This document is scheduled to be published in the
Federal Register on 05/11/2016 and available online at
http://federalregister.gov/a/2016-11017, and on **FDsys.gov**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 156

[CMS-9933-IFC]

RIN 0938-AS87

Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment establishes provisions that alter the parameters of select special enrollment periods and that revise certain rules governing consumer operated and oriented plans (CO-OPs).

DATES: Effective date*:* These regulations are effective on May 11, 2016, with the exception of the amendments to 45 CFR 155.420, which are effective on July 11, 2016.

Comment date*:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **July 5, 2016**.

ADDRESSES: In commenting, please refer to file code CMS-9933-IFC. 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-9933-IFC,

P.O. Box 8016,

Baltimore, MD 21244-8016.

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-9933-IFC,

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:

Jeff Wu, (301) 492-4305, or Lindsey Murtagh, (301) 492-4106, for general information.

Rachel Arguello, (301) 492-4263, for matters related to special enrollment periods.

Kevin Kendrick, (301) 492-4134, for matters related to CO-OPs.

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://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.

I. Executive Summary

The Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended (the Affordable Care Act) enacted a set of reforms that make quality health insurance

coverage and care more affordable and accessible to millions of Americans. These reforms include the creation of competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges" (in this final rule, we also call an Exchange a Health Insurance Marketplace℠, or Marketplace℠[1]) through which qualified individuals and qualified employers can purchase health insurance coverage during open enrollment periods or special enrollment periods, if eligible. These Affordable Care Act reforms also include the establishment of a loan program to foster the creation of Consumer Operated and Oriented Plans (CO-OPs) to offer qualified health plans (QHPs) to individuals and small employers. In previous rulemaking, we have outlined the major provisions and parameters related to these programs.

Section 1311(c)(6) of the Affordable Care Act establishes enrollment periods, including special enrollment periods for qualified individuals, for enrollment into QHPs through an Exchange. This interim final rule with comment amends the eligibility requirements of the special enrollment period for individuals who gain access to new QHPs as a result of a permanent move so that this special enrollment period is generally available only to those individuals who had minimum essential coverage prior to their permanent move. This change aligns the eligibility requirements with the intent of this special enrollment period (that is, to afford individuals the full range of plan options when they relocate), and promotes stability in the health insurance market. This interim final rule with comment does not alter the eligibility for special enrollment periods for (1)

[1] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

those being released from incarceration; (2) those moving to the United States from abroad; or (3) those who previously were in a non-Medicaid expansion State and ineligible for advance payments of the premium tax credit because of a household income below 100 percent of the Federal poverty level, and ineligible for Medicaid during the same timeframe, who make a permanent move to a State where they are newly eligible for advance payments of the premium tax credit.

We are also eliminating the January 1, 2017 implementation deadline for an Exchange to offer advanced availability of the special enrollment period for certain individuals who gain access to new QHPs as a result of a permanent move; and for offering a new special enrollment period for loss of a dependent or for no longer being considered a dependent due to divorce, legal separation, or death. This leaves the implementation of both provisions at the option of the Exchange. We do not believe it is appropriate to require Exchanges to expand eligibility for an existing special enrollment period or offer a new special enrollment period when both could introduce additional uncertainty to the Exchange risk pool at this time.

Section 1322 of the Affordable Care Act establishes the CO-OP program, which is a loan program that funds the establishment of private, non-profit, consumer-operated, consumer-oriented health plan issuers of QHPs. As with many new businesses entering complex, competitive markets, a number of the CO-OPs have encountered challenging market conditions in their early years. Although the Affordable Care Act appropriated $6 billion for the CO-OP program, $4.9 billion was subsequently rescinded, and there are no remaining funds available to award to these entities. In the absence of additional Federal

loans to CO-OPs, many of these entities would benefit from the infusion of private capital to assist them in achieving long-term stability and competitive success in the market.

In this interim final rule with comment, we amend certain CO-OP governance requirements to provide greater flexibility and facilitate private market transactions that can provide access to needed capital. These amendments will permit a CO-OP to recruit potential directors from a broader pool of qualified candidates. We also provide greater clarity with respect to what constitutes non-compliance with rules governing a CO-OP's business and the transactions into which it may enter. These changes will provide CO-OPs with flexibility common among private market health insurance issuers, and will support the financial viability of CO-OPs, while at the same time maintaining the fundamental member-governed, member-focused nature of the CO-OP program, and enabling CO-OPs to continue to benefit their enrollees.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the Affordable Care Act.

Subtitles A and C of title I of the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the Public Health Service Act (PHS

Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 1311(c)(6)(C) of the Affordable Care Act directs the Secretary of HHS to require an Exchange to provide for special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act.

Section 1322 of the Affordable Care Act directs the Secretary to establish the CO-OP program to foster the creation of consumer-governed, private non-profit health insurance issuers to offer QHPs in the individual and small group markets in the States in which they are licensed. The CO-OP program, in addition to improving consumer choice and plan accountability, also seeks to promote integrated models of care and enhance competition in the Exchanges. Section 1322 establishes eligibility standards for the CO-OP program and terms for loans, and provides basic standards that organizations must meet to participate in this program and become a CO-OP, including market participation and governance requirements.

1. Special Enrollment Periods

In the July 15, 2011 **Federal Register** (76 FR 41865), we published a proposed rule establishing special enrollment periods for the individual Health Insurance Exchange. We implemented these special enrollment periods in a final rule published in the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule). In the January 22, 2013 **Federal Register** (78 FR 4594), we published a proposed rule

amending certain special enrollment periods, including the special enrollment periods described in 45 CFR 155.420(d)(3) and (7). We finalized these rules in the July 15, 2013 **Federal Register** (78 FR 42321).

In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed to add a special enrollment period at 45 CFR 155.420(d)(10). We finalized this proposal in the Oct. 30, 2013 **Federal Register** (78 FR 65095). In the May 27, 2014 **Federal Register** (79 FR 30348), we published a proposed rule amending § 155.420(b), (c), (d)(4), (d)(5), (d)(9), (d)(10), and (e). We finalized these provisions in the May 27, 2014 **Federal Register** (79 FR 30348). In the October 1, 2014 **Federal Register** (79 FR 59138), we published a correcting amendment related to §155.420(b).

In the November 26, 2014 **Federal Register** (79 FR 70673), we proposed to amend §155.420(b), (c), (d)(1), (d)(2), (d)(4), and (d)(6). We finalized these provisions in the February 27, 2015 **Federal Register** (80 FR 10866). In the July 7, 2015 **Federal Register** (80 FR 38653), we issued a correcting amendment to § 155.420(b)(d)(2). In the December 2, 2015 **Federal Register** (80 FR 75487) (proposed 2017 Payment Notice), we sought comment and data related to existing special enrollment periods, including data relating to the potential abuse of special enrollment periods. In the March 8, 2016 **Federal Register** (81 FR 12203) (2017 Payment Notice), we stated that in order to review the integrity of special enrollment periods, the Federally-facilitated Exchange (FFE) will conduct an assessment by collecting and reviewing documents from consumers to confirm their eligibility for the special enrollment periods under which they enrolled.

2. CO-OP Program

In the July 20, 2011 **Federal Register** (76 FR 43237), we published a proposed rule governing the CO-OP program (proposed CO-OP Rule). On December 13, 2011, we published the final CO-OP Rule (76 FR 77392).

In the March 27, 2012 **Federal Register**, we published a final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges (77 FR 18474) (Exchange Establishment Rule). This rule amended the regulations regarding the CO-OP program.

B. Stakeholder Consultation and Input

HHS consulted stakeholders on the policies related to implementation of the Affordable Care Act, including special enrollment periods and CO-OPs. We have held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives, to gather public input. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with States, and meetings with health insurance issuers, organizations participating in the CO-OP program, trade groups, consumer advocates, employers, and other interested parties. We have held a number of recent meetings with issuers (including CO-OPs), regulators, and consumer groups relating to the effects of special enrollment periods on the risk pool, and on CO-OPs' attempts to raise private capital. We considered all public input we received as we developed the policies in this interim final rule with comment.

III. Provisions of the Interim Final Rule

A. Special Enrollment Periods (§155.420)

Special enrollment periods provide a critical pathway to coverage for qualified individuals who experience qualifying events and need to enroll in or change plans outside of the annual open enrollment period or during open enrollment with a coverage effective date earlier than generally provided during the open enrollment period. One such special enrollment period described in 45 CFR 155.420(d)(7) may be granted to a qualified individual or enrollee, or his or her dependent, who gains access to new QHPs as a result of a permanent move.

As discussed in the Exchange Establishment Rule (77 FR 18310, 18392), the special enrollment period in §155.420(d)(7) was intended to afford individuals the full range of plan options when they relocate, which maximizes consumer choice and increases competition in the health insurance market. However, this special enrollment period was never intended to provide an opportunity for enrollment in coverage where individuals make a permanent move solely for the purpose of gaining health coverage outside of the annual open enrollment period. Stakeholders have raised significant concerns that while such use of this special enrollment period may be consistent with the plain language of the rule, it is not aligned with the provision's intent. This use has the potential to destabilize the health insurance market by creating an opportunity for adverse selection where persons undertake a permanent move solely for the purpose of gaining health coverage, in which they would otherwise not be qualified to enroll. Because of concerns that unintended uses of the permanent move special enrollment period will lead to adverse selection and immediate, unexpected losses in the remaining months of this

year, which could lead to significant premium increases or issuers exiting the market, we believe that action is needed as soon as possible, and delaying the rule revisions would be impracticable and contrary to the public interest.

Therefore, we are amending the eligibility parameters for this special enrollment period by adding requirements in §155.420(d)(7)(i) and (ii). In paragraph (i), we require that individuals be enrolled in minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days in the 60 days preceding the date of the permanent move in order to qualify for the special enrollment period based on a permanent move.

The addition of paragraph (i) requires further amendments to the rule to maintain the availability of the permanent move special enrollment period for certain other individuals who should continue to be able to access this special enrollment period without the requirement of being previously enrolled in minimum essential coverage. Specifically, we make a necessary addition in paragraph (d)(7)(ii) to maintain eligibility for a special enrollment period for individuals previously living outside of the United States or in a United States territory who move to a location within the United States, so long as they seek to enroll in coverage within 60 days of completing their permanent move.

In light of the addition of these new requirements, we are making a further change to §155.420(d)(7) and to (d)(3) related to incarcerated individuals. As noted in the preamble to the Exchange Establishment Rule (77 FR 18392), qualified individuals newly released from incarceration are eligible for the special enrollment period afforded to individuals under the current version of paragraph (d)(7). However, paragraph (d)(7)

as amended in this interim final rule no longer enables these individuals to qualify for the special enrollment period because the health care coverage offered to incarcerated individuals in correctional facilities is generally not considered minimum essential coverage. Incarcerated individuals are also not eligible for Exchange coverage.

Therefore, we are amending paragraph §155.420(d)(3) to include individuals who become newly eligible for a QHP due to a release from incarceration (other than incarceration pending disposition of charges), in addition to those who become newly eligible for a QHP by becoming a United States citizen or national or a lawfully present non-citizen already included in this paragraph. In so doing, we are removing the current language in paragraph (d)(3) that states that a qualified individual or his or her dependent "which was not previously a citizen, national, or lawfully present individual gains such status" and are replacing it with a cross reference to §155.305(a)(1). This does not change the scope of the current special enrollment period and the population who may currently qualify. We are adding a cross reference to §155.305(a)(2) for individuals who are no longer incarcerated, other than incarcerated pending disposition of charges.

In order that, at their option, Exchanges may continue to offer advanced availability of the special enrollment period for those who become newly eligible for a QHP due to a release from incarceration now included in paragraph (d)(3), we are amending paragraph §155.420(c)(2) to include this population. Should Exchanges exercise or already have exercised this option to offer advance availability to those who become newly eligible for a QHP due to a release from incarceration, the Exchange must ensure that the coverage effective date is on the first day of the month following the

release from incarceration, as was required when this population was included in the special enrollment period in paragraph (d)(7) of this section. Accordingly, we are amending §155.420(b)(2)(iv) to include those who become newly eligible for a QHP due to a release from incarceration now included in paragraph (d)(3).

The amendment to §155.420(d)(7) also makes the special enrollment period for a permanent move inaccessible to qualified individuals who were previously living in a non-Medicaid expansion State and, during the same timeframe, were ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the Federal poverty level (FPL), but who become newly eligible for advance payments of the premium tax credit as a result of a permanent move to another State. By being previously ineligible for both Exchange coverage with advance payments of the premium tax credit (because of their household income) and Medicaid (solely because of the State's decision not to expand), these individuals likely would have been exempted from the requirement under section 5000A(e)(1) of the Code and its implementing regulations to maintain minimum essential coverage or eligible for an exemption from the minimum essential coverage requirement under 45 CFR §155.605(d) or (e), and therefore are unlikely to qualify for the special enrollment period for a permanent move, as amended. In order to continue to provide for a special enrollment period for these individuals, we are amending §155.420(d)(6)(iv) to include individuals who were previously living in a non-Medicaid expansion State and, during the same timeframe, were ineligible for Medicaid, but who become newly eligible for advance payments of the premium tax credit as a result of a permanent move. This change

secures the continued availability of a special enrollment period to qualified individuals who move out of a non-Medicaid expansion State to a State where they may newly qualify for advance payments premium tax credit, but who might no longer qualify for the special enrollment period under §155.420(d)(7), as amended in this interim final rule, because they did not previously have minimum essential coverage for one or more days in the 60 days preceding the date of the permanent move.

In addition, as discussed in the 2017 Payment Notice, we intend to conduct an assessment of QHP enrollments that were made through special enrollment periods in the FFE to ensure that consumers' eligibility for these special enrollment periods were properly determined. Until the FFE has collected and analyzed data on consumer eligibility for special enrollment periods and taken other actions to ensure that consumers are not inappropriately accessing and enrolling in coverage through existing special enrollment periods, we believe it is unnecessary and contrary to the public interest to require Exchanges to offer advanced availability of the special enrollment period in §155.420(d)(7) or to implement the new special enrollment period in paragraph (d)(2)(ii) of this section because it could introduce additional uncertainty to the risk pool at this time.

We also considered that information technology system resources are needed to implement these provisions by January 1, 2017, and are concerned that the requirement to meet the January 1, 2017, deadline could cause needless expenditures of Exchange funds for operational changes to the extent that we propose and finalize rule amendments that delete the requirement to provide by a specific date advance availability for the special

enrollment periods under (d)(7) or offer the special enrollment periods under (d)(2)(ii) based on our current program integrity efforts. In light of the competing financial and operational priorities of Exchanges, we believe it is contrary to the public interest to require that Exchanges meet the January 1, 2017, deadline. We have therefore determined that there is a need to take immediate action to delete this future deadline, rather than engaging in notice and comment rulemaking on this change, in order to avoid the unnecessary expenditure of funds by Exchanges to comply with the January 1, 2017, implementation deadline. Therefore, we are amending the following special enrollment period provisions to leave the implementation timeline for advanced availability at the discretion of the Exchange.

Section 155.420(c)(2) provides for advanced availability of the special enrollment period for a qualified individual or enrollee, or his or her dependent who gains access to new QHPs as a result of a permanent move as described in paragraph (d)(7) of this section, meaning that a qualified individual or enrollee, or his or her dependent, has 60 days before or after the triggering event (the permanent move) to select a QHP. Paragraph (c)(2) also provides that this advanced availability be available by January 1, 2017 or earlier, at the option of the Exchange. We are amending this paragraph to remove the requirement for Exchanges to offer advanced availability of the permanent move special enrollment period by January 1, 2017, which keeps this provision at the option of the Exchange.

We also amend paragraph (d)(2)(ii), which provides for a special enrollment period for an enrollee who loses a dependent or is no longer considered a dependent due

to divorce, legal separation, or death, to remove the requirement that Exchanges offer this special enrollment period by January 1, 2017. We note that, if a loss of a dependent or no longer being considered a dependent due to divorce, legal separation, or death results in a loss of minimum essential coverage, such individuals may qualify for the special enrollment period for loss of minimum essential coverage. Implementation of this provision remains at the option of the Exchange.

We note that certain special enrollment periods in 45 CFR 155.420 are incorporated in the guaranteed availability regulations at §147.104(b) and applied to issuers offering non-grandfathered individual coverage through or outside of the Exchange, and incorporated in the SHOP regulations at §155.725(j) and §156.285(b) and applied to QHP coverage offered through the SHOP. The changes to special enrollment periods in this interim final rule with comment therefore apply to the guaranteed availability and SHOP regulations, to the extent applicable.

B. CO-OP Program

Subpart F of part 156 of title 45 of the Code of Federal Regulations sets forth the standards applicable to the CO-OP Program. In this interim final rule with comment, we are making a number of changes to the rules governing CO-OPs to provide additional flexibility for CO-OP issuers to enter into strategic financial transactions with other entities, to improve the issuer's capital position and to further the ability of the program to facilitate the offering of competitive, high-quality health insurance on Exchanges that increases competition and consumer choice. Given the financial challenges faced by some CO-OPs recently, and the lack of opportunity for further Federal funding, we

believe that these changes are needed as soon as possible. Furthermore, the CO-OPs have requested maximum flexibility in governance requirements to assist their efforts to enter into new, beneficial business relationships.

1. Definitions (§156.505)

In this interim final rule with comment, we are amending the definitions of "pre-existing issuer" and "representative" to permit CO-OPs increased flexibility to explore and advance business opportunities, and increase the pool of eligible candidates for their boards of directors. Both terms are used in provisions governing the standards for membership of a CO-OP board of directors. The amended definitions expand the universe of individuals eligible for membership on a CO-OP board of directors, while ensuring that appropriate standards remain in place to protect against conflicts of interest and insurance industry involvement and interference.

The definition of the term "pre-existing issuer" is amended to limit the definition to State-licensed health insurance issuers that competed in the individual and small group commercial health insurance markets on July 16, 2009, as required by section 1322(c)(2)(A) of the Affordable Care Act).

The definition of the term "representative" is revised to mean an officer, director, or trustee of an organization, or group of organizations; or a senior executive or high level representative of the Federal government, or a State or local government or a sub-unit thereof.

Section 156.515(b)(2) (which we are amending in this interim final rule with comment) provides limitations on board membership that prohibit any agent or employee

of a State government or a unit of State government from serving on a CO-OP's board of directors. This standard was established to codify the requirement in section 1322(e) of the Affordable Care Act, which states that no representative of any Federal, State or local government (or of any political subdivision or instrumentality thereof) and no representative of a person described in section 1322(c)(2)(A) (referring to entities that were health insurance issuers on July 16, 2009) may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under section 1322(d), and to ensure that board members are free of conflicts of interest that could arise from their dual roles as a government representative and a CO-OP board member. For example, a State elected official may act to serve political objectives influenced by established, State-regulated competitors of the CO-OP in the insurance market, rather than acting in the best interest of the CO-OP program. Insurance company employees may pose a similar risk of conflict of interest as government employees – a representative of a competitor may be tempted not to make governance decisions based solely on the best interests of the CO-OP and its members.

The term "representative" is not statutorily defined for purposes of section 1322 of the Affordable Care Act. Based on experience in the early years of the CO-OP program, we believe the current regulatory definition is too broad, and captures individuals for whom these concerns regarding conflicts of interests are not warranted. Specifically, we do not believe it is necessary to include within the definition of representative government employees who are neither senior executives nor high- level representatives (that is, employees, agents, trustees, or other persons who possess the

ability to decide organization-wide or governmental policies or goals), and individuals who are not officers, directors or trustees of an organization or groups of organizations. Although these individuals may be associated with a governmental entity or pre-existing issuer due to their employment relationship, they are unlikely to hold a position in which they would be expected or required to represent their employer's interests in their outside activities. We, therefore, believe it is a reasonable interpretation of the prohibition in section 1322(e) to exclude from the definition of representative individuals who are neither senior executives nor high-level representatives of a government unit, or an officer, director or trustee of an organization or group of organization. Furthermore, we are aware of at least one instance in which this prohibition prevented an individual from joining a CO-OP board of directors, despite the individual having significant expertise that would have been beneficial to the CO-OP and with no discernible conflict of interest arising from the individual's position as a State employee.

Current regulations also prohibit board membership by any agent or employee of an entity that held an insurance license and was subject to State insurance law on July 16, 2009 (a "pre-existing issuer" under the regulations). Under the original definition of "pre-existing issuer," this would prohibit participation from agents and employees of issuers that 1) do not compete in the markets for which CO-OPs were developed to bring competition (individual or small group health insurance markets), and 2) do not market any standard commercial health insurance available to the general public. However, employees of insurance companies that do not compete in the general commercial health insurance market also do not pose a clear or significant risk for conflicts of interest, and

may have expertise that could be valuable to a CO-OP board. Therefore, exclusion of these groups of employees exceeds the purpose of the rule while unnecessarily restricting the available pool of qualified candidates for the CO-OP boards of directors. By amending the definition of "pre-existing issuer" to exclude issuers that do not compete in the individual or group health insurance markets, we narrow the exclusion so that employees of these companies may serve on CO-OP boards. We believe that the concept of a "pre-existing issuer" in the statute was intended to protect CO-OPs from conflicts of interest by barring persons associated with organizations that offer individual and group health insurance policies to the general public from participating on CO-OP boards of directors. This definition of "pre-existing issuer" is consistent with that intent. These revisions would permit representatives of licensees that market only Medicare, Medicaid, or other health insurance products that are not individual and small group insurance (for example, dental, vision, disability products) to sit on a CO-OP board.

2. CO-OP Standards (§156.515)

Under 45 CFR 156.515(b)(1), a CO-OP must be governed by a board of directors, with all of its directors elected by a majority vote of a quorum of the CO-OP's members that are age 18 or older, and the voting directors on the board must be members of the CO-OP. These requirements are based on the statutory requirement that the governance of a CO-OP be "subject to a majority vote of its members."

We are amending these standards to require that only a majority of directors be elected by the members and to remove the requirement that a majority of voting directors be members of the CO-OP. This revision allows entities offering loans, investments, and

services to participate on the board of directors, as is common practice in the private sector, while maintaining the overall control of the board by the members of the CO-OP. We are making this change in response to program experience demonstrating that the inability to grant designated board positions to prospective partners or investors may create obstacles to potentially favorable business arrangements for CO-OPs. This amendment also provides opportunities for CO-OPs to enlist qualified individuals from outside their membership to participate in board governance. CO-OPs have experienced significant obstacles in identifying qualified and willing CO-OP members to serve on their boards of directors, in particular with regard to State requirements concerning industry experience and expertise that directors of insurance companies must possess. However, we believe that these changes will not alter the fundamental member-driven and member-governed nature of CO-OPs, since all of the CO-OP's directors will have a duty to further the CO-OP's goals, and since the membership of the CO-OP will retain control of a majority of the seats on the board of directors, thus ensuring that ultimate control will lie with directors responsible to the membership.

Section 156.515(b)(2) establishes the standards the board must meet. Section 156.515(b)(2)(i) is revised to comport with proposed changes in the types of representatives permitted to sit on the board of directors while still retaining ethical, conflict of interest, and disclosure standards. We note that any fiduciary duties that exist under State law would continue to apply. Section 156.515(b)(2)(ii) is revised to provide that each director has one vote. Section 156.515(b)(2)(iv), which provided that positions on the board designated for individuals with specialized expertise, experience, or

affiliation cannot constitute a majority of the board, is removed and reserved. Our intent in doing so is to increase flexibility for CO-OPs to include on their board of directors members with suitable expertise, to improve governance and potentially facilitate strategic transactions. Section 156.515(b)(2)(v) is revised to permit representatives of State or local governments or organizations described in §156.510(b)(1)(i) to participate on CO-OP boards of directors, provided the CO-OP does not issue policies in the State in which the government representative serves or the organization operates. This amendment is also intended to provide CO-OPs with increased flexibility regarding board membership, as well as to increase business opportunities for CO-OPs.

We also note that the requirements of §156.515(c)(1) have at times posed an obstacle to potential strategic partners of CO-OPs. That paragraph states that at least two-thirds of the policies issued by a CO-OP must be QHPs issued in the individual and small group markets in States in which a CO-OP is licensed. This regulatory requirement is based on a statutory requirement that "substantially all" of the "activities" of CO-OPs consist of issuing QHPs in the individual and small group markets. We understand that considerable uncertainty accompanies the implementation of business plans, particularly for new entrants to complex, dynamic markets, and in relation to a standard that measures voluntary actions taken by third parties. Section 1322 of the Affordable Care Act requires CO-OP loan repayment if this substantially all standard is not met and the CO-OP fails to correct such failure within a reasonable period of time. HHS clarifies that, if a CO-OP fails to meet the standard in a given year, it would not necessarily require immediate loan repayment as long as the CO-OP is in compliance with 45 CFR

156.515(c)(2); has a specific plan and timetable to meet the two-thirds requirement, and acts with demonstrable diligence and good faith to meet the standard. A CO-OP must ultimately come back into compliance with the two-thirds standard in future years.

This clarification reflects HHS's experience in the early years of the CO-OP program, when some CO-OPs were deterred from implementing plans to enter into potentially beneficial new lines of business, such as Medicare or Medicaid products or ancillary lines such as dental or vision, out of concern that they could inadvertently, temporarily, end up with less than two-thirds of policies issued being QHPs in the individual and small group markets.

3. Loan Terms (§156.520)

Under §156.520(f), a CO-OP may not convert or sell to a for-profit or non-consumer operated entity, or undertake a transaction that would result in the CO-OP implementing a governance structure that does not meet our regulatory standards. We note that the question has arisen as to whether this provision prohibits the sale or conversion of policies to a non-CO-OP issuer in connection with the wind-down of a CO-OP. If a CO-OP is out of compliance with this provision, the CO-OP will cease to be a qualified non-profit health insurance issuer, and certain rights under the CO-OP Loan Agreement will become available to CMS, including the right to accelerate repayment of the loans or terminate the Loan Agreement itself. However, in the appropriate circumstances, to preserve coverage for enrollees upon the insolvency of the issuer, notwithstanding those remedies, we recognize that a CO-OP could elect to enter into such a transaction.

We seek comment on these provisions.

C. Risk Adjustment

Based on our experience operating the 2014 benefit year risk adjustment program, HHS has become aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate. HHS has had a number of discussions with issuers and State regulators on ways to help ease issuers' transition to the new health insurance markets and the effects of unanticipated risk adjustment charge amounts. We believe that a robust risk adjustment program that addresses new market dynamics due to rating reforms and guaranteed issue

is critical to the proper functioning of these new markets. However, we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets. Additionally, we will also continue to seek ways to improve the risk adjustment methodology. We updated the risk adjustment models in the 2017 Payment Notice, and we are exploring future improvements to the HHS risk adjustment methodology.

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

Under the Administrative Procedure Act (APA) (5 U.S.C. 551, et seq.), a notice of proposed rulemaking and an opportunity for public comment are generally required before promulgation of a regulation. We also ordinarily provide a 30-day delay in the effective date of the provisions of a rule in accordance with the APA (5 U.S.C. 553(d)), which requires a 30-day delayed effective date, unless the rule is a major rule and subject to the 60-day delayed effective date required by the Congressional Review Act (5 U.S.C. 801(a)(3)) for major rules.

However, the procedure can be waived if the agency, for good cause, finds that notice and public comment and delay in effective date are impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. 5 U.S.C. 553(d)(3); 5 U.S.C. 808(2).

HHS has determined that issuing this regulation in proposed form, such that it would not become effective until after public comments are submitted, considered and responded to in a final rule, would be impracticable and contrary to the public interest.

Regarding the amendments to special enrollment periods, HHS has determined that taking immediate action to amend the parameters of the special enrollment period for qualified individuals, enrollees, or their dependents who gain access to new QHPs as a result of a permanent move, so that it is aligned with the provision's intent, is imperative to guarding against adverse selection and gaming of the permanent move special enrollment period. Immediate action is also necessary to assuring issuer confidence in the appropriate pricing to account for the Exchange risk pool. This issuer confidence is necessary to maintain robust issuer participation in and competition on the Exchanges and to encourage affordability of coverage for enrollees and the continuity of care that is supported by the continued availability of plans on the Exchanges that were available in the previous year. Therefore, HHS has determined that delaying the effective date of the special enrollment period regulatory changes to allow for proposed rulemaking and comment is contrary to the public interest because consumers would be negatively impacted absent robust participation by issuers and by the risk of insurance rate increases that can result from unchecked adverse selection.

In addition, HHS has determined it needs to take immediate action to remove the January 1, 2017 implementation deadline for (1) offering advance availability of the special enrollment period for qualified individuals who gain access to new QHPs as a result of a permanent move and (2) for offering the special enrollment period for losing a dependent or no longer being considered a dependent due to divorce, legal separation, or death. Postponing this change to allow for proposed rulemaking and comment could result in unnecessary expenditures of dollars by Exchanges on information technology

system builds to comply with deadlines that may not be implemented if HHS's current study of special enrollment periods leads to removal of the January 2017 implementation date. If a State is permitted under a no cost extension of its 1311 grant funding to use those funds for establishment activities, including those related to special enrollment periods, it is possible this could also result in the unnecessary expenditure of Federal grant funds. Therefore, delaying action to remove this implementation deadline is contrary to the public interest because it could lead to the unnecessary expenditure of State and possibly Federal funds.

We also believe that it would be impracticable and contrary to the public interest to delay the implementation of the amendments to the CO-OP program regulations. A large fraction of the CO-OPs have ceased operations due to financial conditions and other issues in the past year. The amendments in this rule are intended to enhance the ability of CO-OPs to attract investors or develop new relationships or products that we anticipate will support their short- and long-term financial viability. We believe having the flexibility provided by these amendments may help some CO-OPs engage in new opportunities, and have determined that it would not be in the public interest to delay implementation of this rule. Specifically, we believe it is essential that these regulation changes be effective by the summer of 2016 when, due to the prevailing business cycle, CO-OPs, regulators, and HHS must determine whether a CO-OP will be in a position to enter open enrollment for plan year 2017, and develop and operationalize forms and rates accordingly.

HHS has determined the continued viability of CO-OPs and their participation in open enrollment for plan year 2017 is important to encouraging competition in the individual and small group markets. Because no additional Federal loan funds can be awarded, and all awarded funds have been disbursed for most CO-OPs, a large number of CO-OPs are seeking to stabilize their balance sheets this summer. In order for CO-OPs to benefit from the governance changes described in this interim final rule with comment, those changes must be implemented immediately. Therefore, HHS has determined that delaying the effective date of the regulatory changes to allow for proposed rulemaking, comment or a delayed effective date would be detrimental to the public interest, as markets with healthy competition are essential to consumer choice of affordable coverage options. In addition, by permitting a broader group of people to serve as board members, the rule relieves a restriction on how CO-OPs may operate, which also justifies waiver of the delay in effective date.

We find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. In addition, with respect to the provisions regarding CO-OPs, we find good cause to waive the 30-day delay in the effective date for this interim final rule with comment. Finally, with respect to the provisions regarding CO-OPs, we also find alternate justification for waiving the 30-day delay in effective date. These provisions will be effective on May 11, 2016. The amendments regarding special enrollment periods will be effective on July 11, 2016. The delay in the effective date for these amendments will provide Exchanges with time to operationalize these amendments. We are providing a 60-day public comment period.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

VI. 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.

VII. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2).

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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year).

We do not anticipate that the amendments to the parameters of the special enrollment period for a permanent move in 45 CFR 155.420(d)(7), combined with the amendments to the special enrollment periods in paragraphs (d)(3) and (d)(6)(iv), will reduce the availability of a special enrollment period to those individuals who should qualify under the provision's original intent, and we believe that the effect of the amendments will result in closer alignment with earlier regulatory impact estimates. We seek comment and data on the impact of these amendments on the actual use of special enrollment period by individuals who would previously have qualified for the permanent move special enrollment period.

Although most of the original $6 billion appropriated for the CO-OP program has been rescinded (as mentioned above), the program has issued significant sums to its borrowers. The total loan awards for currently operating CO-OPs is as follows:

CO-OP Name	**State**	**Current Obligations**
HealthyCT, Inc.	CT	$127,980,768
Land of Lincoln Mutual Health Insurance Company	IL	$160,154,812
Minuteman Health, Inc.	MA, NH	$156,442,995
Evergreen Health Cooperative, Inc.	MD	$65,450,900
Maine Community Health Options	ME	$132,316,124

Montana Health Cooperative	MT, ID	$85,019,688
Freelancers Consumer Operated and Oriented Program of New Jersey, Inc.	NJ	$109,074,550
New Mexico Health Connections	NM	$77,317,782
Coordinated Health Mutual, Inc.	OH	$129,225,604
Community Care of Oregon, Inc.	OR	$56,656,900
Common Ground Healthcare Cooperative	WI	$107,739,354
Total	11	$1,207,379,477

With respect to the changes to the CO-OP program that we are implementing, we do not have any data available to estimate the likely number or magnitude of capital-raising transactions that may result from our changes. Directionally, we expect the changes to facilitate the raising of additional capital for some number of CO-OPs, and that the additional capital cushion will strengthen the financial base and allow those CO-OPs to better weather financial stress including both the types of market-wide and CO-OP specific issues that led to wind-downs in 2015. We seek comments and any supporting data that may shed light on that potential impact.

We have concluded that this rule does not reach the economic threshold of $100 million or more in any one year, and therefore is not considered a major rule with economically significant effects.

The Regulatory Flexibility Act, (5 U.S.C. 601, et seq.), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of this interim final

rule with comment 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. For purposes of the Regulatory Flexibility Act, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the Regulatory Flexibility Act because we have determined, and the Secretary certifies, that this interim final rule with comment would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the Regulatory Flexibility Act. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this interim final rule with comment would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits and take certain other actions before issuing any rule that includes any Federal mandate that may result in expenditures in any 1 year by State, local, or Tribal government, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is

approximately $146 million. This interim final rule with comment does not establish Federal mandates that would result in expenditures in any 1 year of more than $146 million by State, local, or Tribal government, in the aggregate, or by the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates an interim final rule with comment that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This interim final rule with comment does not impose substantial direct costs on State and local governments or preempt State law. However, we believe the rule has Federalism implications. In the amendments regarding the CO-OP program, we have amended a prohibition on participation on CO-OP board of directors that previously prevented any State employee from participating to allow certain State employees who are unlikely to have a potential conflict of interest to participate. In removing the January 1, 2017 implementation deadline for (1) offering advance availability of the special enrollment period for qualified individuals who gain access to new QHPs as a result of a permanent move and (2) for offering the special enrollment period for losing a dependent or no longer being considered a dependent due to divorce, legal separation, or death, we leave implementation at the option of Exchanges, including State Exchanges.

This interim final rule with comment 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.

List of Subjects

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant administration, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs-health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

45 CFR Part 156

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

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 155 and 156 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, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083).

2. Section 155.420 is amended by revising paragraphs (b)(2)(iv), (c)(2), (d)(2)(ii), (d)(3), (d)(6)(iv), and (d)(7) to read as follows:

§155.420 Special enrollment periods.

***** ***** ***** ***** *****

(b) * * *

(2) * * *

(iv) If a consumer loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this section, gains access to a new QHP as described in paragraph (d)(7) of this section, becomes newly eligible for enrollment in a QHP through the Exchange in accordance with §155.305(a)(2) as described in paragraph (d)(3) of this section, or becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move as described in paragraph (d)(6)(iv) of this section, if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage

effective date is on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the following month, at the option of the Exchange.

* * * * *

(c) * * *

(2) Advanced availability. A qualified individual or his or her dependent who is described in paragraph (d)(1) or (d)(6)(iii) of this section has 60 days before or after the triggering event to select a QHP. At the option of the Exchange, a qualified individual or his or her dependent who is described in paragraph (d)(7) of this section; who is described in paragraph (d)(6)(iv) of this section and becomes newly eligible for advance payments of the premium tax credit as a result of a permanent move to a new State; or who is described in paragraph (d)(3) of this section and becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly satisfies the requirements under §155.305(a)(2), has 60 days before or after the triggering event to select a QHP.

* * * * *

(d) * * *

(2) * * *

(ii) At the option of the Exchange, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the

State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

(3) The qualified individual, or his or her dependent, becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly satisfies the requirements under §155.305(a)(1) or (2);

* * * * *

(6) * * *

(iv) A qualified individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the qualified individual becoming newly eligible for advance payments of the premium tax credit;

(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either—

(i) Had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move, or

(ii) Was living outside of the United States or in a United States territory at the time of the permanent move;

* * * * *

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

3. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

4. Section 156.505 is amended by revising the definitions of "pre-existing issuer" and "representative" to read as follows:

§ 156.505 Definitions.

*** * * * ***

Pre-existing issuer means a health insurance issuer licensed by a State regulator that marketed individual or group health insurance benefit plans (other than Medicare or Medicaid Managed Care plans) on July 16, 2009.

* * * * *

Representative means an officer, director, or trustee of an organization, or group of organizations; or a senior executive or high-level representative of the Federal government, or a State or local government or a sub-unit thereof.

* * * * *

5. Section 156.515 is amended by:

a. Revising paragraphs (b)(1)(i) through (v), (b)(2)(i), (ii), (iii), and (v);

b. Removing paragraph (b)(1)(vi); and

c. Removing and reserving paragraph (b)(2)(iv).

The revisions read as follows:

§ 156.515 CO–OP standards.

* * * * *

(b) * * *

(1) * * *

(i) The CO–OP must be governed by an operational board with a majority of directors elected by a majority vote of a quorum of the CO–OP's members that are age 18 or older;

(ii) All members age 18 or older must be eligible to vote for each of the directors on the organization's operational board subject to a vote of the members under paragraph (b)(1)(i) of this section;

(iii) Each member age 18 or older must have one vote in each election for each director subject to a vote of the members under paragraph (b)(1)(i) of this section in that election;

(iv) The first elected directors of the organization's operational board must be elected no later than one year after the effective date on which the organization provides coverage to its first member; the entire operational board must be elected or in place, and in full compliance with paragraph (b)(1)(i) of this section, no later than two years after the same date;

(v) Elections of the directors on the organization's operational board subject to a vote of the members under paragraph (b)(1)(i) of this section must be contested so that the total number of candidates for contested seats on the operational board exceeds the number of contested seats for such directors, except in cases where a seat is vacated mid-term due to death, resignation, or removal.

(2) * * *

(i) Each director must meet ethical, conflict-of-interest, and disclosure standards;

(ii) Each director has one vote;

(iii) Positions on the board of directors may be designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, and unions); and

(iv) [Reserved]

(v) Limitation on government and issuer participation. No representative of any Federal, State or local government (or of any political subdivision or instrumentality thereof) and no representative of any organization described in §156.510(b)(1)(i) (in the case of a representative of a State or local government or organization described in §156.510(b)(1)(i), with respect to a State in which the CO-OP issues policies), may serve on the CO–OP's formation board or as a director on the organization's operational board.

* * * * *

Dated: May 5, 2016

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Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Dated: May 5, 2016

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Sylvia M. Burwell,

Secretary,

Department of Health and Human Services.

BILLING CODE 4120-01-P

[FR Doc. 2016-11017 Filed: 5/6/2016 4:15 pm; Publication Date: 5/11/2016]