

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 155 and 156

[CMS-9964-P2]

RIN 0938-AR76

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) related to the Small Business Health Options Program (SHOP). Specifically, this proposed rule would amend existing regulations regarding triggering events and special enrollment periods for qualified employees and their dependents and would implement a transitional policy regarding employees' choice of qualified health plans (QHPs) in the SHOP.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 1, 2013.

ADDRESSES: In commenting, please refer to file code CMS-9964-P2. 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-9964-P2, 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-9964-P2, 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: Leigha Basini at (301) 492-4307.

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.

I. Executive Summary

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces, called Affordable Insurance Exchanges or "Exchanges." Section 1311(b)(1)(B) of the Affordable Care Act directs each state that chooses to operate an Exchange to also establish a SHOP that assists eligible small businesses in providing health insurance options for their employees. The final rule Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Exchange Establishment Rule)¹ as modified by the Notice of Benefit and Payment Parameters for 2014, published elsewhere in this issue of the **Federal Register**, set forth standards for the administration of SHOP Exchanges. In this proposed rule, we would amend some of the standards established in that final rule.

In the Exchange Establishment Rule, we established standards for special enrollment periods for people enrolled through an Exchange or SHOP and provided that, in most instances, a special enrollment period is 60 days from the date of the triggering event. See 45 CFR 155.420. We also made these provisions applicable to SHOPS, at § 155.725(a)(3). We now propose to amend the special enrollment period for the SHOP to 30 days for most applicable triggering events, so that it aligns with the special enrollment periods for the group market established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To further align the SHOP provisions with HIPAA, we also propose that if an employee or dependent becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP) or loses eligibility for Medicaid or CHIP, this would be a triggering event, and the employee or dependent would have a 60-day special enrollment period to select a QHP. This triggering event had previously been inadvertently omitted from the regulations because it applies only to group health plans and health insurance coverage in the group market. We are also proposing to make a conforming change to § 156.285(b)(2), so that this section references the SHOP special enrollment periods in a way that

¹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310 (Mar. 27, 2012) (to be codified at 45 CFR parts 155, 156, & 157).

is consistent with our proposed changes to § 155.725.

In the Exchange Establishment Rule, we also set forth the minimum functions of a SHOP, including that the SHOP must allow employers the option to offer employees all QHPs at a level of coverage chosen by the employer, and that the SHOP may allow employers to offer one or more QHPs to qualified employees by other methods. We now propose the following transitional policy. For plan years beginning on or after January 1, 2014 and before January 1, 2015, a SHOP would not be required to permit qualified employers to offer their qualified employees a choice of QHPs at a single level of coverage but would have the option of doing so. For plan years beginning on or after January 1, 2014 and before January 1, 2015, Federally-facilitated SHOPS (FF-SHOPS) would not exercise this option, but would instead assist employers in choosing a single QHP to offer their qualified employees. This transitional policy is intended to provide additional time to prepare for an employee choice model and to increase the stability of the small group market while providing small groups with the benefits of SHOP in 2014 (such as a choice among competing QHPs and access for qualifying small employers to the small business health insurance tax credit). We are also proposing changes to the effective date of the SHOP premium aggregation function set forth at § 155.705(b)(4) in the Exchange Establishment Rule consistent with this transitional policy.

II. Background

A. Legislative Overview

Section 1311(b) of the Affordable Care Act establishes that each state that operates an Exchange will also operate a SHOP. The SHOP is designed to assist qualified small employers in providing health insurance options to their employees.

Section 1311(c)(6) of the Affordable Care Act sets forth that the Secretary of Health and Human Services (HHS) shall require Exchanges to provide for special enrollment periods. Section 155.420 of the Exchange Establishment Rule established special enrollment periods for the individual market, and § 155.725(a)(3) established them for the SHOP.

Section 1312(a)(2) of the Affordable Care Act provides that qualified employers may offer qualified employees a choice among all QHPs at a level of coverage chosen by the employer. Section 1312(f)(2)(A) defines a qualified employer as a small

employer that elects to make all full-time employees of such employer eligible for one or more QHPs offered in the small group market through an Exchange that offers QHPs. The Exchange Establishment Rule set forth standards for the SHOP and implemented section 1312 at 45 CFR, part 155, subpart H.

B. Stakeholder Consultation and Input

HHS has consulted with a wide range of interested stakeholders on policy matters related to the SHOP, including through regular conversations with the National Association of Insurance Commissioners (NAIC), health insurance issuers, trade groups, consumer advocates, employers, agents and brokers, and other interested parties. HHS has also held many consultations with states about the SHOP, both individually and through group conversations. HHS received many comments in response to the Exchange Establishment proposed rule,² including comments regarding the statutory provisions on SHOP employee choice and special enrollment periods for employees and their dependents, to which we responded in the Exchange Establishment Rule. HHS also received comments in response to the December 2012 Notice of Benefit and Payment Parameters for 2014 proposed rule,³ to which we responded in the Notice of Benefit and Payment Parameters for 2014 final rule, published elsewhere in this issue of the **Federal Register**. We considered these stakeholder comments in developing this proposed rule.

C. Structure of the Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 155 and 156. The provisions in part 155 outline the standards relative to the establishment, operation, and functions of Exchanges, including the SHOP. The provisions in part 156 outline the health insurance issuer standards under the Affordable Care Act, including standards related to Exchanges and SHOPS.

² Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 FR 41866 (July 15, 2011) (to be codified at 45 CFR parts 155 and 156).

³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule, 77 FR 73118 (Dec. 7, 2012) (to be codified at 45 CFR parts 153, 155, 156, 157, and 158).

III. Provisions of the Proposed Regulations

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

1. Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)

a. Functions of a SHOP (§ 155.705)

Facilitating employee choice at a single level of coverage selected by the employer—bronze, silver, gold, or platinum—is a required SHOP function established in the Exchange Establishment Rule (45 CFR 155.705(b)(2)) and discussed in greater detail in the preamble to the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule. In addition, the rules permit SHOPS to allow a qualified employer to choose one QHP for employees (§ 155.705(b)(3)). Because providing employees with a choice of QHPs at the same level of coverage would create no additional costs for an employer who would otherwise offer only one QHP to its employees, we proposed in the December 2012 HHS Notice of Benefit and Payment Parameters for 2014 proposed rule that qualified employers in FF-SHOPS would choose a level of coverage (bronze, silver, gold, or platinum) and a contribution, and employees would then choose any QHP at that level.

When we proposed this policy, we also sought comments on a transitional policy in which a FF-SHOP would allow or direct employers to offer to their employees a single QHP from those offered through the SHOP (77 FR 73184). A few commenters opposed offering the single QHP option, suggesting that each FF-SHOP should focus on providing employee choice. Most commenters on this issue, however, supported offering a single QHP option for employers, either as an additional option or as the only option in the initial years of the FF-SHOP. The commenters who supported providing a qualified employer only the option of offering a single QHP in the initial years of FF-SHOP operation cited several concerns, including the following: Whether issuers could meet the deadlines for submission of small group market QHPs given the new small group market rating rules; whether issuers could complete enrollment and accounting system changes required to interact with the SHOP enrollment and premium aggregation systems required by employee choice; and whether there would be adequate time to educate employers, employees, and brokers

about the employer and employee choices available in the SHOP. The commenters stated that issuer efforts to prepare and price QHPs for an employee choice environment and to make the systems and operational changes required for SHOP enrollment and premium aggregation could compete with efforts to prepare for participation in the Exchange (both individual and SHOP).

Most of these comments supported allowing employers the option to offer only a single QHP in the FF-SHOP. Consequently, we concluded in the final HHS Notice of Benefit and Payment Parameters for 2014, published concurrently with this proposed rule, that the FF-SHOP would provide employers the choice of offering only a single QHP, as employers customarily do today, in addition to the choice of offering all QHPs at a single level of coverage.

We note that the comments in response to the draft Notice of Benefit and Payment Parameters for 2014 identified challenges to effective implementation of employee choice in the FF-SHOP in 2014; we also note that most of the comments also apply to implementation challenges in State-based SHOPS. In order to respond to these comments and to provide both State-based SHOPS and FF-SHOPS with greater flexibility, we therefore now propose to delay until 2015 implementation of the employee choice model as a requirement for all SHOPS. We also now propose that FF-SHOPS should assist qualified employers in offering qualified employees a single QHP choice for plan years beginning during calendar year 2014, which qualifies certain of these employers for the small business tax credit.

The Exchange Establishment Rule also included a premium aggregation function for the SHOP that was designed to assist employers whose employees were enrolled in multiple QHPs. Because this function will not be necessary in 2014 for SHOPS that delay implementation of the employee choice model, we have also proposed at § 155.705(b)(4) that the premium aggregation function be optional for plan years beginning before January 1, 2015.

Specifically, we are now proposing amendments to § 155.705(b)(2), (b)(3), and (b)(4) providing as follows: (1) The effective date of the employer choice requirements at § 155.705(b)(2) and the premium aggregation requirements at § 155.705(b)(4) for both State-based SHOPS and FF-SHOPS will be January 1, 2015; (2) State-based SHOPS could elect to offer employee choice and

perform premium aggregation for plan years beginning before January 1, 2015, but need not do so; and (3) FF-SHOPS will begin to offer employee choice and premium aggregation in plan years beginning on or after January 1, 2015. We welcome further comment on this proposal.

b. Enrollment Periods Under SHOP (§ 155.725)

The Exchange Establishment Rule established special enrollment periods for Exchanges serving the individual market (§ 155.420), and the SHOP regulations adopted most of these provisions by reference (§ 155.725(a)(3)). Under these regulations, unless specifically stated otherwise in the regulations, a qualified individual has 60 days from the date of the triggering event to select a QHP (§ 155.420(c)).

This SHOP provision differs from the length of special enrollment periods in group markets provided by HIPAA, which last for 30 days after loss of eligibility for other private insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption.⁴ Because we believe that there is no rationale for providing a longer special enrollment period in a SHOP than is provided in the group market outside the SHOP, we propose amendments to § 155.725 to clarify that a qualified employee or dependent of a qualified employee who has obtained coverage through the SHOP would have 30 days from the date of most of the triggering events specified in § 155.420 to select a QHP. Additionally, consistent with revisions to HIPAA enacted by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, § 311 (Feb. 4, 2009), we propose that a qualified employee or dependent of a qualified employee who has become ineligible for Medicaid or CHIP or who has become eligible for state premium assistance under a Medicaid or CHIP program would be eligible for a special enrollment period in a SHOP and would have 60 days from the date of the triggering event to select a QHP. Specifically, we propose striking § 155.725(a)(3) and adding a new paragraph (j) consolidating the proposed SHOP special enrollment provisions in one paragraph. We propose a provision clarifying that a dependent of a qualified employee is only eligible for a special enrollment period if the employer offers coverage to dependents of qualified employees. We also propose

paragraphs (j)(5) and (j)(6) that retain certain provisions relating to effective dates of coverage and loss of minimum essential coverage from the original § 155.420. We propose conforming revisions to § 156.285(b)(2), so that provision would reference the special enrollment periods in proposed § 155.725(j) instead of those set forth at § 155.420. We believe these changes appropriately align the SHOP provisions with provisions applicable to the rest of the group market, and welcome comment on the proposal.

IV. Collection of Information Requirements

This proposed rule, if finalized, would not impose new or alter existing information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. 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.

VI. Regulatory Impact Analysis

We have examined the impact of this final 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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). It is HHS's belief that this proposed rule does not reach this economic threshold and thus is not considered a major rule.

This proposed rule consists of a provision to amend the duration of certain special enrollment periods to correspond to the duration in group markets under HIPAA. The rule also proposes to add a triggering event that would create a special enrollment

⁴ See 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117 for regulations regarding special enrollment periods under HIPAA.

period for qualified employees and/or their eligible dependents when an employee or qualified dependent with coverage through the SHOP becomes eligible for state premium assistance under Medicaid or CHIP or loses eligibility for Medicaid or CHIP. HIPAA, as revised by CHIPRA, already includes this triggering event, which was inadvertently omitted from the original list in § 155.420(d) because it applies only to group health plans and health insurance coverage in the group market. We do not believe either of these actions would impose any new costs on issuers, employers, enrollees, or the SHOP. In fact, the proposed amendment would create alignment of SHOP regulations with laws for the existing group market and could potentially create efficiencies for QHP issuers.

Finally, this proposed rule would require SHOPS to provide qualified employers the option to offer qualified employees a choice of any QHP at a single metal level starting with plan years beginning on or after January 1, 2015, instead of January 1, 2014. For plan years beginning in calendar year 2014, qualified employers would offer qualified employees coverage under a single QHP in FF-SHOPS; State-based SHOPS would have the flexibility to offer either employer or employee choice in 2014. In our analysis of the impact of employer and employee choices in the Notice of Benefit and Payment Parameters for 2014 final rule, published elsewhere in this issue of the *Federal Register*, we noted that adding the option for employers to offer a single QHP would have the potential effect of reducing adverse selection and any associated risk premium and a slight effect of decreasing the consumer benefit resulting from choice. We believe the same analysis applies to our proposal to provide employer choice in 2014.

Issuers will incur costs adapting their enrollment and financial systems to interact with a SHOPS enrollment and premium aggregation systems. The costs and benefits of Exchange and SHOP implementation were assessed in the RIA for the Exchange Establishment final rule, titled Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Regulatory Impact Analysis (Exchange RIA).⁵ Because issuers may now have an

additional year to develop these systems and may thus be able to stage their efforts rather than implementing all system changes by October 1, 2013, we believe that the total cost will be unchanged in total.

From the Exchange perspective, in the Exchange RIA, we noted that a State-based Exchange could incur costs in establishing a premium aggregation function for the SHOP. Therefore, the policy in this proposed rule could decrease costs to states that operate a State-based Exchange for the 2014 plan year.

VII. 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 would not have a significant economic impact on a substantial number of small entities. The RFA 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 percent.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a proposed rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Small businesses are those with sizes below thresholds established by the SBA.

For the purposes of the regulatory flexibility analysis, we expect the following types of entities to be affected by this proposed rule—(1) small employers and (2) QHP issuers.

As discussed in Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule,⁶ few, if any,

issuers are small enough to fall below the size thresholds for small business established by the SBA. In that rule, we used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, HHS used total Accident and Health earned premiums as a proxy for annual receipts. We estimated that there are 28 small entities with less than \$7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage.⁷ However, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies’ other lines of business. We further estimate that any issuers that would be considered small businesses are likely to be subsidiaries of larger issuers that are not small businesses.

The SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would meet the SBA standard for small entities. We do not believe that this proposed regulation would impose requirements on employers offering coverage through the SHOP that are more restrictive than current requirements on employers offering employer-sponsored health insurance. Specifically, small employers are currently required to offer the special enrollment period that we propose would apply to eligible employees and dependents with coverage through the SHOP, and the triggering event that we propose currently applies to eligible individuals and dependents, as well. The proposed provision would merely apply existing standards to the SHOP. Additionally, the transitional policy regarding employee choice does not impose new requirements on small employers because most small employers currently offer only one health insurance plan to their employees.

Based on the foregoing, we are not preparing an analysis for the RFA

and Risk Adjustment Regulatory Impact Analysis, March 2012. Available at: <http://ccio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>.

⁶ Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 FR 74864, 74918–20 (Dec. 1, 2010) (to be codified at 45 CFR part 158).

⁷ According to SBA size standards, entities with average annual receipts of \$7 million or less would be considered small entities for North American Industry Classification System (NAICS) Code 524114 (Direct Health and Medical Insurance Carriers). For more information, see “Table of Size Standards Matched To North American Industry Classification System Codes,” effective March 26, 2012, U.S. Small Business Administration, available at <http://www.sba.gov>.

⁵ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers and Standards Related to Reinsurance, Risk Corridors

because we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

VIII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule (and subsequent final rule) that includes any federal mandate that may result in expenditures in any one year by a state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately \$139 million. UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of costs, mainly those “federal mandate” costs resulting from: (1) Imposing enforceable duties on state, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

This proposed rule does not place any financial mandates on state, local, or tribal governments. It proposes the application of a triggering event and special enrollment period to coverage through the SHOP, modification of the duration of certain special enrollment periods, and implementation of employee choice in the SHOP starting with plan years on or after January 1, 2015. These proposed amendments would only affect state governments to the extent that they operate a SHOP and, if they are affected, would not place any new financial mandates on them.

IX. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on state and local governments, preempts state law, or otherwise has Federalism implications. This proposed regulation does not impose any costs on state or local governments.

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, HHS 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 (NAIC), and consulting with State insurance officials on an individual basis. We believe that this proposed rule does not impose substantial direct costs on state and local governments, preempt state law, or otherwise have federalism implications. We note that we have attempted to provide states that choose to operate a SHOP with flexibility such that states may, if they choose, offer employee choice beginning with plan years starting on or after January 1, 2014, or they may delay this implementation until plan years starting on or after January 1, 2015.

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

List of Subjects

45 CFR Part 155

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, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, 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 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, 1334, 1402, 1411, 1412, 1413.

■ 2. Section 155.705 is amended by revising paragraphs (b)(2), (b)(3), and (b)(4) to read as follows:

§ 155.705 Functions of a SHOP.

* * * * *

(b) * * *

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP for plan years beginning on or after January 1, 2015, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) *SHOP options with respect to employer choice requirements.* (i) For plan years beginning before January 1, 2015, a SHOP may allow a qualified employer to make one or more QHPs available to qualified employees:

(A) By the method described in paragraph (b)(2) of this section, or
(B) By a method other than the method described in paragraph (b)(2) of this section.

(ii) For plan years beginning on or after January 1, 2015, a SHOP:

(A) Must allow an employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, and
(B) May allow an employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(iii) For plan years beginning before January 1, 2015, a Federally-facilitated SHOP will only provide a qualified employer the choice to make available to qualified employees a single QHP.

(iv) For plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section, or
(B) The employer may choose a single QHP.

(4)(i) *Premium aggregation.* Consistent with the effective dates set forth in

paragraph (b)(4)(ii) of this section, the SHOP must perform the following functions related to premium payment administration:

(A) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer;

(B) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees; and

(C) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

(ii) Effective dates.

(A) A State-based SHOP may elect to perform these functions for plan years beginning before January 1, 2015, but need not do so.

(B) A Federally-facilitated SHOP will perform these functions only in plan years beginning on or after January 1, 2015.

* * * * *

■ 3. Section 155.725 is amended by removing paragraph (a)(3), and adding paragraph (j) to read as follows:

§ 155.725 Enrollment periods under SHOP.

* * * * *

(j)(1) *Special enrollment periods.* The SHOP must provide special enrollment periods consistent with this section, during which certain qualified employees or a dependent of a qualified

employee may enroll in QHPs and enrollees may change QHPs.

(2) The SHOP must provide a special enrollment period for a qualified employee or dependent of a qualified employee who:

(i) Experiences an event described in § 155.420 (d)(1), (2), (4), (5), (7), (8), or (9);

(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act; or

(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:

(i) 30 days from the date of a triggering event described in paragraph (j)(2)(i) of this section to select a QHP through the SHOP; and

(ii) 60 days from the date of a triggering event described in paragraph (j)(2)(ii) of this section or (iii) of this section to select a QHP through the SHOP;

(4) A dependent of a qualified employee is not eligible for a special election period if the employer does not extend the offer of coverage to dependents.

(5) The effective dates of coverage are determined using the provisions of § 155.420(b).

(6) Loss of minimum essential coverage is determined using the provisions of § 155.420(e).

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

■ 4. 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, 1341–1343, and 1401–1402, Pub l. 111–148, 124 Stat. 119 (42 U.S.C. 18042).

■ 5. Section 156.285 is amended by revising paragraph (b)(2) to read as follows:

§ 156.285 Additional standards specific to SHOP.

* * * * *

(b) * * *

(2) Provide special enrollment periods as described in § 155.725(j).

* * * * *

Dated: February 25, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: February 27, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–04952 Filed 3–1–13; 11:15 am]

BILLING CODE 4120–01–P