qualified health plan and not in X's plan. In December 2014, X pays D a $2,500 bonus. Thus, D's actual 2014 household income is $39,500 and D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a qualified health plan for 2014, the Exchange determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan for 2014.

Example 4. Determination of unaffordability for plan year. The facts are the same as in *Example 3,* except that X's employee health insurance plan year is September 1 to August 31. The Exchange for D's rating area determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a qualified health plan as of September 1, 2014. Under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is not affordable for D and D is not eligible for minimum essential coverage under X's plan for the coverage months September to December 2014 and January through August 2015.

Example 5. No affordability information affirmatively provided for annual redetermination. (i) The facts are the same as in *Example 3,* except the Exchange redetermines D's eligibility for advance credit payments for 2015. D does not affirmatively provide the Exchange with current information regarding affordability and the Exchange determines that D's coverage is not affordable for 2015 and approves advance credit payments based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Because D does not respond to the Exchange notification and the Exchange makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph (c)(3)(v)(A)(*3*) of this section does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for minimum essential coverage for all months in 2015.

Example 6. Determination of unaffordability for part of plan year (part-year period). (i) Taxpayer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is $150 per month ($1,800 for the full plan year). The Exchange for E's rating area projects E's household income for purposes of eligibility for advance credit payments as $18,000. E's actual household income for the 2015 taxable year is $20,000.

(ii) Under paragraph (c)(3)(v)(B) of this section, whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year ($1,800) exceeds 9.5 percent of E's household income (1,800/18,000 = 10 percent). Therefore, the Exchange determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is $20,000 (and E's required contribution of $1,800 does not exceed 9.5 percent of E's household income), under paragraph (c)(3)(v)(A)(*3*) of this section, X's plan is unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for minimum essential coverage under X's plan for the period May through August 2015.

Example 7. Affordability determined for part of a taxable year (part-year period). (i) Taxpayer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is $150 per month or $1,800 for the plan year. F does not enroll in X's plan during X's open season but enrolls in a qualified health plan for September through December 2014. F does not request advance credit payments and does not ask the Exchange for his rating area to determine whether X's coverage is affordable for F. F's household income in 2014 is $18,000.

(ii) Because F is a calendar year taxpayer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (c)(3)(v)(B) of this section. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums ($1,800) to F's 2014 household income. F's required contribution of $1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for minimum essential coverage under X's plan for that period.

(iii) F enrolls in Exchange coverage for 2015 and does not ask the Exchange to approve advance credit payments or determine whether X's coverage is affordable. F's 2015 household income is $20,000.

(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution ($1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for minimum essential coverage for that period.

Example 8. Coverage unaffordable at year end. Taxpayer G is employed by Employer X. In November 2014, the Exchange for G's rating area determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a qualified health plan for 2015 but does not receive advance credit payments. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (c)(3)(v)(A)(*1*) of this section, G is not eligible for minimum essential coverage under X's plan for 2015.

Example 9. Wellness program incentives. (i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is $3,700. Employee C uses tobacco and the cost of her premiums is $4,000.

(ii) Under paragraph (c)(3)(v)(A)(*4*) of this section, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the $300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is $3,700. The $200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

(vi) *Minimum value.* See §1.36B-6 for rules for determining whether an eligible employer-sponsored plan provides minimum value.

(vii) *Enrollment in eligible employer-sponsored plan*—(A) *In general.* Except as provided in paragraph (c)(3)(vii)(B) of this section, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(B) *Automatic enrollment.* An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3)(vii):

Example 1. Taxpayer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

Example 2. The facts are the same as in *Example 1,* except that H terminates plan coverage on June 30, 2014. Under paragraph (c)(3)(vii)(A) of this section, H is eligible for minimum essential coverage under X's plan for January through June 2014 but is not eligible for minimum essential coverage under X's plan for July through December 2014.

Example 3. The facts are the same as in *Example 1,* except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (c)(3)(vii)(B) of this section, H is not eligible for minimum essential coverage under X's plan for January 2015.

(4) *Special eligibility rules*—(i) *Related individual not claimed as a personal exemption deduction.* An individual who may enroll in minimum essential coverage because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction under section 151, is treated as eligible for minimum essential coverage under the coverage only for months that the related individual is enrolled in the coverage.

(ii) *Exchange unable to discontinue advance credit payments*—(A) *In general.* If an individual who is enrolled in a qualified health plan for which advance credit payments are made informs the Exchange that the individual is or will soon be eligible for other minimum essential coverage and that advance credit payments should be discontinued, but the Exchange does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs the Exchange, the individual is treated as eligible for the other minimum essential coverage no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other minimum essential coverage.

(B) *Medicaid or CHIP.* If a determination is made that an individual who is enrolled in a qualified health plan for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for the Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

(d) *Applicability date.* Paragraphs (b)(2) and (c)(3)(v)(C) of this section apply to taxable years beginning after December 31, 2013.

(e) *Effective/applicability date.* (1) Except as provided in paragraph (e)(2) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraph (b)(6)(ii), the last three sentences of paragraph (c)(2)(v), paragraph (c)(3)(i), paragraph (c)(3)(iii)(A), the last three sentences of paragraph (c)(3)(v)(A)(*3*), and paragraph (c)(4) of this section apply to taxable years beginning after December 31, 2016. Paragraphs (b)(6), (c)(3)(i), (c)(3)(iii)(A), and (c)(4) of §1.36B-2 as contained in 26 CFR part I edition revised as of April 1, 2016, apply to taxable years ending after December 31, 2013, and beginning before January 1, 2017.

[T.D. 9590, 77 FR 30385, May 23, 2012, as amended by T.D. 9611, 78 FR 7265, Feb. 1, 2013; T.D. 9683, 79 FR 43626, July 28, 2014; 80 FR 78974, Dec. 18, 2015; T.D. 9804, 81 FR 91764, Dec. 19, 2016; T.D. 9822, 82 FR 34606, July 26, 2017]

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Title 42 → Chapter IV → Subchapter C → Part 435 → Subpart G → §435.603

Title 42: Public Health
PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA
Subpart G—General Financial Eligibility Requirements and Options

§435.603 Application of modified adjusted gross income (MAGI).

(a) *Basis, scope, and implementation.* (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver.

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in §435.4 of this part.

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.

(d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

(e) *MAGI-based income.* For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—

(A) Rights of ownership or possession in any lands described in paragraph (e)(3)(ii) of this section; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements—

(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(f) *Household*—(1) *Basic rule for taxpayers not claimed as a tax dependent.* In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

(2) *Basic rule for individuals claimed as a tax dependent.* In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

(g) *No resource test or income disregards.* In the case of individuals whose financial eligibility for Medicaid is determined in accordance with this section, the agency must not—

(1) Apply any assets or resources test; or

(2) Apply any income or expense disregards under sections 1902(r)(2) or 1931(b)(2)(C), or otherwise under title XIX of the Act, except as provided in paragraph (d)(1) of this section.

(h) *Budget period*—(1) *Applicants and new enrollees.* Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries.* For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at §435.940 through §435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

(i) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e).

(j) *Eligibility Groups for which MAGI-based methods do not apply.* The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in §435.601 and §435.602 of this subpart.

(1) Individuals whose eligibility for Medicaid does not require a determination of income by the agency, including, but not limited to, individuals receiving Supplemental Security Income (SSI) eligible for Medicaid under §435.120 of this part, individuals deemed to be receiving SSI and eligible for Medicaid under §435.135, §435.137 or §435.138 of this part and individuals for whom the State relies on a finding of income made by an Express Lane agency, in accordance with section 1902(e)(13) of the Act.

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under §435.121, §435.232 or §435.234 of this part or

under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group under which long-term care services and supports not covered for individuals determined eligible using MAGI-based financial methods are covered, or for individuals being evaluated for an eligibility group for which being institutionalized, meeting an institutional level of care or satisfying needs-based criteria for home and community based services is a condition of eligibility. For purposes of this paragraph, "long-term care services and supports" include nursing facility services, a level of care in any institution equivalent to nursing facility services; and home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

(5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

(k) *Eligibility.* In the case of an individual whose eligibility is being determined under §435.214, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (d) of this section.

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

[77 FR 17206, Mar. 23, 2012, as amended at 78 FR 42302, July 15, 2013; 81 FR 86456, Nov. 30, 2016]

§155.205 Consumer assistance tools and programs of an Exchange.

(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (c)(2)(i), and (c)(3) of this section, unless it enters into a Federal platform agreement through which it relies on HHS to carry out call center functions, in which case the Exchange must provide at a minimum a toll-free telephone hotline to respond to requests for assistance and appropriately directs consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:

(1) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, and at a minimum includes:

(i) Premium and cost-sharing information;

(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with §155.1040; and

(viii) The provider directory made available to the Exchange in accordance with §156.230.

(2) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;

(iv) Administrative costs of such Exchange; and

(v) Monies lost to waste, fraud, and abuse.

(3) Provides applicants with information about Navigators as described in §155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.

(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.

(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

(7) A State-based Exchange on the Federal platform must at a minimum maintain an informational Internet Web site that includes the capability to direct consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including

(i) For all entities subject to this standard, oral interpretation.

(A) For Exchanges and QHP issuers, this standard also includes telephonic interpreter services in at least 150 languages.

(B) For an agent or broker subject to §155.220(c)(3)(i), beginning November 1, 2015, or when such entity been registered with the Exchange for at least 1 year, whichever is later, this standard also includes telephonic interpreter services in at least 150 languages.

(ii) Written translations; and

(iii) For all entities subject to this standard, taglines in non-English languages indicating the availability of language services.

(A) For Exchanges and QHP issuers, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. If an Exchange is operated by an entity that operates multiple Exchanges, or if an Exchange relies on an entity to conduct its eligibility or enrollment functions and that entity conducts such functions for multiple Exchanges, the Exchange may aggregate the limited English proficient populations across all the States served by the entity that operates the Exchange or conducts its eligibility or enrollment functions to determine the top 15 languages required for taglines. A QHP issuer may aggregate the limited English proficient populations across all States served by the health insurance issuers within the issuer's controlled group (defined for purposes of this section as a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended), whether or not those health insurance issuers offer plans through the Exchange in each of those States, to determine the top 15 languages required for taglines. Exchanges and QHP issuers may satisfy tagline requirements with respect to Web site content if they post a Web link prominently on their home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if they also include taglines on any critical stand-alone document linked to or embedded in the Web site. Exchanges, and QHP issuers that are also subject to §92.8 of this subtitle, will be deemed in compliance with paragraph (c)(2)(iii)(A) of this section if they are in compliance with §92.8 of this subtitle.

(B) For an agent or broker subject to §155.220(c)(3)(i), beginning when such entity has been registered with the Exchange for at least 1 year, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. An agent or broker subject to §155.220(c)(3)(i) that is licensed in and serving multiple States may aggregate the limited English populations in the States it serves to determine the top 15 languages required for taglines. An agent or broker subject to §155.220(c)(3)(i) may satisfy tagline requirements with respect to Web site content if it posts a Web link prominently on its home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if it also includes taglines on any critical stand-alone document linked to or embedded in the Web site.

(iv) For Exchanges, QHP issuers, and an agent or broker subject to §155.220(c)(3)(i), Web site translations.

(A) For an Exchange, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, content that is intended for qualified individuals, applicants, qualified employers, qualified

employees, or enrollees on a Web site that is maintained by the Exchange must be translated into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(B) For a QHP issuer, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, if the content of a Web site maintained by the QHP issuer is critical for obtaining health insurance coverage or access to health care services through a QHP, within the meaning of §156.250 of this subchapter, it must be translated into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(C) For an agent or broker subject to §155.220(c)(3)(i), beginning on the first day of the individual market open enrollment period for the 2017 benefit year, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, content that is intended for qualified individuals, applicants, qualified employers, qualified employees, or enrollees on a Web site that is maintained by the agent or broker must be translated into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.

(d) *Consumer assistance.* (1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in §155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

(2) The Exchange must provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.

(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 42859, July 17, 2013; 80 FR 10864, Feb. 27, 2015; 81 FR 12337, Mar. 8, 2016; 81 FR 94175, Dec. 22, 2016]

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Title 45: Public Welfare
PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT
Subpart C—General Functions of an Exchange

§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

(a) *General rule.* A State may permit agents and brokers to—

(1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;

(2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and

(3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

(b)(1) *Web site disclosure.* The Exchange or SHOP may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to information regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process.

(2) A Federally-facilitated Exchange or SHOP will limit the information provided on its Web site regarding licensed agents and brokers to information regarding licensed agents and brokers who have completed registration and training.

(c) *Enrollment through the Exchange.* A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent or broker if—

(1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Internet Web site as described in §155.405, or ensures that the eligibility application information is submitted for an eligibility determination through the Exchange-approved web service subject to meeting the requirements in paragraphs (c)(3)(ii) and (c)(4)(i)(F) of this section;

(2) The Exchange transmits enrollment information to the QHP issuer as provided in §155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.

(3)(i) When an Internet Web site of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:

(A) Disclose and display all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of §155.205(b)(1) and (c), and to the extent that not all information required under §155.205(b)(1) is displayed on the agent or broker's Internet Web site for a QHP, prominently display a standardized disclaimer provided by HHS stating that information required under §155.205(b)(1) for the QHP is available on the Exchange Web site, and provide a Web link to the Exchange Web site;

(B) Provide consumers the ability to view all QHPs offered through the Exchange;

(C) Not provide financial incentives, such as rebates or giveaways;

(D) Display all QHP data provided by the Exchange;

(E) Maintain audit trails and records in an electronic format for a minimum of ten years and cooperate with any audit under this section;

(F) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in §155.205(b) instead at any time;

(G) For the Federally-facilitated Exchange, prominently display a standardized disclaimer provided by HHS, and provide a Web link to the Exchange Web site; and

(H) Differentially display all standardized options prominently and in accordance with the requirements under §155.205(b)(1) in a manner consistent with that adopted by HHS for display on the Federally-facilitated Exchange Web site and with standards defined by HHS, unless HHS approves a deviation;

(I) Prominently display information provided by HHS pertaining to a consumer's eligibility for advance payments of the premium tax credit or cost-sharing reductions;

(J) Allow the consumer to select an amount for advance payments of the premium tax credit, if applicable, and make related attestations in accordance with §155.310(d)(2);

(K) Demonstrate operational readiness and compliance with applicable requirements prior to the agent or broker's Internet Web site being used to complete the QHP selection; and

(L) HHS may immediately suspend the agent or broker's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS's satisfaction.

(ii) When an Internet Web site of an agent or broker is used to complete the Exchange eligibility application, at a minimum, the Internet Web site must:

(A) Comply with the requirements in paragraph (c)(3)(i) of this section;

(B) Use exactly the same eligibility application language as appears in the FFE Single Streamlined Application required in §155.405, unless HHS approves a deviation;

(C) Ensure that all necessary information for the consumer's applicable eligibility circumstances are submitted through the Exchange-approved web service; and

(D) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§155.230 and 155.260(b).

(4) When an agent or broker, through a contract or other arrangement, uses the Internet Web site of another agent or broker to help an applicant or enrollee complete a QHP selection in the Federally-facilitated Exchange, and the agent or broker accessing the Web site pursuant to the arrangement is listed as the agent of record on the enrollment:

(i) The agent or broker who makes the Web site available must:

(A) Provide HHS with a list of agents and brokers who enter into such an arrangement to the Federally-facilitated Exchange, if requested by HHS;

(B) Verify that any agent or broker accessing or using the Web site pursuant to the arrangement is licensed in the State in which the consumer is selecting the QHP; and has completed training and registration and has signed all required agreements with the Federally-facilitated Exchange pursuant to paragraph (d) of this section and §155.260(b);

(C) Ensure that its name and any identifier required by HHS prominently appears on the Internet Web site and on written materials containing QHP information that can be printed from the Web site, even if the agent or broker that is accessing the Internet Web site is able to customize the appearance of the Web site;

(D) Terminate the agent or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker;

(E) Report to HHS and applicable State departments of insurance any potential material breach of the standards in paragraphs (c) and (d) of this section, or the agreement entered into under §155.260(b), by the agent or broker accessing the Internet Web site, should it become aware of any such potential breach. An agent or broker that provides access to its Web site to complete the QHP selection or the Exchange eligibility application or ability to transact information with HHS to another agent or broker Web site is responsible for ensuring compliance with applicable requirements in paragraph (c)(3) of this section for any Web pages of the other agent's or broker's Web site that assist consumers, applicants, qualified individuals, and enrollees in applying for APTC and CSRs for QHPs, or in completing enrollment in QHPs, offered in the Exchanges.

(F) When an Internet Web site of an agent or broker is used to complete the Exchange eligibility application, obtain HHS approval verifying that all requirements in this section are met.

(ii) HHS retains the right to temporarily suspend the ability of the agent or broker making its Web site available to transact information with HHS, if HHS discovers a security and privacy incident or breach, for the period in which HHS begins to conduct an investigation and until the incident or breach is remedied to HHS' satisfaction.

(5) HHS or its designee may periodically monitor and audit an agent or broker under this subpart to assess its compliance with the applicable requirements of this section.

(d) *Agreement.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with the terms of an agreement between the agent or broker and the Exchange under which the agent or broker at least:

(1) Registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;

(2) Receives training in the range of QHP options and insurance affordability programs; and

(3) Complies with the Exchange's privacy and security standards adopted consistent with §155.260.

(e) *Compliance with State law.* An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with applicable State law related to agents and brokers, including applicable State law related to confidentiality and conflicts of interest.

(f) *Termination notice to HHS.* (1) An agent or broker may terminate its agreement with HHS by sending to HHS a written notice at least 30 days in advance of the date of intended termination.

(2) The notice must include the intended date of termination, but if it does not specify a date of termination, or the date provided is not acceptable to HHS, HHS may set a different termination date that will be no less than 30 days from the date on the agent's or broker's notice of termination.

(3) Prior to the date of termination, an agent or broker should—

(i) Notify applicants, qualified individuals, or enrollees that the agent or broker is assisting, of the agent's or broker's intended date of termination;

(ii) Continue to assist such individuals with Exchange-related eligibility and enrollment services up until the date of termination; and

(iii) Provide such individuals with information about alternatives available for obtaining additional assistance, including but not limited to the Federally-facilitated Exchange Web site.

(4) When the agreement between the agent or broker and the Exchange under paragraph (d) of this section is terminated under paragraph (f) of this section, the agent or broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(g) *Standards for termination for cause from the Federally-facilitated Exchange.* (1) If, in HHS's determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's or broker's agreement with the Federally-facilitated Exchange for cause.

(2) An agent or broker may be determined noncompliant if HHS finds that the agent or broker violated—

(i) Any standard specified under this section;

(ii) Any term or condition of the agreement with the Federally-facilitated Exchanges required under paragraph (d) of this section, or any term or condition of the agreement with the Federally-facilitated Exchange required under §155.260(b);

(iii) Any State law applicable to agents or brokers, as required under paragraph (e) of this section, including but not limited to State laws related to confidentiality and conflicts of interest; or

(iv) Any Federal law applicable to agents or brokers.

(3) HHS will notify the agent or broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(4) After the period in paragraph (g)(3) of this section has elapsed and the agreement under paragraph (d) of this section is terminated, the agent or broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's or broker's agreement with the Exchange under §155.260(b)(2) will also be terminated through the process set forth in that agreement. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(5) Fraud or abusive conduct—

(i)(A) If HHS reasonably suspects that an agent or broker may have may have engaged in fraud, or in abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for up to 90 calendar days. Suspension will be effective on the date of the notice that HHS sends to the agent or broker advising of the suspension of the agreements.

(B) The agent or broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90-day period. If the agent or broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 30 days of receipt of such evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent or broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause under paragraph (g)(5)(ii) of this section.

(ii) If there is a finding or determination by a Federal or State entity that an agent or broker engaged in fraud, or abusive conduct that may result in imminent or ongoing consumer harm, using personally identifiable information of Exchange enrollees or applicants or in connection with an Exchange enrollment or application, HHS will terminate the agent's or broker's agreements required under paragraph (d) of this section and under §155.260(b) for cause. The termination will be effective starting on the date of the notice that HHS sends to the agent or broker advising of the termination of the agreements.

(iii) During the suspension period under paragraph (g)(5)(i) of this section and following termination of the agreements under paragraph (g)(5)(i)(B) or (g)(5)(ii) of this section, the agent or broker will not be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent or broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with a Federally-facilitated Exchange.

(6) The State department of insurance or equivalent State agent or broker licensing authority will be notified by HHS in cases of suspensions or terminations effectuated under this paragraph (g).

(h) *Request for reconsideration of termination for cause from the Federally-facilitated Exchange*—(1) *Request for reconsideration.* An agent or broker whose agreement with the Federally-facilitated Exchange has been terminated may request reconsideration of such action in the manner and form established by HHS.

(2) *Timeframe for request.* The agent or broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written notice from HHS.

(3) *Notice of reconsideration decision.* The HHS reconsideration entity will provide the agent or broker with a written notice of the reconsideration decision within 30 calendar days of the date it receives the request for reconsideration. This decision will constitute HHS's final determination.

(i) *Use of agents' and brokers' Internet Web sites for SHOP.* For plan years beginning on or after January 1, 2015, in States that permit this activity under State law, a SHOP may permit agents and brokers to use an Internet Web site to assist qualified employers and facilitate enrollment of enrollees in a QHP through the Exchange, under paragraph (c)(3) of this section.

(j) *Federally-facilitated Exchange standards of conduct.* (1) An agent or broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs sold through a Federally-facilitated Exchange, must—

(i) Have executed the required agreement under paragraph §155.260(b);

(ii) Be registered with the Federally-facilitated Exchanges under paragraph (d)(1) of this section; and

(iii) Comply with the standards of conduct in paragraph (j)(2) of this section.

(2) Standards of conduct. An individual or entity described in paragraph (j)(1) of this section must—

(i) Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment Web site that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(ii) Provide the Federally-facilitated Exchanges with correct information under section 1411(b) of the Affordable Care Act;

(iii) Obtain the consent of the individual, employer, or employee prior to assisting with or facilitating enrollment through a Federally-facilitated Exchange, or assisting the individual in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs;

(iv) Protect consumer personally identifiable information according to §155.260(b)(3) and the agreement described in §155.260(b)(2); and

(v) Comply with all applicable Federal and State laws and regulations.

(3) If an agent or broker fails to provide correct information, he or she will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent or broker acted in good faith.

(k) *Penalties other than termination of the agreement with the Federally-facilitated Exchanges.* (1) If HHS determines that an agent or broker has failed to comply with the requirements of this section, in addition to any other available remedies, that agent or broker—

(i) May be denied the right to enter into agreements with the Federally-facilitated Exchanges in future years; and

(ii) May be subject to civil money penalties as described in §155.285.

(2) HHS will notify the agent or broker of the proposed imposition of penalties under paragraph (k)(1)(i) of this section and, after 30 calendar days from the date of the notice, may impose the penalty if the agent or broker has not requested a reconsideration under paragraph (h) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under §155.285.

(l) *Application to State-Based Exchanges using a Federal platform.* An agent or broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through an State-Based Exchange using a Federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through an State-Based Exchange using a Federal platform must comply with all applicable Federally-facilitated Exchange standards in this section.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 15533, Mar. 11, 2013; 78 FR 54134, Aug. 30, 2013; 79 FR 13837, Mar. 11, 2014; 80 FR 10865, Feb. 27, 2015; 81 FR 12338, Mar. 8, 2016; 81 FR 94176, Dec. 22, 2016]

EDITORIAL NOTE: At 78 FR 54134, Aug. 30, 2013, §155.220 was amended by revising (d)(3); however, the amendment could not be incorporated because there was no regulatory text provided in the amendment for (d)(3).

§155.260 Privacy and security of personally identifiable information.

(a) *Creation, collection, use and disclosure.* (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in §155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

(i) For the Exchange to carry out the functions described in §155.200;

(ii) For the Exchange to carry out other functions not described in paragraph (a)(1)(i) of this section, which the Secretary determines to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act and for which an individual provides consent for his or her information to be used or disclosed; or

(iii) For the Exchange to carry out other functions not described in paragraphs (a)(1)(i) and (ii) of this section, for which an individual provides consent for his or her information to be used or disclosed, and which the Secretary determines are in compliance with section 1411(g)(2)(A) of the Affordable Care Act under the following substantive and procedural requirements:

(A) *Substantive requirements.* The Secretary may approve other uses and disclosures of personally identifiable information created or collected as described in paragraph (a)(1) of this section that are not described in paragraphs (a)(1)(i) or (ii) of this section, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act, and that the uses and disclosures are also permissible under relevant law and policy.

(B) *Procedural requirements for approval of a use or disclosure of personally identifiable information.* To seek approval for a use or disclosure of personally identifiable information created or collected as described in paragraph (a)(1) of this section that is not described in paragraphs (a)(1)(i) or (ii) of this section, the Exchange must submit the following information to HHS:

(*1*) Identity of the Exchange and appropriate contact persons;

(*2*) Detailed description of the proposed use or disclosure, which must include, but not necessarily be limited to, a listing or description of the specific information to be used or disclosed and an identification of the persons or entities that may access or receive the information;

(*3*) Description of how the use or disclosure will ensure the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act; and

(*4*) Description of how the information to be used or disclosed will be protected in compliance with privacy and security standards that meet the requirements of this section or other relevant law, as applicable.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) *Application to non-Exchange entities*—(1) *Non-Exchange entities.* A non-Exchange entity is any individual or entity that:

(i) Gains access to personally identifiable information submitted to an Exchange; or

(ii) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

(2) Prior to any person or entity becoming a non-Exchange entity, Exchanges must execute with the person or entity a contract or agreement that includes:

(i) A description of the functions to be performed by the non-Exchange entity;

(ii) A provision(s) binding the non-Exchange entity to comply with the privacy and security standards and obligations adopted in accordance with paragraph (b)(3) of this section, and specifically listing or incorporating those privacy and security standards and obligations;

(iii) A provision requiring the non-Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with paragraph (a)(5) of this section;

(iv) A provision requiring the non-Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environments defined as material within the contract; and

(v) A provision that requires the non-Exchange entity to bind any downstream entities to the same privacy and security standards and obligations to which the non-Exchange entity has agreed in its contract or agreement with the Exchange.

(3) When collection, use or disclosure is not otherwise required by law, the privacy and security standards to which an Exchange binds non-Exchange entities must:

(i) Be consistent with the principles and requirements listed in paragraphs (a)(1) through (6) of this section, including being at least as protective as the standards the Exchange has established and implemented for itself in compliance with paragraph (a)(3) of this section;

(ii) Comply with the requirements of paragraphs (c), (d), (f), and (g) of this section; and

(iii) Take into specific consideration:

(A) The environment in which the non-Exchange entity is operating;

(B) Whether the standards are relevant and applicable to the non-Exchange entity's duties and activities in connection with the Exchange; and

(C) Any existing legal requirements to which the non-Exchange entity is bound in relation to its administrative, technical, and operational controls and practices, including but not limited to, its existing data handling and information technology processes and protocols.

(c) *Workforce compliance.* The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) *Written policies and procedures.* Policies and procedures regarding the creation collection, use, and disclosure of personally identifiable information must, at minimum:

(1) Be in writing, and available to the Secretary of HHS upon request; and

(2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.

(e) *Data sharing.* Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:

(1) Meet any applicable requirements described in this section;

(2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;

(3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and

(4) For those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

(f) *Compliance with the Code.* Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.

(g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012; 79 FR 13837, Mar. 11, 2014; 79 FR 30346, May 27, 2014; 81 FR 12341, Mar. 8, 2016; 81 FR 61581, Sept. 6, 2016]

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