

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**45 CFR Parts 155 and 156**

[CMS–9958–P]

RIN 0938–AR68

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

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would implement certain functions of the Affordable Insurance Exchanges (“Exchanges”), consistent with title I of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. These specific statutory functions include determining eligibility for and granting certificates of exemption from the shared responsibility payment for not maintaining minimum essential coverage as described in section 5000A of the Internal Revenue Code. Additionally, this proposed rule implements the responsibility of the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, to designate other health benefits coverage as minimum essential coverage by providing that certain coverage be designated as minimum essential coverage. It also outlines substantive and procedural requirements that other types of individual coverage must fulfill in order to be certified as minimum essential coverage under the Internal Revenue Code.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 18, 2013.

**ADDRESSES:** In commenting, please refer to file code CMS–9958–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention:

CMS–9958–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9958–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Lauren Block, (301) 492–4425, for provisions related to exemptions from the shared responsibility payment.

Amanda Ledford, (410) 786–1565, for provisions related to minimum essential coverage.

**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments

received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

**Executive Summary**

To ensure effective and efficient implementation of the insurance market reforms, the Affordable Care Act requires a nonexempt individual to maintain minimum essential coverage or make a shared responsibility payment. The Affordable Care Act specifies the categories of individuals who are eligible to receive exemptions from the shared responsibility payment under section 5000A of the Code, which provides nonexempt individuals with a choice: Maintain minimum essential coverage for themselves and any nonexempt family members or include an additional payment with their federal income tax return. Many individuals are exempt from the shared responsibility payment, including some whose religious beliefs conflict with acceptance of the benefits of private or public insurance and those who do not have an affordable health insurance coverage option available. Section 1311(d)(4)(H) of the Affordable Care Act (42 U.S.C. 18031(d)(4)(H)) directs the new health insurance marketplaces, called Affordable Insurance Exchanges (Exchanges), to issue certifications of exemption from the shared responsibility payment under section 5000A of the Code to eligible individuals. Section 1411 of the Affordable Care Act (42 U.S.C. 18081) generally provides procedures for determining an individual’s eligibility for various benefits relating to health coverage, including exemptions from the application of section 5000A of the Code.

This proposed rule sets forth standards and processes under which the Exchange will conduct eligibility determinations for and grant certificates of exemption from the shared responsibility payment. Furthermore, it supports and complements rulemaking conducted by the Secretary of the

Treasury with respect to section 5000A of the Internal Revenue Code (the Code), as added by section 1501(b) of the Affordable Care Act, published elsewhere in this issue of the **Federal Register**. The intent of this rule is to implement the relevant provisions while continuing to afford states substantial discretion in the design and operation of an Exchange, with greater standardizations provided where directed by the statute or where there are compelling practical, efficiency, or consumer protection reasons.

Under section 5000A(f)(1)(E), the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, may designate other health benefits coverage as minimum essential coverage. This proposed rule provides standards for determining whether certain other types of health insurance coverage constitute minimum essential coverage and procedures for sponsors to follow for a plan to be identified as minimum essential coverage under section 5000A. This rule proposes to designate certain types of existing health coverage as minimum essential coverage. Other types of coverage, not statutorily specified and not designated as minimum essential coverage in this regulation, may be recognized as minimum essential coverage if certain substantive and procedural requirements are met as proposed in this rule. These additional categories of minimum essential coverage, both those designated per se and those that may apply for recognition are neither group health insurance coverage nor individual health insurance. Consumers with types of coverage that are recognized as minimum essential coverage in accordance with this rule would be determined to have minimum essential coverage for purposes of the minimum essential coverage requirement if the coverage is certified to be substantially compliant with the requirements of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market.

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## Abbreviations

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

BHP Basic Health Program

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

FPL Federal Poverty Level

HHS Department of Health and Human Services

IRS Internal Revenue Service

NAIC National Association of Insurance Commissioners

QHP Qualified Health Plan

SSA Social Security Administration

SSN Social Security Number

The Code Internal Revenue Code of 1986, as amended

## I. Background

### A. Legislative Overview

Section 1501(b) of the Affordable Care Act added section 5000A of the Internal Revenue Code (the Code) to a new

chapter 48 of subtitle D (Miscellaneous Excise Taxes) of the Code effective for months beginning after December 31, 2013. Section 5000A of the Code, which was subsequently amended by the TRICARE Affirmation Act of 2010, Public Law 111–159 (124 Stat. 1123) and Public Law 111–173 (124 Stat. 1215), requires that nonexempt individuals either maintain minimum essential coverage or make a shared responsibility payment, includes standards for the calculation of the shared responsibility payment, describes categories of individuals who may qualify for an exemption from the shared responsibility payment, and provides the definition of “minimum essential coverage.”

Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will, subject to section 1411 of the Affordable Care Act, grant certifications of exemption from the shared responsibility payment specified in section 5000A of the Code. Section 1311(d)(4)(I)(i) of the Affordable Care Act specifies that the Exchange will transfer to the Secretary of the Treasury a list of the individuals to whom the Exchange provided such a certification. Section 1411(a)(4) of the Affordable Care Act provides that the Secretary of Health and Human Services (the Secretary) will establish a program for determining whether a certification of exemption from the shared responsibility requirement and penalty will be issued by an Exchange under section 1311(d)(4)(H) of the Affordable Care Act. We propose to interpret this provision as authorizing the Secretary to determine “whether,” with respect to the nine exemptions provided for under section 5000A of the Code, Exchanges would perform the role of issuing certifications of exemption under section 1311(d)(4)(H) of the Affordable Care Act, whether eligibility for the exemption would be determined solely through tax filing, or whether both processes would be available. Under this interpretation, the responsibility under section 1311(d)(4)(H) of the Affordable Care Act to issue certifications of exemption would be “subject to” these determinations by the Secretary under section 1411(a)(4) of the Affordable Care Act, and Exchanges would thus only be required to issue certifications of exemption with respect to exemptions not exclusively assigned to IRS.

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related requirements. Section 1321(a) of the Affordable Care Act provides broad authority for the

Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges and other components of title I of the Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of Title I of the Affordable Care Act.

In accordance with our interpretation of these sections of the Affordable Care Act, and the authority provided by, *inter alia*, section 1321(a) of the Affordable Care Act, we propose that under the program established under section 1411(a)(4) of the Affordable Care Act, the Exchange would determine eligibility for and grant certificates of exemption as described below. We also note that consistent with prior guidance, a state-based Exchange can be approved to operate by HHS if it uses a federally-managed service to make eligibility determinations for exemptions.

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

Section 5000A(f) of the Code designates certain types of coverage as minimum essential coverage. The term "minimum essential coverage" includes all of the following: Government sponsored programs (the Medicare program under part A of title XVII of the Social Security Act (the Act); the Medicaid program under title XIX of the Social Security Act; the CHIP program

under title XXI of the Act; medical coverage under chapter 55 of title 10, United States Code, including the TRICARE program; a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretaries of Health and Human Services and Treasury; a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; and coverage under a grandfathered health plan. In addition, section 5000A(f)(1)(E) of the Code directs the Secretary of Health and Human Services, in coordination with the Secretary of Treasury, to designate other health benefits coverage, such as a state health benefits risk pool, as minimum essential coverage for purposes of their enrollees satisfying the minimum coverage requirement. This proposed regulation would designate certain additional types of coverage qualify as minimum essential coverage and also proposes a process by which other types of coverage could be recognized as minimum essential coverage.

#### B. Stakeholder Consultation and Input

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

The public response to the RFC yielded comment submissions from consumer advocacy organizations, medical and health care professional trade associations and societies, medical and health care professional entities, health insurers, insurance trade associations, members of the general public, and employer organizations. The majority of the comments were related to the general functions and standards for Exchanges, qualified health plans (QHPs), eligibility and enrollment, and coordination with Medicaid. While this proposed rule does not directly respond to comments from the RFC, the comments received are described, where applicable, in discussing specific

regulatory proposals. We intend to respond to relevant comments from the RFC, along with comments received on this proposed rule, as part of the final rule.

In addition to the RFC, HHS has consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, and meetings with tribal representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. For example, we received feedback from health care sharing ministries about the process for how individual members can obtain certificates of exemption based on their membership in a health care sharing ministry, and an expression of interest in a process for allowing health care sharing ministries to obtain recognition that they meet the standards under section 5000A(d)(2)(B) of the Code. We also received information from various stakeholder groups regarding types of "other coverage" as described in section 5000A(f)(1)(E) of the Code. Similar consultation will continue throughout the development of further Exchange guidance on exemptions and "other coverage."

#### C. Structure of the Proposed Rule

The provisions of this proposed rule include the addition of subpart G to 45 CFR part 155, which includes standards for Exchanges related to conducting eligibility determinations for and granting certificates of exemption from the shared responsibility payment. We also propose to amend § 155.200(a) to add a reference to indicate that, consistent with existing language in § 155.200(b), granting certificates of exemption is a minimum function of the Exchange. Furthermore, we add subpart G to 45 CFR part 156 which includes standards related to minimum essential coverage.

#### D. Alignment With Related Rules and Published Information

As noted above, this proposed rule is published in coordination with the Department of Treasury's proposed rule, "Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage" (Treasury proposed rule). This regulation includes numerous cross-references to the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**.

## II. Provisions of the Proposed Regulation

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

#### 1. Subpart A—General Provisions

##### a. Definitions (§ 155.20)

We propose to make a technical correction to the definition of “applicant” to note that it does not apply to an applicant seeking an exemption pursuant to proposed subpart G. We propose a separate definition for “applicant” that is specific to exemptions in § 155.600.

We propose to make a technical correction to the definition of “application filer” to note that it does not apply to an application filer seeking an exemption pursuant to proposed subpart G. We propose a separate definition for “application filer” that is specific to exemptions in § 155.600.

#### 2. Subpart C—General Functions of an Exchange

##### a. Functions of an Exchange (§ 155.200)

The Exchange final rule specifies that the Exchange will perform the minimum functions described in subparts D, E, H, and K of part 155. In accordance with section 1311(d)(4)(H) of the Affordable Care Act and existing 45 CFR 155.200(b), in paragraph (a), we propose to add that the Exchange would also perform the functions described in subpart G of this part related to eligibility determinations for exemptions.

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

##### a. Definitions and General Requirements (§ 155.600)

In paragraph (a) of § 155.600, we propose definitions for terms that apply throughout subpart G. First, we propose to define “applicant” as an individual who is seeking an exemption from the shared responsibility payment for him or herself through an application submitted to the Exchange. We provide this definition to distinguish the use of applicant in this subpart from the definition in § 155.20 of this chapter, which is specific to an individual who is submitting an application for an eligibility determination for enrollment in a QHP.

We propose to define “application filer” as an applicant, an individual who expects to be liable for the shared responsibility payment, in accordance with 26 CFR 1.5000A–1(c) of the Treasury proposed rule, published

elsewhere in this issue of the **Federal Register**, for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant. This is consistent with the definition that is used for the eligibility process for enrollment in a QHP and for insurance affordability programs, with one exception. In this proposed rule, we use the liability structure established in 26 CFR 1.5000A–1(c) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register** to assist in defining the range of potential application filers, while the definition of application filer in § 155.20 uses the tax household or Medicaid household, as they are the relevant units for eligibility for enrollment in a QHP and for insurance affordability programs. We note that we expect to modify the proposed language in § 155.227 (78 FR 4711) to incorporate the minor changes necessary to clarify that authorized representatives can assist individuals seeking exemptions. Similarly, we intend to modify the proposed language in § 155.225 (78 FR 4710) to clarify that certified application counselors can assist individuals seeking exemptions. We seek comment on how authorized representatives and certified application counselors can best support individuals seeking certificates of exemption from the Exchange.

We propose to define “exemption” as an exemption from the shared responsibility payment. While sections 5000A(d)(2) through (4) of the Code describe individuals who are not “applicable individuals” for purposes of the requirement to maintain minimum essential coverage in section 5000A of the Code, and sections 5000A(e)(1) through (5) of the Code describe individuals who are exempt from liability for the shared responsibility payment imposed under section 5000A(b) of the Code, the consequence for individuals described in either category is the same: Individuals in both categories are not subject to the shared responsibility payment for not maintaining minimum essential coverage.

We propose to define “health care sharing ministry” in the same manner as provided in 26 CFR 1.5000A–3(b) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**.

We propose to define “required contribution” in the same manner as provided in 26 CFR 1.5000A–3(e) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**.

We propose to define “Indian tribe” in the same manner as in 26 CFR 1.5000A–3(g) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**, which in turn references the definition in section 45A(c)(6) of the Code. We note that section 45A(c)(6) of the Code describes certain federally-recognized Indian tribes (including any qualified Alaska Native village or regional or village corporation).

We welcome comment on these definitions.

Consistent with 45 CFR 155.300(c), in paragraph (b), we propose that for purposes of this subpart, any attestation that an applicant is to provide under this subpart may also be provided by an application filer on behalf of the applicant.

In paragraph (c) of § 155.600, we propose that for the purposes of this subpart, the Exchange must consider information through electronic data sources, other information as provided by the applicant, or other information as available in the records of the Exchange to be reasonably compatible with an applicant’s attestation if the difference or discrepancy does not impact the eligibility for the relevant exemption that the applicant requested. This is the same standard that is used in 45 CFR 155.300(d) for eligibility for enrollment in a QHP and for insurance affordability programs. This proposal minimizes the administrative burden on applicants by limiting additional requests for information to only those situations in which there is good cause for such requests. We note that as provided in subpart D, this threshold does not preclude flexibility for Exchanges in further defining reasonable compatibility, particularly with regard to specific categories of exemptions, as long as the Exchange adheres to this general standard as well.

We also propose to add paragraphs (d) and (e) in order to specify that the accessibility and notice requirements in § 155.205(c) and § 155.230, respectively, apply to exemptions as well, given that the definition of applicant in this subpart is otherwise specific to exemptions. We note that 45 CFR 155.230(d), as proposed (78 FR 4594), specifies that notices will be provided either through standard mail, or, if an individual elects, electronically, provided that standards for use of electronic notices are met as set forth in 42 CFR 435.918, as proposed in the same issue of the **Federal Register**. Further discussion of this approach is at 78 FR 4601–4602 and 4635.

b. Eligibility standards for Exemptions (§ 155.605)

Section 5000A of the Code provides nine categories of exemptions. Of these nine categories, section 5000A expressly provides that certifications of exemptions in two categories (religious conscience and hardship) be provided by the Exchange under section 1311(d)(4)(H) of the Affordable Care Act. Under the program established under section 1411(a)(4) of the Affordable Care Act for determining whether certifications of exemptions are to be issued by Exchanges under section 1311(d)(4)(H) of the Affordable Care Act, we are proposing that Exchanges would issue certifications of exemption in these two categories. With respect to the other seven exemptions, for reasons set forth below, we propose that under the program provided for in section 1411(a)(4) of the Affordable Care Act, Exchanges would issue certifications of exemption with respect to three additional categories of exemption (with exemptions also available through the tax filing process). In the four remaining exemption categories, however, we propose that under the program established under section 1411(a)(4) of the Affordable Care Act, certifications would not be issued by Exchanges under section 1311(d)(4)(H) of the Affordable Care Act, and the determination of whether an individual is eligible for an exemption under section 5000A of the Code in these categories would be made exclusively by IRS through the tax filing process.

In this section, we propose standards related to the five categories of exemptions that we are proposing that the program under section 1411(a)(4) of the Affordable Care Act assign to Exchanges, and discuss our reasons for assigning the remaining four categories of exemptions exclusively to the IRS at the end of this section.

In paragraph (a) of § 155.605, we propose that except as specified in paragraph (g), the Exchange would determine an applicant eligible for and grant a certificate of exemption for a month if the Exchange determines that he or she meets the requirements for one of the categories of exemptions described in this section for at least one day in the month, consistent with 26 CFR 1.5000A-3 of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. We note that an individual will not need to submit a separate application for each month in which he or she is applying for an exemption. We also note that the proposed standards for hardship exemptions specify that depending on

the circumstances for each specific hardship exemption category, the certificate may be provided for an entire calendar year or instead for a specific month or period of months, including periods of time that stretch across more than one calendar year (for example, in the case of a hardship that occurs for the first time in December); this is discussed further in the preamble associated with paragraph (g) of this section.

We note that an individual may be eligible for multiple exemptions simultaneously; while there is no practical reason to have multiple exemptions in effect at any given time, we believe that an applicant should be able to apply for multiple exemptions in case some are denied, and also receive any exemptions for which he or she is eligible. We considered specifying that the Exchange could only accept an application for one category of exemption at a time from an applicant, but did not propose this approach because we believe that it increases the length of time required to conclude the overall eligibility process in cases where the initial application is denied. Further, we considered specifying that once the Exchange granted a certificate of exemption based on one category, it would not provide additional exemptions for the same time period. However, we believe that the statute does not provide the flexibility for the Exchange to deny an exemption to an applicant who is otherwise eligible, and think that the number of applicants who will continue to pursue exemptions after receiving one for a coverage month is too small to increase administrative burden in any significant way. We solicit comments regarding this approach.

In paragraph (b), we propose that except as specified, an applicant is required to submit a new application for each year for which an applicant would like to be considered for an exemption through the Exchange, and that an exemption will only be provided for a calendar year that the applicant submitted an application. This proposal is based on the recognition that for many categories of exemptions, an applicant's exemption status may change from year to year. There are exceptions for exemptions provided based on membership in an Indian tribe and for religious conscience, in recognition that an individual's qualification for these exemptions is expected to remain the same from year to year. There are also exceptions for hardship, since some categories of hardship will be provided for one or more months and may be provided for periods of time that stretch across more

than one calendar year (for example, in the case of a hardship that occurs for the first time in December), and some categories of hardship can only be provided after the close of a calendar year. We welcome comments on this approach and how the Exchange can expedite and streamline the process.

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

In paragraphs (c) through (g) of this section, we propose standards for eligibility for an exemption through the Exchange. First, in paragraph (c), we propose to codify the statutory eligibility standards for the exemption based on religious conscience. In paragraph (c)(1), we propose that the Exchange will determine an applicant eligible for an exemption for a month if he or she is a member of a recognized religious sect or division described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division for such month, in accordance with 26 CFR 1.5000A-3(a) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. We note that the statute prescribes the religious sects and divisions that are covered by this exemption, and that as such, HHS does not have discretion to expand it to cover other groups.

In paragraph (c)(2), we propose eligibility standards regarding the duration of the exemption for religious conscience. In paragraph (c)(2)(i), we propose that the Exchange grant the exemption for religious conscience to an applicant that meets the standards of paragraph (c)(1) of this section for a month on a continuing basis, until such time that the applicant either reaches the age of 18, or reports that he or she no longer meets the standards provided in (c)(1) of this section. This proposal is based on our understanding that membership in the religious sects or divisions described in section 1402(g)(1) of the Code will not typically change from year to year, along with the provision in § 155.620(b), which provides that an applicant who receives a certificate of exemption from the Exchange must report changes with respect to the eligibility standards for exemptions established in this section. Further, the provision in § 155.620(a)

also provides that if an individual reports to the Exchange that they no longer meet the standards established in paragraph (c)(1) of this section, such as if the individual chooses to terminate his or her membership in a religious sect or division, the Exchange will redetermine his or her eligibility, which will result in the Exchange discontinuing the individual's exemption. We solicit comment on this approach.

We propose to add paragraph (c)(2)(ii) to specify how the Exchange should handle a situation in which an individual who has a certificate of exemption based on religious conscience that was granted prior to the individual reaching the age of 18 turns 18. We believe that a special process is necessary in this situation so that any future exemption is based on the individual's own attestation and not an attestation provided by a parent or legal guardian. Accordingly, we propose that the Exchange send such an individual a notice when he or she reaches the age of 18 that informs the individual that he or she needs to submit a new exemption application if he or she would like to maintain the certificate of exemption. If the applicant submits a new application that reflects uninterrupted membership, and it is approved, the Exchange will provide a new certificate of exemption that is retroactive and leaves no gap.

We propose to add paragraph (c)(3) to specify that the Exchange will grant an exemption in this category prospectively or retrospectively, including after the close of the calendar year, which provides flexibility for applicants and ensures that this exemption will be available as needed during the tax filing process, as it can only be provided by the Exchange.

In paragraph (d), we propose that the Exchange will determine an applicant eligible for an exemption for a month if the applicant is a member of a health care sharing ministry for such month in accordance with 26 CFR 1.5000A-3(b) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. This exemption is discussed further in the preamble associated with 26 CFR 1.5000A-3(b) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. We note that unlike the exemption for religious conscience, our understanding is that membership in a health care sharing ministry can fluctuate over time, particularly as we understand that membership is contingent on a financial contribution. Consequently, we propose that an applicant must re-apply for this exemption each calendar year. Further,

for the same reason, we note that the language of this proposal specifies that the Exchange will only determine an individual eligible for an exemption in this category if he or she is a member of a health care sharing ministry at the time the application for an exemption is submitted; that is, the Exchange would not provide this exemption based on likely or probable future membership, including likely or probable membership beyond the calendar year. Lastly, consistent with these proposals, we propose to add paragraph (d)(2) to specify that the Exchange may only provide an exemption in this category retrospectively. We note that an individual may also receive this exemption retrospectively through the tax filing process. Furthermore, as proposed below in § 155.610(h), after December 31 of a given calendar year, the Exchange will not accept an application for an exemption in this category for months for such calendar year. We solicit comments on this approach.

In paragraph (e), we propose the eligibility standards for the exemption based on incarceration. We specify that the Exchange must determine an individual eligible for an exemption for a month that he or she meets the definition specified in 26 CFR 1.5000A-3(d) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**, which covers anyone who is confined after the disposition of charges in a jail, prison, or similar penal institution or correctional facility, which we believe can be implemented identically to the standard used for eligibility for enrollment in a QHP. We note that this proposed language does not provide for this exemption to be granted in cases where future incarceration is in doubt; rather, we propose that the Exchange will only provide this exemption for months in which an individual was incarcerated. We also considered specifying that this exemption could be provided based on an expectation of continued incarceration, but ultimately decided not to provide an exemption in this case since individuals are frequently released from incarceration ahead of the initially-expected release date, at which point they would need to obtain minimum essential coverage unless they apply for and are determined eligible for a separate exemption. Further, unlike some other categories of exemptions, it seems unlikely that an applicant who is seeking an exemption based on incarceration is doing so to obtain guidance regarding a purchasing decision, which is the primary purpose

of providing prospective exemptions. We solicit comments on this approach.

We propose to add paragraph (e)(2) to specify that the Exchange may only provide an exemption in this category retrospectively. We note that an individual may also receive this exemption retrospectively through the tax filing process. Furthermore, as proposed below in § 155.610(h), after December 31 of a given calendar year, the Exchange will not accept an application for an exemption in this category for months for such calendar year.

In paragraph (f), we propose eligibility standards for the exemption based on membership in an Indian tribe. In paragraph (f)(1), we propose to codify that the Exchange must determine an applicant eligible for an exemption for a month if he or she is a member of an Indian tribe for such month, in accordance with 26 CFR 1.5000A-3(g) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. We note that the definition of Indian used in the statute for this exemption is the same as is used for the cost-sharing and special enrollment provisions in subparts D and E, respectively.

In paragraph (f)(2), we propose eligibility standards regarding the duration of the exemption for membership in an Indian tribe, such that the Exchange must grant the exemption for membership in an Indian tribe to an applicant who meets the standards of paragraph (f)(1) of this section for a month on a continuing basis, until such time that the individual reports that he or she no longer meets the standards provided in (f)(1) of this section. This proposal is based on our understanding that an individual's membership in an Indian tribe, as defined in section 45A(c)(6) of the Code, will not typically change from year to year. As such, we seek to reduce the administrative burden on the Exchange and individuals who are members of Indian tribes. We note that the provision in § 155.620(a) also provides that if an individual reports to the Exchange that they no longer meet the standards established in paragraph (f)(1) of this section, such as if the individual chooses to terminate his or her membership in an Indian tribe, as defined in section 45A(c)(6) of the Code, the Exchange will redetermine his or her eligibility, which will result in the Exchange discontinuing the individual's exemption. We solicit comment on this approach.

We propose to add paragraph (f)(3) to specify that the Exchange will grant an exemption in this category during the

year prospectively or retrospectively. We note that an individual may also receive this exemption retrospectively through the tax filing process. This permits flexibility depending on when an application is submitted.

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

First, in paragraph (g)(1) of § 155.605, we propose that the Exchange provide an exemption for hardship for a month or months in which an applicant experienced financial or domestic circumstances, including unexpected natural or human-caused events, such that he or she has a significant, unexpected increase in essential expenses; the expense of purchasing health insurance would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or he or she has experienced other factors similar to those described in paragraphs (g)(1)(i) and (ii) of this section that prevented him or her from obtaining minimum essential coverage. We propose broad language to include a range of personal scenarios that could negatively impact an applicant such that he or she would be eligible for this exemption, and we expect to clarify these criteria in future guidance. This proposal provides necessary flexibility for the Exchange to tailor an exemption for hardship to particular circumstances that impact an individual, but cannot adequately be predicted in advance. We expect that these circumstances will include, but not be limited to, situations in which an applicant is homeless, receives a shut-off notice from a utility company, faces a natural disaster, or experiences other unexpected natural or human-caused event causing significant damage to the applicant or his or her home. We request comment on these criteria, including on whether additional standards should be established in regulation or guidance. We note that we strive to set clearly defined standards as

much as possible without preventing an applicant in need from being determined eligible for an exemption for hardship. We also solicit comments regarding whether the proposed time standard can be effectively implemented, or whether we should instead specify that a hardship under this paragraph that occurs at any point during a year should result in a hardship exemption for that entire year, as well as potentially for the entire next year, depending on when the hardship occurred.

Second, in paragraph (g)(2), we propose that the Exchange provide an exemption for hardship for a calendar year if an applicant, or another individual for whom the applicant attests will be included in the applicant’s family (as defined in 26 CFR 1.5000A–1(d)(6)), is unable to afford coverage for such calendar year in accordance with 26 CFR 1.5000A–3(e) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**, calculated using projected annual household income. We propose identical standards to those defined for the lack of affordable coverage exemption in 26 CFR 1.5000A–3(e), except that the Exchange would use projected household income to determine whether coverage is affordable under this exemption, instead of actual household income from the tax return for the year for which the exemption is requested. We note that the preamble associated with 26 CFR 1.5000A–3(e) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register** recognizes that the information necessary to determine the portion of the required contribution made through a salary reduction arrangement and excluded from gross income may not be available to the applicant or the IRS. Accordingly, Treasury has solicited comments about practicable ways to administer this requirement. We also solicit comments regarding whether the approach in paragraph (g)(5) of this section should also be applied to this hardship category.

We propose these standards as a component of hardship, rather than as a separate category of exemption, in order to ensure that an applicant can prospectively receive this exemption during a calendar year, and in doing so, obtain the information needed to make a purchasing decision and also qualify to purchase a catastrophic plan. We also clarify that we propose that this exemption is not available for a calendar year for an application that is submitted after the last date on which an applicant could enroll in a QHP through the

Exchange for the calendar year for which the exemption is requested. This is because this exemption is designed to ensure that an applicant can obtain the information needed to make a purchasing decision, including for a catastrophic plan, which is not applicable after the last date on which enrollment would be possible. After this point, an individual will be able to seek an exemption on his or her tax return for the year.

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

We propose to add paragraph (g)(4) to specify that the Exchange provide an exemption for hardship for a calendar year for an individual who has been determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act. We provide an exemption for hardship in this circumstance to address situations in which a state’s decision regarding the Medicaid expansion included in the Affordable Care Act results in an individual being ineligible for Medicaid. We believe that this determination is an appropriate use of the hardship exemption given that the Affordable Care Act anticipates that Medicaid will be available to such individuals. With this situation noted, we believe that many such individuals could also receive exemptions based on the standards specified in paragraph (g)(2) of this section (the inability to afford coverage), or section 5000A(e)(2) of the Code (income below filing threshold), and so propose this paragraph to ensure that any such individuals remaining are not liable for a shared responsibility payment regardless of a state’s decision with respect to the Medicaid expansion under the Affordable Care Act. We seek comment on whether this exemption should be limited to such individuals who are also not eligible for advance payments of the premium tax credit (that is, with projected annual household income below the poverty threshold).

We propose to add paragraph (g)(5) of § 155.605 to specify that the Exchange provide an exemption for hardship for a calendar year if an applicant and one or more employed members of his or her family, as defined in 26 CFR 1.5000A-1(d)(6) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**, are each determined eligible for self-only coverage in separate eligible employer-sponsored plans that are affordable, pursuant to 26 CFR 1.5000A-3(e) for one or more months during the calendar year, but for whom the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of the household income for that month or those months, in accordance with 26 CFR 1.5000A-3(e). This proposal aligns with 26 CFR 1.5000A-3(e)(3)(i) and (ii), which specify that for an employed individual, the affordability of coverage under an eligible employer-sponsored plan offered through such individual's employer is determined based on the cost of self-only coverage, regardless of whether the employed individual is eligible for family coverage under another eligible employer-sponsored plan because of the individual's relationship to another employed individual in the family. Thus, this hardship category is designed to provide relief for employed members of a family who have affordable self-only coverage options available and as a result do not qualify for the lack of affordable coverage exemption under 26 CFR 1.5000A-3(e) even though the family's aggregate cost of covering all of the employed members may exceed 8 percent of household income. We note that this category only covers those individuals who are actually offered self-only coverage in an eligible employer-sponsored plan, as the lack of affordable coverage exemption in paragraph 26 CFR 1.5000A-3(e) already provides an exemption based on affordability computed using the cost of family coverage for children and others who are not offered self-only coverage in an eligible employer-sponsored plan.

Lastly, as noted above, section 5000A of the Code provides for four additional categories of exemptions that we propose, under our authority in section 1411(d)(4) of the Affordable Care Act to determine whether certificates of exemptions are issued by Exchanges under section 1311(d)(4)(H) of the Affordable Care Act, to make available solely through the tax filing process and not to be subject to certification by Exchanges. Specifically, we propose that the Exchange would not issue

certifications of exemption with respect to household income below the filing threshold (other than the limited hardship exemption proposed in § 155.605(g)(3) and described above); not being lawfully present; short coverage gaps; and inability to afford coverage (other than the limited hardship exemption proposed in § 155.605(g)(2) and described above).

The exemptions for inability to afford coverage under section 5000A(e)(1) of the Code and income below the filing threshold under section 5000A(e)(2) of the Code necessitate an assessment of actual household income, which will be unavailable until after the close of the tax year and which would be provided to the individual through the tax filing process, making a process of seeking a duplicative certification from an Exchange an unnecessary administrative burden. Under the authority in section 5000A(e)(1)(A) and (e)(2) of the Code to determine the year for which income will be evaluated for purposes of these exemptions, the Secretary (in consultation with the Secretary of Treasury) has determined that the relevant year is the taxable year that includes a month for which an individual seeks one of these exemptions. Verification of an individual's household income once the year is over is a matter of tax administration and tax compliance. Accordingly, we are proposing under our authority in section 1411(d)(4) that certifications by Exchanges not be issued with respect to these two exemptions (other than the hardship exemption proposed in § 155.605(g)(2) and § 155.605(g)(3)).

With respect to the exemption based on an individual not being lawfully present under section 5000A(d)(3) of the Code, we do not believe it is appropriate to provide for a process under which an individual would be required to present himself or herself to an Exchange as not lawfully present. Consequently, we are proposing that this exemption also be implemented exclusively through the tax filing process.

Lastly, with respect to the exemption for short coverage gaps under section 5000A(e)(4) of the Code, as short coverage gaps can only be confirmed after the year has concluded, and as IRS will have authoritative information about whether an individual has coverage based on information reported by health insurance issuers under section 6055 of the Code, we propose that this exemption also be implemented exclusively through the tax filing process, as proposed at 26 CFR 1.5000A-5 of the Treasury proposed rule, published elsewhere in this issue

of the **Federal Register**, in order to reduce administrative burden on individuals and the Exchange. We solicit comment on this approach and if there are alternative approaches that HHS should consider.

#### c. Eligibility Process for Exemptions (§ 155.610)

In § 155.610, we propose the process by which the Exchange will determine an applicant's eligibility for exemptions.

In paragraph (a), we propose to specify that the Exchange will use an application established by HHS in order to collect the information necessary to determine eligibility and grant a certificate of exemption for an applicant, unless the Exchange receives approval to use an alternative application in accordance with paragraph (b). We also clarify that in cases in which relevant information has already been collected through the eligibility process for enrollment in a QHP and for insurance affordability programs, the Exchange will use this information for the purpose of eligibility for an exemption to the maximum extent possible. This proposal promotes an efficient process that minimizes the burden on the applicant, and is parallel to the approach used for eligibility for enrollment in a QHP and for insurance affordability programs, as specified in 45 CFR 155.405. We intend to provide the HHS-developed application in the near future, and expect it will share data elements with the application defined in 45 CFR 155.405 for information that is common to the two applications.

In paragraph (b) of § 155.610, we propose that the Exchange may seek approval from HHS for an alternative application. We further specify that such alternative application must only request the minimum information necessary for the purposes identified in paragraph (a) of this section. Our intent is to simplify the application process by reducing the collection of unnecessary information. As such, we seek to preserve flexibility for Exchanges to utilize an alternative application if it efficiently assists individuals in applying for exemptions while also minimizing potential administrative burdens.

We also note that there are exemptions that share common data and verifications with the eligibility process for enrollment in a QHP and for insurance affordability programs. There are also situations in which an individual may submit the application described in 45 CFR 155.405, and ultimately need an exemption, including when he or she is determined ineligible for enrollment in a QHP based



on being incarcerated (other than incarceration pending the disposition of charges); when available coverage is unaffordable in accordance with proposed § 155.605(g)(2); and when he or she is ineligible for Medicaid based solely on a state's decision with respect to the Medicaid expansion under the Affordable Care Act. As such, in paragraph (c) of § 155.610, we propose that if an individual submits the application in 45 CFR 155.405 and then requests an exemption, the Exchange must use the information collected on the application for coverage and not duplicate any verification processes that share the standards specified in this subpart. We solicit comments on how best to coordinate these processes to ensure maximum administrative simplicity for all involved parties.

In paragraph (d) of § 155.610, we propose the Exchange must accept the application for an exemption from an application filer, and provide tools for the submission of an application. Section 1413(b)(1)(A)(ii) of the Affordable Care Act, 45 CFR 155.405(a) specifies that the single, streamlined application for enrollment in a QHP through the Exchange and insurance affordability programs via an Internet Web site, by telephone, by mail, and in person. However, the Affordable Care Act does not contain similarly specific language for the application for an exemption; consequently, we have opted to not specify particular channels here. With that said, we believe that this language would allow the Exchange to deploy any or all of the methods described in 45 CFR 155.405. We solicit comments regarding whether we should specify some or all of the channels specified in 45 CFR 155.405.

In paragraph (e) of § 155.610, we propose that the Exchange will specify that an applicant who has a social security number (SSN) will provide such number to the Exchange. This provision is particularly important in the exemption process because the Secretary of the Treasury uses the SSN to coordinate information in the tax filing process. Further, the SSN provides the Exchange with additional abilities to ensure program integrity. However, we clarify in paragraphs (e)(2) and (e)(3) that the Exchange may not require an individual who is not seeking an exemption for him or herself to provide a SSN, except that the Exchange will require an application filer to provide the SSN for a non-applicant tax filer only if the applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized to verify household income and family size for a hardship exemption as

discussed in § 155.605(g) that involves such verification. This proposal follows the approach used for eligibility for insurance affordability programs, as specified in 45 CFR 155.305(e)(6), and ensures that information collected by the Exchange is only that information which is necessary to support the eligibility process. We solicit comments on the applicability of this provision in the context of the exemption eligibility process.

In paragraph (f) of § 155.610, we propose that the Exchange will grant a certificate of exemption to any applicant determined eligible in accordance with the standards for exemptions provided in § 155.605. As specified in section 1311(d)(4)(H) of the Affordable Care Act, the responsibility of the Exchange is to "grant a certification", which is what will be provided to the IRS to support the tax filing process. Depending on the exemption for which an applicant receives a certificate, the certificate may cover a month, multiple months, a calendar year, or multiple calendar years, and may represent multiple exemption categories, to the extent that an individual receives multiple exemptions for a single tax year.

In paragraph (g)(1) of § 155.610, we propose that the Exchange will determine eligibility for exemptions promptly and without undue delay. This proposal uses the same timing threshold used throughout subpart D, including in 45 CFR 155.310(e)(1), with respect to eligibility determinations for enrollment in a QHP and for insurance affordability programs. We note in paragraph (g)(2) in § 155.610 that the assessment of timeliness of eligibility determinations by the Exchange is based on the period from the date of the application until the date on which the Exchange notifies the applicant of its decision. We expect that the Exchange will monitor the timeliness of eligibility determinations and strive to improve performance over time. We solicit comments regarding specific performance standards for the eligibility process described in this subpart, and whether we should define an outer bound in which an eligibility determination will be made (e.g., 45 days).

In paragraph (h), we propose to clarify that except for the exemption for religious conscience under § 155.605(c) and for hardship described in § 155.605(g), after December 31 of a given calendar year, the Exchange will not accept an application for an exemption for months for such calendar year. As described above, the other seven categories of exemptions will be

available through the tax filing process, which we believe is a more appropriate and efficient avenue through which to receive exemptions after the coverage year is over. With the exception of the two exemptions that can only be granted by the Exchange, we consider the availability of exemptions from the Exchange necessary only until an individual can file an income tax return claiming an exemption for a given coverage year. We solicit comments regarding this approach, and whether there should be additional categories of exemptions for which the Exchange will grant exemptions after the close of a calendar year.

In paragraph (i) of § 155.610, we propose that the Exchange will provide timely written notice to an applicant of any eligibility determination for an exemption made in accordance with this subpart. We note that as proposed in § 155.600(e), written notice can be provided through electronic means, consistent with § 155.230(d). We further note that, for purposes of tax administration, if the Exchange determines an applicant eligible for a certificate of exemption, the notification provided will include an exemption certificate number, which we will further define in systems guidance. An individual will use this certificate number as part of the tax filing process.

In paragraph (j) of § 155.610, we propose that an individual who has been certified by an Exchange as qualifying for an exemption will retain the records that demonstrate not only receipt of the certificate of exemption but also qualification for the underlying exemption. For tax purposes, the Code provides that every taxpayer must keep records sufficient to establish all information required to be shown on any return the taxpayer must file. These records include any records and information substantiating any claim for exemption on the taxpayer's federal income tax return. We note that to the extent that the Exchange provides a certificate of exemption for which the underlying verification is based in part on the special circumstances exception proposed in § 155.615(h), an individual will retain records that demonstrate receipt of the certificate of exemption, as well as the circumstances that warranted the use of the special circumstances exception.

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

Section 1411(b)(5) of the Affordable Care Act provides that an applicant who is seeking an exemption will provide information as a part of the eligibility process, and section 1411(c)(1) of the

Affordable Care Act specifies that the Exchange will verify this information. Section 1411(d) of the Affordable Care Act provides flexibility to the Secretary to define verification processes for those data elements for which a process is not otherwise defined in section 1411 of the Affordable Care Act. In this section, we propose language regarding the verification process related to eligibility for exemptions. Similar to the verification process outlined in § 155.315 governing the verification process related to eligibility for enrollment in a qualified health plan through the Exchange, the Exchange will undertake a series of steps designed to assemble the information needed to determine an applicant's eligibility for the exemption for which he or she applied. These processes are designed not only to minimize the burden on applicants, but also to serve a valuable program integrity function in order to assure that applicants are only deemed eligible for exemptions if they meet the standards specified in § 155.605.

First, in paragraph (a) of § 155.615, we propose that unless HHS grants a request for modification under paragraph (i) of this section, the Exchange will verify or obtain information as provided in this section in order to determine that the applicant is eligible for an exemption.

In paragraph (b), we propose the verification process concerning the exemption for religious conscience. We specify that for any applicant requesting this exemption, the Exchange will verify that he or she meets the standards as outlined in § 155.605(c). First, in paragraph (b)(1) of § 155.615, we propose that except as specified in paragraph (b)(2) of this section, the Exchange will accept a form that reflects that an applicant has been approved under section 1402(g)(1) of the Code by the Internal Revenue Service (IRS). This is to accommodate those situations in which an applicant has already received approval from IRS for an exemption from Social Security and Medicare taxes, which use an identical standard to that used for the purposes of the religious conscience exemption. Second, in paragraph (b)(2), we propose that except as specified in paragraphs (b)(3) and (4) of this section, the Exchange will accept an applicant's attestation that he or she is a member of a recognized religious sect or division described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division. Next, the Exchange will verify that the religious sect or division to which the applicant attests membership is recognized by the Social Security

Administration (SSA) as a religious sect or division under section 1402(g)(1) of the Code. We expect that this verification will involve comparing the religious sect or division to which an applicant attests membership to a list maintained by SSA that is available for this purpose.

Third, in paragraph (b)(3) of § 155.615, we propose that if the information provided by an applicant regarding his or her membership in a recognized religious sect or division is not reasonably compatible with other information provided by the individual or the records of the Exchange, the Exchange will follow the procedures specified in paragraph (g) of this section concerning situations in which the Exchange is unable to verify information. These procedures are used throughout this section and described in the preamble associated with paragraph (g) of this section.

Fourth, in paragraph (b)(4), we propose that if an applicant attests to membership in a religious sect or division that is not recognized by SSA as a religious sect or division under section 1402(g)(1) of the Code, the Exchange will determine an applicant ineligible for this exemption. Because SSA has an established process for religious sects and divisions to follow in order to become recognized, sects or divisions that are not currently recognized but are interested in pursuing such status will follow the existing SSA process. With that said, we note that our understanding is that there are few, if any, religious sects or divisions that could be approved under section 1402(g)(1) of the Code that have yet to be approved, as this provision of the Code requires that a sect or division to have been in existence at all times since December 31, 1950.

In paragraph (c) of § 155.615, we propose the verification process concerning the exemption for membership in a health care sharing ministry. We specify that for any applicant requesting this exemption, the Exchange will verify whether he or she meets the standards in § 155.605(d). First, in paragraph (c)(1) of § 155.615, we propose that except as specified in paragraphs (c)(2) and (3) of this section, the Exchange will first accept an attestation from an applicant that he or she is a member of a health care sharing ministry. Next, the Exchange will verify that the health care sharing ministry to which the applicant attests membership is known to the Exchange as a health care sharing ministry. We expect that this verification will involve comparing the health care sharing ministry to which an applicant attests membership

with a list of health care sharing ministries that will be developed by HHS based on outreach to health care sharing ministries, which HHS will then make available to Exchanges.

In paragraph (c)(2), we propose that if the information provided by an applicant regarding his or her membership in a health care sharing ministry is not reasonably compatible with other information provided by the individual or the records of the Exchange, the Exchange will follow the procedures specified in paragraph (g) of this section concerning situations in which the Exchange is unable to verify information. These procedures are used throughout this section and described in the preamble associated with paragraph (g) of this section.

In paragraph (c)(3), we propose that if an applicant attests to membership in a health care sharing ministry that is unknown to the Exchange as a health care sharing ministry according to the standards in § 155.605(d), the Exchange will then notify HHS and not determine an applicant eligible or ineligible for this exemption until HHS informs the Exchange regarding the attested health care sharing ministry's status with respect to the standards specified in 26 CFR 1.5000A-3(b) of the Treasury proposed rule, published elsewhere in this issue of the **Federal Register**. This process allows an applicant who is a member of a health care sharing ministry that meets the standards specified in § 155.605(d), but is previously unknown to the Exchange, to have the opportunity to receive this exemption. We have conducted preliminary outreach regarding health care sharing ministries that meet the requirements specified in the statute, and note that this provision of the Code normally requires a health care sharing ministry to have been in existence at all times since December 31, 1999, although a new organization can meet the criteria based on the history of its predecessor, and some existing health care sharing ministries may not currently meet all the statutory requirements, but can later perfect their status by, for example, obtaining 501(c)(3) status.

In paragraph (d), we propose the verification process concerning the exemption for incarceration. We specify that for any applicant requesting this exemption, the Exchange will verify, through the process described in 45 CFR 155.315(e), that he or she was incarcerated, which means that there is no additional burden associated with developing a process to support this verification for purposes of the incarceration exemption.

As with other verifications, we also specify in paragraph (d)(2) of § 155.615 that if the Exchange is unable to verify an applicant's incarceration status through the verification process outlined, the Exchange will follow the procedures in paragraph (g) of this section concerning situations in which the Exchange is unable to verify information.

In paragraph (e), we propose the verification process concerning the exemption for members of Indian tribes. We specify in paragraph (e)(1) that for any applicant requesting this exemption, the Exchange will verify his or her membership in an Indian tribe through the process outlined in 45 CFR 155.350(c), which means that there is no additional burden associated with developing a process to support this verification for purposes of this exemption. In paragraph (e)(2) of § 155.615, we also propose that the Exchange follow the procedures specified in paragraph (g) of this section if it is unable to verify an applicant's tribal membership.

In paragraph (f), we propose the verification process concerning exemptions for hardship. In paragraph (f)(2), we propose that for an applicant applying for a hardship exemption prospectively based on an inability to afford coverage, as described in § 155.605(g)(2), the Exchange use procedures established under subpart D of this part to verify the availability of affordable coverage through the Exchange based on projected income, and the procedures described in § 155.320(e) to verify eligibility for qualifying coverage in an eligible employer-sponsored plan. As noted in the preamble to § 155.605(g)(2), we propose that this exemption is not available for a calendar year for an application that is submitted after the last date on which an applicant could enroll in a QHP through the Exchange for the calendar year for which the exemption is requested. We anticipate providing additional guidance regarding procedures for the Exchange to verify whether an applicant has experienced other categories of hardship; we expect that these will likely include some amount of paper documentation, but solicit comments regarding appropriate verification procedures that will ensure a high degree of program integrity while minimizing administrative burden.

Paragraph (g) provides procedures for the Exchange to follow in the event the Exchange is unable to verify information necessary to make an eligibility determination for an exemption, including situations in which an applicant's attestation is not reasonably

compatible with information in electronic data sources or other information in the records of the Exchange, or when electronic data is required but unavailable. These procedures mirror those provided in § 155.315(f), with modifications to preclude eligibility pending the outcome of the verification process, made in accordance with the Secretary's authority under section 1411 of the Affordable Care Act. These modifications are based on the fact that individuals need to account for exemptions when they file income tax returns after the coverage year is over, which means that delaying the granting of a certificate until information can be verified does not create significant issues for an applicant. We also note that given that the process in this paragraph may be applied to more than one piece of information and applicants can apply for more than one exemption at a time, it is possible for the process in paragraph (g) to run simultaneously for multiple pieces of information that are relevant to eligibility for a single exemption, or across multiple exemptions.

First, under paragraph (g)(1) of § 155.615, the Exchange will make a reasonable effort to identify and address the causes of the issue, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer. We anticipate that when an applicant applies via an internet Web site or the telephone, this process will occur during the application session. Second, in paragraph (g)(2)(i), we propose that if the Exchange is unable to resolve the issue, the Exchange will notify the applicant of the issue. After providing this notice, in paragraph (g)(2)(ii), the Exchange will provide 30 days from the date on which the notice is sent for the applicant to present satisfactory documentary evidence via the channels available for the submission of an application, except by telephone, or otherwise resolve the issues. We note that, following the same approach in the Exchange final rule, all listed timelines refer to calendar days. In paragraph (g)(3), we propose that the Exchange may extend the period for an applicant to resolve the issue if the applicant can provide evidence that a good faith effort has been made to obtain the necessary documentation. And in paragraph (g)(4), we propose that the Exchange will not grant a certificate of exemption during this period based on the information that is the subject of the request under

this paragraph. This is distinct from the approach taken for the eligibility process for enrollment in a QHP and for advance payments of the premium tax credit and cost-sharing reductions, since, while there is a strong benefit associated with providing access to health insurance pending the outcome of a verification process, there is no apparent health benefit to an applicant in receiving an exemption pending the outcome of such a process.

In paragraph (g)(5), we propose that, if after the conclusion of the period described in paragraph (g)(2)(ii) of this section, the Exchange is unable to verify the applicant's attestation, the Exchange will determine the applicant's eligibility based on the information available from the data sources specified in this subpart, as applicable, unless such applicant qualifies for the exception provided under paragraph (h), and notify the applicant in accordance with the procedures described under § 155.610(i), including the inability to verify the applicant's attestation.

In paragraph (h) of § 155.615, we propose a provision under which the Exchange would provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available. We proposed this language to account for situations in which documentation cannot be obtained. This standard is consistent with the standard in subpart D at 45 CFR 155.315(g); examples of individuals for whom this provision may apply include homeless individuals, and victims of domestic violence or natural disasters.

Section 1411(c)(4)(B) of the Affordable Care Act provides that the Secretary may modify the methods used under the Secretary's program under section 1411 for the verification of information. In paragraph (i) of § 155.615, we propose to codify this flexibility, as we did in 45 CFR 155.315(h). Specifically, we propose that HHS may approve an Exchange Blueprint or a significant change to an Exchange Blueprint to modify the methods for the collection and verification of information as described in this subpart, as well as the specific information to be collected, based on a finding by HHS that the requested modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that any applicable requirements under 45 CFR 155.260, 45 CFR 155.270, paragraph (j) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met. We also note

that all information exchanges specified in this section will comply with 45 CFR 155.260 and 155.270.

In paragraph (j) of § 155.615, we propose that the Exchange will not require an applicant to provide information beyond what is necessary to support the process of the Exchange for eligibility determinations for exemptions, including the process for resolving inconsistencies described in § 155.615(g).

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

Section 1411(f)(1) of the Affordable Care Act provides that the Secretary shall establish procedures for periodic redeterminations of eligibility. In § 155.620, we propose to codify this by providing that the Exchange will redetermine an individual's eligibility for an exemption if the Exchange receives and verifies new information as reported by an individual. Similar to the standards in 45 CFR 155.330, in paragraph (b) of § 155.620, we propose that the Exchange will require an individual with a certificate of exemption to report any changes related to the eligibility standards described in § 155.605.

In 45 CFR 155.330(b)(3), which relates to the redetermination process for eligibility for enrollment in a QHP and for insurance affordability programs, we provide that the Exchange may establish a reasonable threshold for changes in income, such that an individual who experiences a change in income that is below the threshold is not required to report such change. We also note, however, that the Exchange will always allow an individual to report a change of any size. The intent of this provision was to limit the burden associated with reporting very small changes in income, with the understanding that the reconciliation process for advance payments of the premium tax credit would ultimately resolve these differences. We considered proposing similar flexibility for the purpose of eligibility for exemptions, but chose not to due to the absence of a reconciliation process. We solicit comment as to whether we should establish such flexibility in this section.

Also, in paragraph (b)(2) of § 155.620, we propose that the Exchange would allow an individual to report changes by the channels acceptable for the submission of an exemption application.

In paragraph (c), we propose that the Exchange use the verification processes used at the point of initial application, as described in § 155.615, in order to

verify any changes reported by an individual prior to using the self-reported information in an eligibility determination for an exemption. In paragraph (c)(2), we propose that the Exchange notify an individual in accordance with § 155.610(i) after re-determining his or her eligibility based on a reported change. Lastly, in paragraph (c)(3), similar to standards established in 45 CFR 155.330(c), we propose that the Exchange will provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption and who has elected to receive electronic notifications, unless he or she has declined to receive such notifications.

We also note that unlike 45 CFR 155.330, we do not propose that the Exchange conduct periodic data matching regarding an individual's eligibility for an exemption. The data matches that are established in 45 CFR 155.330(d), which were established based on a combination of relevance to eligibility for insurance affordability programs and the availability of electronic data sources, relate to data that is not significant in determining eligibility for exemptions: Death, and whether an individual has been determined eligible for Medicare, Medicaid, CHIP, or the Basic Health Program (BHP), where applicable. Further, with the exception of income, we are unaware of electronic data sources with which it would be useful to conduct data matching for purposes of eligibility for exemptions, particularly given the fact that generally, exemptions that are provided by the Exchange will be provided for prior months based on actual information. And while income data are available, we do not believe that the administrative complexity associated with implementing these matches, which are not required under 45 CFR 155.330, produces sufficient benefit. We solicit comments as to whether we should establish similar data matching provisions, and if so, whether we should specify that the Exchange should handle changes identified through the matching process in a similar manner as to that specified in 45 CFR 155.330, or take a different approach.

Lastly, also unlike the eligibility process for enrollment in a QHP and for insurance affordability programs, we do not propose an annual Exchange redetermination process for exemptions. We believe that an individual's exemption status may change significantly from year to year, and have proposed in § 155.605 that certain

exemptions for which information is unlikely to change (i.e., the exemptions for members of an Indian tribe, and for members of recognized religious sects) remain in effect unless an individual reports that his or her status has changed. For all other exemptions, we propose that an individual who has a certificate of exemption will submit an application for any subsequent calendar year for which he or she requests the same exemption. We do anticipate, however, that the Exchange can expedite and streamline this process significantly through the use of online accounts and other administrative tools, and welcome comment regarding how this can occur, including whether it should be reflected explicitly in regulation.

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

As previously noted, section 1411 of the Affordable Care Act provides that the Secretary will establish a program for eligibility determinations for exemptions. As described above, in general, we propose that the Exchange conduct the eligibility process for exemptions. However, as noted in the State Exchange Implementation Questions and Answers released by HHS on November 29, 2011<sup>1</sup> and the Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid released by HHS on December 10, 2012,<sup>2</sup> based on significant comments and feedback from states, a state-based Exchange can be approved if it uses a federally-managed service to make eligibility determinations for exemptions. As such, in § 155.625, we propose this option, and we solicit comment regarding the specific configuration of a service that would be useful for states and also feasible within the time remaining for implementation.

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

Second, in § 155.625(b), we specify that the Exchange may implement an eligibility determination for an

<sup>1</sup> State Exchange Implementation Questions and Answers, published November 29, 2011: [http://ccio.cms.gov/resources/files/Files2/11282011/exchange\\_q\\_and\\_a.pdf.pdf](http://ccio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf).

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

exemption made by HHS, provided that the Exchange accepts the application, as specified in § 155.610(d), and issues the eligibility notice, as specified in § 155.610(i), and that verifications and other activities required in connection with eligibility determinations for exemptions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (b)(4) of § 155.625. We also propose that under this option, the Exchange will transmit all applicant information and other information obtained by the Exchange to HHS, and adhere to HHS's determination. Lastly, in paragraph (b)(4), we propose that the Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for exemptions.

We considered establishing a process under which HHS would accept the application for an exemption certificate and provide the notice under § 155.610(i), but did not propose this for two reasons. First, we believe that it is more straightforward, and also not administratively burdensome, for the Exchange to provide and accept the application, since the exemption application process shares similar features with the coverage application process, and the Exchange will be identified to applicants through outreach campaigns and other means as a primary contact point for many activities regarding the Affordable Care Act in a particular state. Further, it facilitates the provision of exemptions that originate through applications for eligibility for enrollment in a QHP and for insurance affordability programs, which will be accepted by the Exchange. Second, we propose that the Exchange issue the notice, and the certificate, as section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange must, “\* \* \* grant a certification attesting that \* \* \* an individual is exempt \* \* \*”

Consequently, we see issuing the notice and any certificate as a necessary activity of the Exchange. We also believe that this does not present a significant administrative burden to the Exchange, since the contents of the notice can be standardized and provided by HHS. We solicit comments regarding maintaining these responsibilities at the Exchange, whether there are other responsibilities that should be specifically attributed to the Exchange or to HHS, and how this service can be implemented most

efficiently, including with a focus on the first year of operations.

In § 155.625(c), we outline the standards to which the Exchange will adhere when eligibility determinations are made in accordance with paragraph (b). Such standards include that the arrangement does not increase administrative costs and burdens on individuals, or increase delay, and that applicable requirements under 45 CFR 155.260, 155.270, and 155.315(i), and section 6103 of the Code are met with respect to the confidentiality, disclosure, maintenance or use of information. These are the same standards that are used in 45 CFR 155.302(d) regarding advance payments of the premium tax credit and cost-sharing reductions.

#### g. Reporting (§ 155.630)

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

#### h. Right to Appeal (§ 155.635)

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

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

Some individuals are currently enrolled in health coverage that is not statutorily designated as minimum essential coverage. Under section 5000A(f)(1)(E), the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, may designate other health benefits coverage as minimum essential coverage. This proposed rule would allow these individuals to keep their current coverage without incurring the shared responsibility payment for not maintaining minimum essential coverage, and would ensure that such coverage includes consumer protections.

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

Under section 36B of the Code, individuals eligible to enroll in minimum essential coverage other than coverage in the individual market are generally not eligible for the premium tax credit. Recognizing that some of the categories of coverage designated by the Secretary may be widely available, the Treasury Department will consider providing appropriate rules in guidance under Code section 36B to address when individuals are treated as eligible to enroll in various types of coverage designated by the Secretary.

#### a. Definition of Minimum Essential Coverage (§ 156.600)

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

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

Prior to the Affordable Care Act, many people did not have access to employer-sponsored health coverage and could not qualify for, or otherwise seek alternatives to, individual health insurance coverage. Some individuals turned to other types of health coverage, such as self-funded student health coverage or state high risk pools.

We propose to specifically recognize certain types of coverage that have not been designated in the statute, as minimum essential coverage. HHS is familiar with the scope of coverage under these plans and they are comparable to other coverage that is designated as minimum essential coverage under the statute. The following types of coverage would be designated *per se* as minimum essential coverage for purposes of the minimum essential coverage requirement:

1. Self-funded student health insurance plans. Some institutions of higher education (as defined in the Higher Education Act of 1965) offer student health coverage to students with their own funds, assuming the risk for payment of claims. These plans are neither group health insurance nor individual insurance in most states.

2. Foreign health coverage. Many foreign nationals reside in this country and many of these individuals are covered by health coverage from their country of citizenship.

3. Refugee medical assistance supported by the Administration for Children and Families (45 CFR 400.90 through 400.107) This is a federally-funded program that provides up to eight months of coverage to certain non-citizens who are considered refugees under the Immigration and Naturalization Act.

4. Medicare advantage plans. The Medicare program under part C of title XVIII of the Social Security Act, which provides Medicare parts A and B benefits through a private insurer. While these plans provide the same coverage as that described in part A of Title XVIII of the Social Security Act, section 5000A(f)(1)(a)(i) specifically designated only Medicare coverage under Part A of Title XVIII as minimum essential coverage.

5. AmeriCorps coverage (45 CFR 2522.250(b)). Coverage offered to AmeriCorps volunteers, which is the domestic counterpart to the Peace Corps.

The types of coverage enumerated above have been in existence for a significant period of time. Although

they vary in scope, they each provide a meaningful level of coverage that meets certain fundamental health needs for the people who are enrolled and protect against catastrophic losses. Three of the five are public programs, and even though student health plans are not individual or group market coverage, they are subject to certain consumer protections. Accordingly, individuals who wish to remain in these plans should not be subject to the shared responsibility payment under section 5000A of the Code. We welcome comments on these and whether there are other existing categories of coverage that should be recognized as minimum essential coverage. We also solicit comments regarding whether self-funded student health coverage should be limited to institutions of higher education, as defined by the Higher Education Act of 1965, or if coverage offered by other institutions, such as primary or secondary educational institution, or unaccredited educational institutions, should be included. Lastly, we included coverage for AmeriCorps volunteers in the list of types of coverage designated as minimum essential coverage. Coverage for Peace Corps volunteers is statutorily designated as minimum essential coverage, and since AmeriCorps is a similar organization, coverage offered to volunteers under AmeriCorp should be provided the same status as minimum essential coverage. We welcome comments on the inclusion of AmeriCorps coverage in the designated list.

State high risk pools are specifically noted in section 5000A(f)(1)(E) of the Code as coverage that could be designated by the Secretary as minimum essential coverage. This rule proposes that state high risk pools be designated as minimum essential coverage for a period of time to be determined by the Secretary. State high risk pools across the country vary in their coverage and benefits and some high risk pools may not substantially comply with the requirements of the Affordable Care Act, as specified in this proposed rule. Accordingly, while we are proposing that state high risk pools will initially be designated minimum essential coverage, we reserve the right to review and monitor the extent and quality of coverage, and in the future to reassess whether they should be designated minimum essential coverage or should be required to go through the process outlined in § 156.604 this proposed rule. We solicit comments on whether state high risk pools should automatically be designated as minimum essential

coverage or whether they should be required to follow the process outlined in § 156.604 of this proposed rule.

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

In addition to the types of coverage recognized above, there may be other types of individual coverage that provide important coverage to enrollees comparable to the statutorily designated types of minimum essential coverage. Accordingly, the proposed rule outlines a process in which other types of coverage could seek to be recognized as minimum essential coverage. Such recognition would apply only to the particular plan sponsored by the submitting organization seeking recognition.

Employment-based coverage would not be recognized as minimum essential coverage through this proposed process. This is because employment-based group coverage is generally subject to the provisions of either ERISA, the Code and/or the PHS Act, and there is a separate statutory category of minimum essential coverage under the Department of Treasury's authority that addresses eligible employer-sponsored plans.

Coverage recognized as minimum essential coverage through this process would need to offer substantially the same consumer protections as those enumerated in the Title I of Affordable Care Act relating to non-grandfathered, individual coverage to ensure consumers are receiving the protections of the Affordable Care Act. Furthermore, setting standards for other coverage qualifying as minimum essential coverage creates a disincentive for the creation of coverage that is designed to circumvent the important consumer protections of the Affordable Care Act. We solicit comments on the proposed "substantially comply" standard as it applies to other types of individual coverage. We also solicit comments on the process for recognizing other coverage as minimum essential coverage.

We propose that sponsors of minimum essential coverage also meet other criteria specified by the Secretary. We anticipate that there may be organizational standards that could disqualify a type of coverage from being recognized as minimum essential coverage, such as if individuals are prohibited from membership in the organization based on a health factor. We seek comment on the types of criteria the Secretary should consider in

this process as well as whether they should be added to the final rule.

We propose that sponsors of a plan that seeks to have such coverage recognized as minimum essential coverage adhere to certain procedures. Sponsors would submit to HHS electronically the following information: (1) Name of the organization sponsoring the plan; (2) name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization; (3) address of the individual named above; (4) phone number of the individual named above; (5) number of enrollees; (6) eligibility criteria; (7) cost sharing requirements, including deductible and out-of-pocket maximum; (8) essential health benefits covered (as defined in § 1302(b) of the Affordable Care Act and its implementing regulations); and (9) a certification that the plan substantially complies with the provisions of Title I of the Affordable Care Act as applicable to non-grandfathered individual health insurance coverage. Once HHS receives a submission from a sponsor, it will review the information. If HHS determines that the coverage meets the necessary criteria to be recognized by the Secretary as minimum essential coverage, HHS would then inform the sponsor of the minimum essential coverage status of its coverage. This coverage would then be placed in a public list the types of coverage that have submitted information and have been determined by the Secretary to meet the eligibility requirements to be recognized as minimum essential coverage. The proposed rule also provides the Secretary the authority to revoke the minimum essential coverage status of a type of coverage that had previously been recognized minimum essential coverage if it has been determined that the coverage no longer meets the requirements to be minimum essential coverage. We solicit comments on whether there should be an appeal process for sponsors of coverage that had the minimum essential coverage status revoked by the Secretary. Such an appeal process could be internal within HHS, where the initial decision to revoke would be reviewed by an HHS staff person other than the one who made the initial decision. Comments are also welcome on whether this appeal process should be available to sponsors whose initial request for recognition of minimal essential coverage status for their coverage was denied by HHS.

#### d. HHS Audit Authority (§ 156.606)

Under this proposed rule, HHS would have the ability to audit plans to ensure the accuracy of the certification either

randomly or when triggered by certain information. For example, errors in the submission, complaints from enrollees, communications with state insurance regulators, media reports, etc., may result in an audit of a sponsoring organization.

We believe this process strikes the appropriate balance between efficiency and ensuring compliance. Comments are solicited on the proposed procedures and if and when audits should be conducted. Comments are also welcome on whether sponsors of the types of coverage that have been designated as minimum essential coverage in the proposed rule should also submit the above information required to CMS.

Once recognized as minimum essential coverage, a plan would have to provide notice to its enrollees, specifying that the plan has been recognized as minimum essential coverage for the purposes of the individual coverage requirement. This notice could be included in existing enrollment materials and in other plan documents. The sponsor of any plan recognized as minimum essential coverage would also be required to provide the annual information reporting to the IRS specified in section 6055 of the Code and furnish statements to individuals enrolled in such coverage to assist them in establishing that they are not subject to the shared responsibility payment of section 5000A of the Code. We request comments on whether all plans and programs designated as minimum essential coverage under this regulation must provide notice to enrollees, or only plans recognized through the process in § 156.604 of this regulation.

### III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The proposed rule entitled “Exchange Functions: Eligibility for Exemptions” proposes standards with regard to the minimum function of an Exchange to perform eligibility determinations and issue certificates of exemption from the shared responsibility payment. The rule proposes standards related to eligibility for exemptions, including the verification and eligibility determination process, eligibility redeterminations, options for conducting eligibility determinations, and reporting related to exemptions. The rule also proposes to designate certain types of coverage as minimum essential coverage and outlines substantive and procedural requirements that other types of coverage must fulfill in order to be recognized as minimum essential coverage under section 5000A(f)(5) of the Code, as added by the Affordable Care Act.

This section outlines the information collection requirements in the proposed regulation that will be addressed through this notice and comment process under the Paperwork Reduction Act (PRA). We are soliciting public comment on each of these issues for the following sections of the proposed rule that contain information collection requirements (ICRs). We used data from the Bureau of Labor Statistics to derive average costs for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits, calculated at 30.4 percent of salary, which is based on the June 2012 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics. Additionally, we used estimates from the Congressional Budget Office to derive estimates of the number of exemption applications we anticipate Exchanges to receive, and the number of exemption eligibility determination notifications we anticipate Exchanges to generate.

#### 1. Exemption Application (§ 155.610)

Throughout this subpart, we propose that the Exchange collect attestations from applicants for a certificate of exemption. These attestations will be collected using the application described in § 155.610(a). In § 155.610(a), we provide that the Exchange use an application created by HHS to collect the information necessary for determining eligibility for and granting certificates of exemption. The burden associated with this

requirement is the time and effort estimated for an applicant to complete an application. The exemption application may be available in both paper and electronic formats. An electronic application process would vary depending on each applicant's circumstances and which exemption an applicant is applying for, such that an applicant is only presented with questions relevant to the exemption for which he or she is applying. The goal is to solicit sufficient information so that in most cases no further inquiry will be needed. We estimate that on average, it will take .27 hours (16 minutes) for an application filer to complete an application, which is based on the estimates created for the single, streamlined application for enrollment in a QHP<sup>3</sup>, with a 90% electronic/10% paper mix (noting that no specific application channel is specified in this proposed rule). While the Congressional Budget Office<sup>4</sup> estimates that 24 million individuals would be exempt from the shared responsibility penalty in 2016, it is unclear how many individuals will seek these exemptions from an Exchange. Some of these individuals will apply for and receive an exemption through the tax filing process, while others will apply for and receive an exemption through the Exchange. Therefore, of the 24 million individuals, we conservatively anticipate that approximately half will apply for an exemption through the Exchange, and half will seek an exemption through the tax filing process and specifically seek comment on this assumption. Accordingly, we estimate that approximately 12 million applications for exemptions will be submitted to the Exchange for calendar year 2016, for a total of 3.2 million burden hours. We also note that some individuals will apply for an exemption but be determined ineligible for an exemption, but it is difficult for us to estimate this number, and that in an unknown number of cases, multiple individuals in a single household may submit a single application.

We do not estimate any cost to the Exchanges of evaluating the exemption applications. For the purposes of this estimate, we expect all applications to be submitted electronically and

processed through the system, which would result in no additional labor costs to evaluate and review the exemption applications. We request comment on this assumption.

We estimate that the cost to develop the exemption application will be significantly less than the estimated cost of developing the coverage application because the coverage application takes into account additional factors necessary in order to perform eligibility determinations for insurance affordability programs. We also note that as with the coverage application, HHS will be releasing a model application for use by Exchanges, which will significantly decrease the burden associated with the implementation of the application. On average, we estimate that the implementation of the exemption application will take approximately 1,059 hours of software development at a labor cost of \$98.50 per hour, for a total cost of \$104,312 per Exchange and a total cost of \$5,319,887 for 51 Exchanges.

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

Several provisions in subpart G outline specific notices that the Exchange will send to individuals during the exemption eligibility determination process, including the notice of eligibility determination described in § 155.610(i). The purpose of these notices is to alert an applicant of his or her eligibility determination for an exemption and related actions taken by the Exchange. To the extent that an applicant is determined eligible for an exemption, the notice of eligibility determination described in § 155.610(i) will serve as the certificate of exemption. Accordingly, we do not provide a separate burden estimate for the certificates of exemption described throughout this subpart. When possible, we anticipate that the Exchange will consolidate notices when multiple members of a household are applying together and receive an eligibility determination at the same time. Consistent with 45 CFR 155.230(d), the notice may be in paper or electronic format, based on the election of an individual, will be in writing, and will be sent after an eligibility determination has been made by the Exchange; these are the same standards that are used for eligibility notices for enrollment in a QHP through the Exchange and for insurance affordability programs, as described in 45 CFR 155.310(g). It is difficult to estimate the number of applicants that will opt for electronic versus paper notices, although we anticipate that a large volume of

applicants will request electronic notification. We estimated the associated mailing costs for the time and effort needed to mail notices in bulk to applicants who request paper notices.

We expect that the exemption eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application throughout the eligibility determination process. A health policy analyst, senior manager, and an attorney would review the notice. HHS is currently developing model notices, which will decrease the burden on Exchanges associated with providing such notices. If a state opts to use the model notices provided by HHS, we estimate that the Exchange effort related to the development and implementation of the exemption eligibility determination notice will necessitate 44 hours from a health policy analyst at an hourly cost of \$49.35 to learn exemptions rules and draft notice text; 20 hours from an attorney at an hourly cost of \$90.14, and four hours from a senior manager at an hourly cost of \$79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of \$52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each Exchange, at a cost of approximately \$5,971 per Exchange and a total cost of \$304,497 for 51 Exchanges. For most notices outlined in subpart G of this proposed rule, we estimate that the notice development as outlined in the paragraph above, including the systems programming, would take each Exchange an estimated 100 hours to complete in the first year.

We expect that the burden on the Exchange to maintain this notice will be significantly lower than to develop it. We estimate that it will take each professional approximately a quarter of the time to maintain the notice as compared to developing the notice. Accordingly, we estimate the maintenance of the eligibility determination notice in subsequent years will necessitate 11 hours from a health policy analyst at an hourly cost of \$49.35; 5 hours from an attorney at an hourly cost of \$90.14; one hour from a senior manager at an hourly cost of \$79.08 and eight hours from a computer programmer at an hourly cost of \$52.50. In total, we estimate that this will take a total of 25 hours for each Exchange, at a cost of approximately \$1,492 per Exchange and a total cost of \$76,092 for 51 Exchanges.

Pursuant to section 5000A of the Code, the Secretary of Treasury must collect the necessary data from QHP issuers to determine the national

<sup>3</sup> The estimates may be found in the information collection request entitled, "Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies."

<sup>4</sup> Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Affordable Care Act," September 2012 [http://cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv\\_Mandate\\_Penalty.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf).



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

### 3. *Electronic Transmissions (§§ 155.615, 155.630)*

Section 155.615 specifies that the Exchange will utilize applicable procedures established under subpart D of the Exchange final rule in order to obtain data through electronic data sources for purposes of determining eligibility for and granting certificates of exemption. This involves the electronic transmission of data through procedures established under subpart D in order to verify an applicant's incarceration status, to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, and to determine eligibility for advance payments of the premium tax credit. Section 155.615 also includes additional electronic transmissions that are specific to the eligibility process for exemptions, including those related to health care sharing ministries and religious conscience. In section 155.630, we propose that the Exchange will provide relevant information to IRS regarding certificates of exemption for the purposes of tax administration, such as the name and other identifying information for the individual who received the exemption. As we expect that these transmissions of information will all be electronic, and through the same channels used for reporting to IRS established in § 155.340, we do not anticipate for there to be any additional burden other than that which is required to design the overall eligibility and enrollment system. We do not provide a burden estimate for the electronic transmissions, as the cost is incorporated into the development of the IT system for the Exchange eligibility and enrollment system.

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

The Exchange will use the same verification processes for new applications and for changes that are

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

### 5. *ICRs Regarding Agreements (§ 155.625)*

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

The burden associated with these provisions is the time and effort necessary for the Exchange to establish an agreement with HHS. We estimate that the creation of the necessary agreement will necessitate 35 hours from a health policy analyst at an hourly cost of \$49.35, and 35 hours from an operations analyst at an hourly cost of \$54.45 to develop the agreement; and 30 hours from an attorney at an hourly cost of \$90.14 and five hours from a senior manager at an hourly cost of \$79.14 to review the agreement. Accordingly, the total burden on the Exchange associated with the creation of the necessary agreement will be approximately 105 hours and \$6,733 per Exchange, for a total cost of \$343,382 for 51 Exchanges.

### 6. *ICRs Regarding Minimum Essential Coverage (§§ 156.604(a)(3), 156.604(c))*

Organizations that currently provide health coverage that are not statutorily specified and not designated as minimum essential coverage in this regulation may submit a request to CMS that their coverage be recognized as

minimum essential coverage. As described in § 156.604(a)(3), sponsoring organizations would have to electronically submit to CMS information regarding their plans and certify that their plans meet substantially all of the requirements in the Title I of Affordable Care Act, as applicable to non-grandfathered, individual coverage. Because we do not know how many sponsoring organizations would submit a request, we have estimated the burden for one entity. We seek comments on how many organizations are likely to submit such requests. The burden associated with this certification includes the time needed to collect and input the necessary plan information, and maintain a copy for recordkeeping by clerical staff and for a manager and legal counsel to review it and for a senior executive to review and sign it. The certification would be submitted to CMS electronically at minimal cost. We estimate that it would take a combined total of 4.25 hours (3 hours for clerical staff at an hourly cost of 30.64, 0.5 hour for a manager at an hourly cost of \$55.22, 0.5 hours for legal counsel at an hourly cost of \$83.10 and 0.25 hours for a senior executive at an hourly cost of \$112.43) to prepare and submit the information and certification to CMS and to retain a copy for recordkeeping purposes. The total cost for one organization is estimated to be approximately \$190.

Section 156.604(c) specifies that sponsoring organizations whose health coverage are recognized as minimum essential coverage would have to provide a notice to enrollees informing them that the plan has been recognized minimum essential coverage for the purposes of the individual coverage requirement. The notice requirement may be satisfied by inserting the model statement provided in this proposed rule into existing plan documents. Plan documents are usually reviewed and updated annually before a new plan year begins. Sponsoring organizations may insert the model language in their plan documents at that time at minimal cost. Once the notice is included in the plan documents the first year, no additional cost will be incurred in future years. Therefore this notice is not subject to the Paperwork Reduction Act of 1995.

The sponsor of any type of coverage recognized as minimum essential coverage would also be required to provide the annual information reporting to the IRS specified in section 6055 of the Code and furnish statements to individuals enrolled in such coverage to assist them in establishing that they

are not subject to the shared responsibility payment of section 5000A of the Code. The Department of

Treasury plans to publish for public comment, in accordance with the Paperwork Reduction Act of 1995 (44

U.S.C. Chapter 35), the required ICRs in the near future.

TABLE 1—PROPOSED ANNUAL INFORMATION COLLECTION REQUIREMENTS

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)
§ 155.610 .....	0938—New .....	51	51	1,059	54,009
§ 155.610 .....	0938—New .....	12,000,000	12,000,000	0.27	3,200,000
§§ 155.610, 155.615, 155.620 .....	0938—New .....	51	51	125	6,275
§ 155.615, 155.620 .....	0938—New .....	1	1	0.2	0.2
§ 155.625 .....	0938—New .....	51	51	105	5,355
§§ 156.604(b) .....	0938—New .....	1	1	4.25	4.25
Total .....	.....	.....	.....	.....	3,265,643

C. Submission of PRA-Related Comments

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

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

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS-9958-P) Fax: (202) 395-5806; or Email: [OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov).

IV. Response to Comments

Because of the large number of public comments we normally receive on Federal Register documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Summary of Regulatory Impact Statement

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). This rule has been designated a “significant regulatory action” under Executive Order 12866. Accordingly, this rule has been reviewed by the Office of Management and Budget.

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

As noted in our discussion, above, of information collection requirements,

while CBO estimates that 24 million individuals would be exempt from the penalty in 2016, it is unclear how many individuals will seek these exemptions from an Exchange. These submissions would be associated with a variety of effects, including: costs to Exchanges to review the exemption requests; costs to applicants to request exemptions and retain documents; potential effects on enrollment in health coverage and its benefits; and a transfer from the federal government to individuals receiving exemptions in cases in which there is a foregone shared responsibility payment.

We note that the cost to an applicant of submitting a request and retaining documents is bounded above by the expected shared responsibility payment; otherwise, he or she would not necessarily apply for the exemption. Though we currently lack data to precisely characterize the effects of these proposed provisions, we note that the potential number of individuals seeking exemptions through the Exchange could place the overall impact of the proposed rule over the \$100 million threshold for economic significance, even at a low economic cost per individual. The minimum essential coverage provisions included in this proposed rule could lead to transfers from the federal government to affected individuals (in this case, individuals whose coverage is designated to be minimum essential coverage) and have effects on health coverage enrollment (e.g., decreased switching between plans). Decreased switching between plans would entail time savings for affected individuals and uncertain effects on premium payments and use of medical services and products. We currently lack data to estimate the number of individuals whose coverage would be designated minimum essential coverage by this proposed rule. In light of our incomplete data and quantification of

impacts, we request data and comments on all likely economic effects of the provisions of this proposed rule.

#### VI. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent. As the burden for this proposed regulation falls on either Exchanges or individuals, the proposed regulations will not have a significant economic impact on a substantial number of small entities, and therefore, a regulatory flexibility analysis is not required.

#### VII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. In 2012, that threshold is approximately \$139 million. This final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of \$136 million. The majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 2012 Medicaid eligibility rule. Furthermore, the proposed rule does not set any mandate on states to set up an Exchange.

#### VIII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. We wish to note again that the impact of changes related to

implementation of the Affordable Care Act were described in the RIA associated with the Exchange final rule. As discussed in the Exchange final rule RIA, we have consulted with states to receive input on how the various Affordable Care Act provisions codified in this proposed rule would affect states.

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

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the states, the Department has engaged in efforts to consult with and work cooperatively with affected states, including participating in conference

calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state officials on an individual basis.

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

#### IX. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

#### List of Subjects

##### 45 CFR Part 155

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

##### 45 CFR Part 156

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

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

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

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

**Authority:** Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413.

**Subpart A—General Provisions**

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

**§ 155.20 Definitions.**

\* \* \* \* \*

*Applicant* means:

(1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the shared responsibility payment for not maintaining minimum essential coverage pursuant to subpart G, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

\* \* \* \* \*

*Application filer* means an applicant, an adult who is in the applicant’s household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant, excluding those individuals seeking eligibility for an exemption pursuant to subpart G.

\* \* \* \* \*

**Subpart C—General Functions of an Exchange**

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

**§ 155.200 Functions of an Exchange.**

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

\* \* \* \* \*

■ 4. Add subpart G to read as follows:

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

Sec.

- 155.600 Definitions and general requirements.
- 155.605 Eligibility standards for exemptions.
- 155.610 Eligibility process for exemptions.
- 155.615 Verification process related to eligibility for exemptions.
- 155.620 Eligibility redeterminations for exemptions during a calendar year.
- 155.625 Options for conducting eligibility determinations for exemptions.
- 155.630 Reporting.
- 155.635 Right to appeal.

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

**§ 155.600 Definitions and general requirements.**

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

*Applicant* means an individual who is seeking an exemption for him or herself through an application submitted to the Exchange.

*Application filer* means an applicant, an individual who is liable for the shared responsibility payment in accordance with 26 CFR 1.5000A–1(c) for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

*Exemption* means an exemption from the shared responsibility payment.

*Health care sharing ministry* has the same meaning as it does in 26 CFR 1.5000A–3(b).

*Required contribution* has the same meaning as it does in 26 CFR 1.5000A–3(e).

*Shared responsibility payment* has the same meaning as in 26 CFR 1.5000A–1 *et seq.*

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

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

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

(d) *Accessibility.* Information, including notices, forms, and applications, must be provided to applicants in accordance with the standards specified in 45 CFR 155.205(c).

(e) *Notices.* Any notice required to be sent by the Exchange to an individual in accordance with this subpart must be provided in accordance with the standards specified in 45 CFR 155.230.

**§ 155.605 Eligibility standards for exemptions.**

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

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

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

(2) *Duration of exemption for religious conscience.* (i) The Exchange must grant the certificate of exemption specified in this paragraph to an applicant who meets the standards provided in paragraph (c)(1) of this section for a month on a continuing basis, until the month after the month of the individual’s 18th birthday, or until such time that an individual reports that he or she no longer meets the standards provided in paragraph (c)(1).

(ii) If the Exchange granted a certificate of exemption in this category to an applicant prior to him or her reaching the age of 18, the Exchange must send such an applicant a notice upon reaching the age of 18 informing the applicant that he or she must submit a new exemption application if seeking to maintain the certificate of exemption.

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

(d) *Membership in a health care sharing ministry.* (1) The Exchange must determine an applicant eligible for an

exemption for a month if the applicant is a member of a health care sharing ministry for such month as defined in 26 CFR 1.5000A-3(b).

(2) The Exchange may only provide an exemption in this category retrospectively.

(e) *Incarceration.* (1) The Exchange must determine an applicant eligible for an exemption for a month if he or she meets the standards as defined in 26 CFR 1.5000A-3(d) for such month.

(2) The Exchange may only provide an exemption in this category retrospectively.

(f) *Membership in an Indian tribe.* (1) The Exchange must determine an applicant eligible for an exemption for any month if he or she is a member of an Indian tribe, as defined in section 45A(c)(6) of the Code, for such month, as defined in 26 CFR 1.5000A-3(g).

(2) *Duration of exemption for membership in an Indian tribe.* The Exchange must grant the exemption specified in this paragraph to an applicant who meets the standards specified in § 155.605(f)(1) for a month on a continuing basis, until such time that the applicant reports that he or she no longer meets the standards provided in § 155.605(f)(1).

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

(g) *Hardship.* The Exchange must determine an applicant eligible for an exemption—

(1) For a month or months during which—

(i) He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she has a significant, unexpected increase in essential expenses;

(ii) The expense of purchasing minimum essential coverage would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or

(iii) He or she has experienced other factors similar to those described in paragraphs (g)(1)(i) and (ii) of this section that prevented him or her from obtaining minimum essential coverage, as described in 26 CFR 1.5000A-2.

(2) For a calendar year if he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.5000A-1(d)(6), is unable to afford coverage for such calendar year in accordance with the standards specified in 26 CFR 1.5000A-3(e), calculated using projected annual household income, and provided that the applicant applies for this exemption prior to the last date on which he or she could enroll in a

QHP through the Exchange for the calendar year for which the exemption is requested;

(3) For a calendar year if he or she was not required to file an income tax return for such calendar year because his or her gross income was below the filing threshold, but who nevertheless filed to receive a tax benefit, claimed a dependent with a filing requirement, and as a result, had household income exceeding the applicable return filing threshold described in 26 CFR 1.5000A-3(f)(2);

(4) For a calendar year if he or she has been determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act; or

(5) For a calendar year if he or she, as well as one or more employed members of his or her family, as defined in 26 CFR 1.5000A-1(d)(6), has been determined eligible for affordable self-only employer-sponsored coverage pursuant to 26 CFR 1.5000A-3(e) through their respective employers for one or more months during the calendar year, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of household income for that month or those months.

#### **§ 155.610 Eligibility process for exemptions.**

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

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

(c) *Exemptions through the eligibility process for coverage.* If an individual submits the application described in 45 CFR 155.405 of this chapter and then requests an exemption, the Exchange must use information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination and must not request duplicate information or conduct repeat verifications that adhere to the standards specified in this subpart.

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

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

(2) Provide the tools to file an application.

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

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

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

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

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

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

(h) *Exemptions for previous tax years.* Except for the exemptions described in 155.605(c) and (f) of this subpart, after December 31 of a given calendar year, the Exchange will not accept an application for an exemption for months for such calendar year, and must provide information to individuals regarding the process for claiming an exemption through the tax filing process.

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

(j) *Retention of records for tax compliance.* (1) Consistent with the requirements of section 6001 of the Code, an individual must retain the

records that demonstrate not only receipt of the certificate of exemption but also qualification for the underlying exemption.

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

**§ 155.615 Verification process related to eligibility for exemptions.**

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

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

(1) Except as specified in paragraph (b)(2) of this section, accepting a form that reflects that he or she is approved by the Internal Revenue Service under section 1402(g)(1) of the Code;

(2) Except as specified in paragraphs (b)(3) and (4) of this section, accepting his or her attestation, and verifying that the religious sect or division to which the applicant attests membership is recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code.

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

(4) If an applicant attests to membership in a religious sect or division that is not recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code, the Exchange must determine the applicant ineligible for this exemption.

(c) *Verification related to exemption for membership in a health care sharing ministry.* For any applicant who requests an exemption based on membership in a health care sharing

ministry, the Exchange must verify that the applicant meets the standards specified in § 155.605(d) of this subpart by—

(1) Except as provided in paragraphs (c)(2) and (3) of this section, accepting his or her attestation; and verifying that the health care sharing ministry to which the applicant attests membership is known to the Exchange based on data provided by HHS as a health care sharing ministry.

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

(3) If an applicant attests to membership in a health care sharing ministry that is not known to the Exchange as a health care sharing ministry, the Exchange must notify HHS and not determine the applicant eligible or ineligible until such time as HHS notifies the Exchange regarding the attested health care sharing ministry's status with respect to the standards specified in 26 CFR 1.5000A-3(b).

(d) *Verification related to exemption for incarceration.* (1) For any applicant who provides information attesting that he or she was incarcerated for a given month in accordance with the standards specified in § 155.605(e) of this subpart, the Exchange must verify his or her attestation through the same process as described in 45 CFR 155.315(e) of this part.

(2) To the extent that the Exchange is unable to verify an applicant's attestation that he or she was incarcerated for a given month in accordance with the standards specified in § 155.605(e) through the process described in 45 CFR 155.315(e) of this part, the Exchange must follow the procedures specified in paragraph (g) of this section.

(e) *Verification related to exemption for members of Indian tribes.* (1) For any applicant who provides information attesting that he or she is a member of an Indian tribe, the Exchange must use the process outlined in 45 CFR 155.350(c) of this part to verify that the applicant is a member of an Indian tribe.

(2) To the extent that the Exchange is unable to verify an applicant's status as a member of an Indian tribe through the process described in 45 CFR 155.350(c) of this part, the Exchange must follow the procedures specified in paragraph (g) of this section.

(f) *Verification related to exemption for hardship.*—(1) *In general.* For any

applicant who requests an exemption based on hardship, the Exchange must verify whether he or she has experienced the hardship to which he or she is attesting.

(2) *Cannot afford coverage.* For any applicant who requests an exemption based on the hardship described in § 155.605(g)(2) of this subpart, the Exchange must verify the unavailability of affordable coverage through the procedures used to determine eligibility for advance payments of the premium tax credit, as specified in subpart D of this part, and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in 45 CFR 155.320(e) of this part.

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

(g) *Inability to verify necessary information.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for an exemption, including but not limited to when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination for an exemption are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within 2 days of the initial request to the data source, the Exchange—

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

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

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

(ii) Provide the applicant with a period of 30 days from the date on which the notice described in paragraph (g)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in 45 CFR 155.610(d) of this subpart, except for by telephone, or otherwise to resolve the inconsistency.

(3) May extend the period described in paragraph (g)(2)(ii) of this section for

an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

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

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

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

(i) *Flexibility in information collection and verification.* HHS may approve an Exchange Blueprint in accordance with 45 CFR 155.105(d) of this part or a significant change to the Exchange Blueprint in accordance with 45 CFR 155.105(e) of this part modify the methods to be used for collection of information and verification as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements under 45 CFR 155.260, 155.270 of this part, and paragraph (j) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

(j) *Applicant information.* The Exchange must not require an applicant to provide information beyond the

minimum necessary to support the eligibility process for exemptions as described in this subpart.

**§ 155.620 Eligibility redeterminations for exemptions during a calendar year.**

(a) *General requirement.* The Exchange must redetermine the eligibility of an individual with an exemption if it receives and verifies new information reported by such an individual.

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

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

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

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

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

(3) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption who has elected to receive electronic notifications, unless he or she has declined to receive such notifications.

**§ 155.625 Options for conducting eligibility determinations for exemptions.**

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

(1) Directly or through contracting arrangements in accordance with 45 CFR 155.110(a) of this part; or

(2) Through the approach described in paragraph (b) of this section, subject to the standards in paragraph (c) of this section.

(b) *Use of HHS service.*

Notwithstanding the requirements of this subpart, the Exchange may adopt an exemption eligibility determination made by HHS, provided that—

(1) The Exchange accepts the application, as specified in § 155.610(c)

of this subpart, and issues the eligibility notice, as specified in § 155.610(i) of this subpart;

(2) Verifications and other activities required in connection with eligibility determinations for exemptions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (b)(5) of this section;

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

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

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

(c) *Standards.* To the extent that eligibility determinations for exemptions are made in accordance with paragraph (b) of this section, the Exchange must ensure that—

(1) Such arrangement does not increase administrative costs and burdens on individuals, or increase delay; and

(2) Applicable requirements under 45 CFR 155.260, 155.270, and 155.315(i) of this part, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance or use of information are met.

**§ 155.630 Reporting.**

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

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

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

**§ 155.635 Right to appeal.**

*Individual appeals.* The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 155.610(i) and § 155.625(b)(1) of this subpart.

**PART 156—PROCEDURAL AND SUBSTANTIVE REQUIREMENTS FOR MISCELLANEOUS COVERAGES WISHING TO BE DESIGNATED AS MINIMUM ESSENTIAL COVERAGE**

■ 5. The authority citation for subpart G is revised to read as follows:

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

■ 6. Add subpart G to read as follows:

**Subpart G—Minimum Essential Coverage**  
Sec.

156.600 The definition of minimum essential coverage.

156.602 Other coverage that qualifies as minimum essential coverage.

156.604 Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart.

156.606 HHS audit authority.

**Subpart G—Minimum Essential Coverage**

**§ 156.600 The definition of minimum essential coverage.**

The term *minimum essential coverage* has the same meaning as provided in 26 CFR 1.5000A–2 for purposes of this subpart.

**§ 156.602 Other coverage that qualifies as minimum essential coverage.**

The following types of coverage are designated by the Secretary as minimum essential coverage for purposes of section 5000A(f)(1)(E) of the Code:

(a) *Self-funded student health coverage.* Coverage offered to students, by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims.

(b) *Foreign health coverage.* Coverage for non-citizens residing in the United States, provided by their home country.

(c) *Refugee medical assistance supported by the Administration for Children and Families (45 CFR Subpart G).* A federally-funded program that provides up to 8 months of coverage to certain noncitizens who are considered refugees under the Immigration and Naturalization Act.

(d) *Medicare advantage plans.* Medicare program under Part C of title XVIII of the Social Security Act, which provides Medicare Parts A and B benefits through a private insurer.

(e) *State high risk pool coverage.* State high risk pools are designated as minimum essential coverage subject to further review by the Secretary.

(f) *Coverage for AmeriCorp volunteers.* Health coverage provided to volunteers of AmeriCorp.

(g) *Other coverage.* Other coverage that qualifies pursuant to § 156.604 of this subpart.

**§ 156.604 Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart.**

The Secretary may recognize “other coverage” as minimum essential coverage provided HHS determines that the coverage meets the following substantive and procedural requirements:

(a) *Coverage requirements.* A plan must meet substantially all the requirements pertaining to non-grandfathered, individual health insurance coverage, of title I of the Affordable Care Act.

(b) *Sponsoring organization requirements.* In order for “other coverage” to be considered by the Secretary for recognition as minimum essential coverage, the sponsor, or in the case of a government-sponsored program, the government agency responsible for administering the program, must meet criteria at the discretion the Secretary.

(c) *Procedural requirements.* Procedural requirements for recognition as miscellaneous minimum essential coverage. To be considered for recognition as minimum essential coverage, a sponsor must submit the following information to HHS:

(1) Identity of the plan sponsor and appropriate contact persons;

(2) Basic information about the plan, including:

(i) Name of the organization sponsoring the plan;

(ii) Name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization;

(iii) Address of the individual named above;

(iv) Phone number of the individual named above;

(v) Number of enrollees;

(vi) Eligibility criteria;

(vii) Cost sharing requirements, including deductible and out-of-pocket maximum limit;

(viii) Essential health benefits covered; and

(ix) A certification by the appropriate individual, named pursuant to paragraph (c)(2)(ii) of this section, that the health coverage sponsored by the organization substantially complies with the requirements of title I of the Affordable Care Act and sponsor standards required by this rule.

(d) CMS will maintain a public list of types of coverage that the Secretary has recognized as minimum essential coverage.

(e) If at any time the Secretary determines that a type of coverage previously recognized as minimum essential coverage no longer meets the coverage requirements of paragraph (a) of this section or the sponsoring organization requirements of paragraph (b) of this section, the Secretary may revoke the recognition of such coverage.

(f) *Notice.* Once recognized as minimum essential coverage, a plan must provide notice to all enrollees of its minimum essential coverage status.

**§ 156.606 HHS audit authority.**

The Secretary may audit a plan or program recognized as minimum essential coverage under § 156.604 of this subpart at any time to ensure compliance with the requirements of § 156.604(a) of this subpart.

Dated: January 25, 2013.

**Marilyn Tavenner,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

Approved: January 28, 2013.

**Kathleen Sebelius,**

*Secretary, Department of Health and Human Services.*

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**DEPARTMENT OF COMMERCE**

**National Oceanic and Atmospheric Administration**

**50 CFR Part 660**

[Docket No. 110708376–3052–01]

**RIN 0648–BB17**

**Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; Trawl Rationalization Program; Cost Recovery**

**AGENCY:** National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

**ACTION:** Proposed rule; request for comments.

**SUMMARY:** This action would implement a cost recovery program for the Pacific coast groundfish trawl rationalization program, which is a catch share program and type of limited access privilege program (LAPP), as required by the Magnuson-Stevens Fishery Conservation and Management Act (MSA). This action includes regulations