

§ 156.10 Basis and scope.

(a) *Basis.* (1) This part is based on the following sections of title I of the Affordable Care Act:

(i) 1301. QHP defined.

(ii) 1302. Essential health benefits requirements.

(iii) 1303. Special rules.

(iv) 1304. Related definitions.

(v) 1311. Affordable choices of health benefit plans.

(vi) 1312. Consumer choice.

(vii) 1313. Financial integrity.

(viii) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(ix) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(xi) 1334. Multi-State plans.

(xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) *Scope.* This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.