DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155 and 156

[RIN 0938–AS17]

Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule amends the date by which a qualified individual must select a qualified health plan (QHP) through any Exchange for an effective coverage date of January 1, 2014. This rule generally allows consumers to select a QHP until December 23, 2013, which is a change from the previously stated regulatory date of December 15, 2013, but permits State Exchanges to select a different date. It also establishes a related policy regarding the date by which a consumer needs to pay any applicable initial premium to ensure timely effectuation of coverage. This rule pertains to the individual market and Small Business Health Options Program in both the Federally-facilitated Exchanges and State Exchanges. This rule does not change the plan selection or premium payment dates for coverage offered outside of the Exchanges.

DATES: Effective date: These regulations are effective on December 15, 2013.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 23, 2013.

ADDRESSES: In commenting, please refer to file code CMS–9945–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–9945–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–9945–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:


(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: Devon Trolley, (301) 492–4404, for questions related to this rule.

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 be also 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.

Table of Contents

I. Background
II. Provisions of the Interim Final Rule
III. Waiver of Proposed Rulemaking and Waiver of Delay in Effective Date
IV. Collection of Information Requirements
V. Regulatory Impact Analysis

I. Background

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. 111–129), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this interim final rule, we refer to the two statutes collectively as the “Affordable Care Act.”

As of October 2013, for coverage starting as soon as January 1, 2014, qualified individuals and qualified employers have been able to enroll in QHPs—private health insurance that has been certified as meeting certain standards—through competitive marketplaces called “Exchanges” or “Health Insurance Marketplaces.” The word “Exchanges” refers to both State Exchanges, also called State-based...
individual and small group markets. Since the publication of the Exchange Establishment Rule and the Draft Enrollment Guidance, there have been unforeseen barriers to enrollment in the Exchanges. This interim final rule includes policy changes aimed at allowing additional enrollment opportunities for qualified individuals and qualified employers seeking January 1 coverage. Policy clarifications regarding premium payment are also included.

II. Provisions of the Interim Final Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

The Exchange Establishment Rule outlined an initial open enrollment period from October 1, 2013 through March 31, 2014 and coverage effective dates based on when a plan is selected. Through the Market Reform Rule, published in the February 27, 2013 Federal Register (78 FR 13406), the coverage effective dates established in § 155.410(c) of the Exchange Establishment Rule apply to the entire individual and small group health insurance markets (except for grandfathered health plans). Since the provisions of this interim final rule are specifically designed to address unforeseen barriers to enrollment in QHPs offered through the Exchange, we do not believe it is necessary to extend plan selection and coverage purchased outside of the Exchange.

Accordingly, this rule adds regulatory text at § 147.104(b)(1)(i) to make clear that, for coverage offered outside an Exchange or SHOP, for plan selections received on or before December 15, 2013, coverage must take effect on January 1, 2014 and that for plan selections received between December 16th and December 31st, 2013, coverage generally must become effective February 1, 2014. These amendments maintain for individual and small group market coverage outside of an Exchange or SHOP the plan selection and coverage effective dates originally finalized in the Exchange Establishment Rule. However, we also permit issuers to align their plan selection and corresponding coverage effective dates with those in the applicable Exchange.

We note that for ease of reference to the coverage effective dates in the SHOP, we have amended the cross reference in § 147.104(b)(1)(i) to refer to § 155.725(a)(2) rather than § 155.725(h).

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

Section 155.410(c) of the Exchange Establishment Rule specifically provides that an Exchange must ensure a January 1, 2014 effective date of coverage for any QHP selected by a qualified individual on or before December 15, 2013. As noted above, the reference in § 155.725(a)(2) applies the same timeframe to QHPs selected in the SHOP. The following changes are made to paragraph (c) in this interim final rule to amend the dates by which a plan must be selected for the individual market Exchanges and the SHOPs for coverage to be effective January 1, 2014.

In § 155.410(c)(1)(i), this rule amends the regulation text to specify that an Exchange must ensure that any QHP selected for plan selections received on or before December 23, 2013, in contrast to the previous regulatory date of December 15, 2013. This policy applies to the various types of plans sold through the Exchanges, including SHOP QHPs, multi-State plans, and stand-alone dental plans. While we do not expect to do so, we will consider moving this deadline to a later date should exceptional circumstances pose barriers to consumers enrolling on or before December 23, 2013. We note that, if a consumer is not able to enroll in a QHP with a coverage effective date of January 1, 2014 due to an error made by the Exchange, it would warrant a special enrollment period as previously stated in § 155.420(d)(4).

In § 155.410(c)(1)(i), a conforming amendment is made to the regulatory text so that standard coverage effective dates apply only to plan selections starting after January 16, instead of the previously stated December 16. This means that the schedule of coverage effective dates based on plan selection will generally resume as previously established in § 155.410 in the Exchange Establishment Rule starting for plan selections made on December 24, 2013 or later. For example, if a plan selection is made between December 24, 2013 and January 15, 2014, the coverage effective date will be no later than February 1, 2014, unless the issuer elects to make the coverage effective earlier. If a plan selection is made between January 16 and January 31, of 2014, the coverage effective date will be March 1, 2014. We note that, generally, the dates by which an Exchange must ensure coverage based on the date of plan selection are considered the latest date for effectuation; nothing prohibits an issuer from establishing coverage effective
dates earlier than those listed in § 155.410(c). In § 155.410(c)(1)(iv), this interim final rule permits a State Exchange or a State-based SHOP to establish later plan selection dates for coverage that must be effective on January 1, 2014. Given the varying experiences of State Exchanges and SHOPS, we believe that this flexibility would avoid any inconsistencies with those states that may have already extended the plan selection date and that may have different procedural requirements regarding the consumer payment date from those applicable in the FFES and FF–SHOPS. Section 155.410(c)(1)(iv) also provides that a SHOP can require plan selection by as early as December 15, 2013 to ensure coverage effective January 1, 2014, as we understand that some State-based SHOPS have already established their own deadlines for QHP selection or may wish to align plan selection dates with the rest of the small group market. The FF–SHOPS will require issuers to ensure a January 1, 2014 coverage date for plan selections received on or before December 23, 2013, which differs from date by which plan selections must be received in the small group market outside the FF–SHOPS to ensure a January 1, 2014 coverage effective date. In states with an FF–SHOP, we expect issuers to allow a small employer to enroll employees in a SHOP QHP on or before December 23, 2013 for a January 1, 2014 coverage effective date if the employer has indicated that it is seeking SHOP coverage. If the employer indicates that it is seeking SHOP coverage, the employer would need to ensure that issuer has received all employee enrollment forms for those employees not waiving coverage on or before December 23, 2013. Employers may indicate their desire to seek SHOP coverage by selecting a SHOP QHP, or by following any issuer guidance on how to make the indication.

In § 155.410(c)(1)(v), this rule states that the Exchange may allow issuers to provide for a coverage effective date of January 1, 2014 for plan selections received after December 23, 2013 but on or before January 31, 2014, if a QHP issuer is willing to accept such enrollments. We note that if the QHP issuer allows enrollment in January for a January 1 coverage effective date, any services provided to the enrollee in January would need to be covered retroactively as if the enrollee had been enrolled from January 1. QHP issuers in an FFE will have this option, and while we understand that enrolment may create challenges for issuers in processing the premium payments and providing retroactive coverage, we urge issuers to consider a January 1, 2014 coverage effective date for plan selections after December 23, 2013 for this year, given the newness of the enrollment process.

By moving the plan selection date later into December, we believe that clarifying the timing of a consumer’s payment of premium becomes more critical. In the Draft Enrollment Guidance, we set forth a process for the FFES that involved any applicable initial premium being paid on or before the day before the coverage effective date. However, given the shorter timeframe between plan selection and the coverage effective date established in this rule for coverage effective on January 1, 2014, we desire to both provide more flexibility to consumers and issuers regarding the payment date and to more firmly establish the way in which a payment date is established in the FFES.

Accordingly, this interim final rule adds regulatory text at § 156.285(d)(2) to establish that a QHP issuer in an FFE must establish the date by which a qualified individual who has selected a QHP within the initial open enrollment period must make a premium payment in order to effectuate coverage by the applicable coverage effective date, provided that payment dates are no earlier than the last day before the coverage effective date and are consistently applied to all applicants in a non-discriminatory manner. We note that this payment date policy applies only for the initial open enrollment period; we intend to address payment policies applicable beyond the initial open enrollment period in future rulemaking. In addition, this policy applies specifically to the FFES. State Exchanges can establish their own payment policies.

We note that QHP issuers in an FFE may accept premium payments after January 1, 2014 for coverage that would be effectuated with a retroactive effective date of January 1, 2014, to the extent permitted by applicable state law. With a later plan selection date, we believe that this flexibility will allow issuers additional time to process a payment and to effectuate enrollments, which we think may be helpful if consumer activity increases as the plan selection date for coverage effective January 1, 2014 nears. State Exchanges can elect to have the same policy or set a different policy for payment cutoff dates.

We recognize that, in the FFES, the flexibility provided to issuers to establish premium payment dates and to accept payments after a coverage effective date of January 1, 2014 will require additional flexibility regarding the submission of enrollment confirmation transactions from QHP issuers to the FFES. The Draft Enrollment Guidance outlines a procedural timeline that specifies that QHP issuers must send enrollment confirmation transactions to the FFES by the fifth calendar day of the effective month of coverage. Instead, the FFES will accept enrollment confirmation transactions from QHP issuers for coverage beginning on January 1, 2014 throughout the month of January.

We note that this interim final rule also does not require the full premium to be paid to effectuate coverage. For example, the Draft Enrollment Guidance stated that, in the individual market FFES, QHP issuers could implement a premium payment threshold policy. QHP issuers electing to establish such a policy may effectuate enrollment when the enrollee pays an amount less than the total amount owed by the enrollee but greater than the threshold amount established by the issuer. This rule provides flexibility to QHP issuers in the FFES to set payment dates, which can include a single payment date for the full premium or an initial payment date for a threshold amount of the premium with subsequent payment dates for the remaining amounts. Payment dates and other enrollment procedures would need to be consistently applied in a non-discriminatory manner for all FFE enrollees. We note that, while issuers may permit less than the full payment of the applicable premium to effectuating coverage, the grace period described in § 156.270(d) for enrollees receiving advance payments of the premium tax credit still requires that at least one full month’s premium has been paid. Even if an issuer sets a payment date for a January 1, 2014 coverage effective date beyond December 31, 2013, the coverage must take effect January 1, 2014 as long as the plan selection is made by the applicable date, as set forth in § 155.410(c) as amended by this interim final rule, and payment is made by the issuer-established date, regardless of when the enrollment confirmation transaction is sent to the FFE. For QHP issuers in the FFES that accept payments after January 1 for a coverage effective date of January 1, 2014, we note that this rule does not establish specific standards related to the communication with consumers regarding the distribution of welcome materials and insurance cards and the manner in which coverage for any services rendered before the enrollment is fully processed. However, we note that an
effective coverage date of January 1, 2014 means that the individual must receive coverage for any services received on or after that date, even if the payment and enrollment are not processed by that time.

C. Other Policies to Smooth Transitions

In addition to the change in coverage effective dates outlined in this interim final rule, we also strongly encourage issuers to take other approaches to ease the transition to QHPs for consumers who may be switching from other coverage. Two areas of focus for a smooth transition are access to providers and prescription drug coverage.

When shopping for coverage on an Exchange, prospective enrollees may base QHP selection decisions on whether their provider is considered in-network using the issuer’s online provider directory. However, evolving provider networks may result in some issuer provider directories containing outdated information. As a result, an enrollee may later discover that his or her provider is considered out-of-network. We are concerned that this could cause hardship to new QHP enrollees in the early months of coverage and could disrupt what could otherwise be a more seamless transition into a QHP. We strongly encourage QHP issuers to take all steps possible to ease this transition.

In particular, we interpret the requirement at § 156.230(b) that issuers make their provider directories for QHPs available to the Exchange for publication online to mean that issuers must make current provider directories for QHPs available to the Exchange for publication online. Accordingly, issuers should ensure that provider directories listed with the QHPs on Exchanges contain the most current listing of in-network providers so that consumers are relying upon accurate information to make enrollment decisions.

For those directories that cannot be maintained in a current status, we believe that it would be reasonable for issuers to consider services received out-of-network as having been received in-network (subject to in-network coverage and cost-sharing standards) with respect to any provider listed in the version of the provider directory as of the date of that enrollee’s enrollment for the beginning months of coverage. We strongly encourage issuers to adopt this approach.

We also encourage issuers to adopt policies in January to prevent disruptions in direct of episodes of care (for example, considering a provider as in the plan’s network for an acute episode of care at the start of the plan year). Some states like Arkansas have adopted policies like this. We are considering factoring into the QHP renewal process, as part of the determination regarding whether making a health plan available is in the interest of qualified individuals and qualified employers, whether consumers have up-to-date provider directories and how QHPs ensure continuity of care during transitions.

Prescription drug coverage is another area where we strongly urge issuers to take steps to ensure a smooth transition for new QHP enrollees. In the Essential Health Benefits Final Rule \(^4\) at § 156.122(c), we established that issuers providing EHB must have in place procedures that allow enrollees to request and gain access to clinically appropriate drugs not covered by the health plan. We believe that the standard for issuers to have a drug exceptions process, as established in § 156.122(c), will provide strong protections on an ongoing basis to enrollees with health needs that require drugs that are not on an issuer’s formulary, particularly if issuers use the process outlined in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges.\(^5\)

However, we are also cognizant that new enrollees may be unfamiliar with what is covered in their new plan’s formulary and the drug exceptions process. Also, some enrollees whose drugs are covered by a QHP issuer’s formulary may need to obtain prior authorization or go through step therapy in order to have coverage for the drug. Since new QHP enrollees may need more immediate coverage for drugs they have been prescribed and are currently taking, we strongly urge QHP issuers to temporarily cover non-formulary drugs (including drugs that are on a QHP issuer’s formulary but require prior authorization or step therapy) as if they were on formulary (or without imposing prior authorization or step therapy requirements) during the first 30 days of coverage, starting on January 1, 2014.

While not required, we encourage this approach because this policy would accommodate the immediate needs of QHP enrollees, while allowing the issuer and/or the enrollee sufficient time to go through the prior authorization and/or drug exception processes.


III. Waiver of Proposed Rulemaking and Waiver of Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the Federal Register and invite public comments on the proposed rule, typically for 30 days, before publishing a final rule that responds to comments and sets forth final regulations that generally take effect at least thirty days later. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. CMS for good cause, under 5 U.S.C. 553(d)(B), finds that the notice-and-comment requirements of the Administrative Procedure Act (APA) would be impracticable and contrary to the public interest given the unforeseen nature of the barriers to enrollment in QHPs in the Exchanges and the time remaining for individuals to enroll in coverage that would be effective January 1, 2014, as further described below.

Additionally, section 553(d) of the APA (5 U.S.C. 553(d)) ordinarily requires that a final rule be effective not less than 30 days from the date of their publication in the Federal Register. This 30-day delay in effective date can be waived, however, if otherwise provided by an agency for good cause found and published with the rule.

For the reasons set forth below, we also find good cause to waive the 30-day delay in effective date as unnecessary, impracticable and contrary to the public interest.

In this case, given the short timeframe under which this change must be implemented, delaying the promulgation and effectiveness of these rules would inhibit the ability of Exchanges and QHP issuers to effectuate the extended opportunity to enroll in a QHP. Exchanges may need to make system and process adjustments immediately, to ensure that consumers have the additional flexibility to submit applications and select a plan. We consider providing additional time to enroll to be a benefit to consumers. The need to provide additional opportunities for consumers to enroll was not clear until a date by which a 30-day comment period and 30-day delay of the effective date would make it impossible to implement on time. If we were to open the policy for 30 days of public comments and a 30-day delay of effective date, the policy would not be effective until well beyond January 1, 2014, which would be contrary to the public interest.
We note that the Exchange Establishment Rule at § 155.410(c)(2) provided that an Exchange could establish shorter coverage effective date timeframes (such as December 23 for coverage effective January 1) if, among other requirements, the Exchange can demonstrate that all participating QHP issuers agree to such timeframes. This condition would likely be an obstacle if CMS were seeking to establish the December 23, 2013 date under the current regulations. However, CMS has the legal authority to, by rulemaking, amend the regulation as necessary to impose the requirement that issuers accept enrollments as late as December 23 for coverage effective January 1. Further, this interim final rule does not introduce substantially different policies, but instead alters operational procedures, but instead alters operational issues a change in revenues of more than 3 percent.

A. 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 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.” CMS 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 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 are classifying types of small entities to be affected by this interim final rule: (1) 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, 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 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, CMS 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. 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. Therefore, we are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this interim final rule will not have a significant economic impact on a substantial number of small entities.

B. 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 or more in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 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 interim final rule amends the
date by which a QHP must be selected
for an effective date of coverage of
January 1, 2014. There may be minor
additional costs for Exchanges to make
system and process adjustments before
December 16, 2013, to ensure that
consumers have the additional
flexibility to submit applications and
select a plan. CMS has concluded that
this rule does not place any mandates
on state, local, or tribal governments or
the private sector that exceed the
threshold for 2013.

C. 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. There may be
minor additional costs for States to
make system and process adjustments
before December 16, 2013, to ensure that
consumers have the additional
flexibility to submit applications and
select a plan. This rule does not impose
any costs on state or local governments
not otherwise imposed by already-
finalized provisions of the regulations
implementing the Affordable Care Act.

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, CMS has engaged in efforts to
consult with and work cooperatively
with affected states, including
participating in conference calls with
and attending conferences of the NAIC,
and consulting with state insurance
officials on an individual basis. We
believe that this rule does not impose
substantial direct costs on state and
local governments, preempt state law, or
otherwise have federalism implications.
We are amending the date by which a
plan may be selected for coverage
effective January 1, 2014.

Under 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
interim final rule in a meaningful and
timely manner.

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

D. Congressional Review Act

The Congressional Review Act, 5
U.S.C. 801, et seq., as added by the
Small Business Regulatory Enforcement
Fairness Act of 1996, generally provides
that before a rule may take effect, the
agency promulgating the rule must
submit a rule report, which includes a
copy of the rule, to each House of the
Congress and to the Comptroller General
of the United States. We will submit a
report containing this rule and other
required information to the U.S. Senate,
the U.S. House of Representatives, and
the Comptroller General of the United
States prior to publication of the rule in
the Federal Register. This interim final
rule is not a “major rule” as defined by
5 U.S.C. 804(2).

List of Subjects

45 CFR Part 147

Health care, Health insurance,
Reporting and recordkeeping
requirements.

45 CFR Part 155

Administrative practice and
procedure, Health care access, Health
insurance, Reporting and recordkeeping
requirements, State and local
governments, Cost-sharing reductions,
Advance payments of premium tax
credit, Administration and calculation
of advance payments of the premium
tax credit, Plan variations, Actuarial
value.

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 amends 45 CFR parts
147, 155, and 156 as set forth below:

PART 147—HEALTH INSURANCE
REFORM REQUIREMENTS FOR THE
GROUP AND INDIVIDUAL HEALTH
INSURANCE MARKETS

1. The authority citation for part 147
continues to read as follows:

Authority: Secs. 2701 through 2763, 2791,
and 2792 of the Public Health Service Act (42
U.S.C. 300gg through 300gg–63, 300gg–91,
and 300gg–92), as amended.

2. Section 147.104 is amended by
revising the last sentence of paragraphs
(b)(1)(i) and (b)(1)(iii) and adding
paragraph (b)(1)(iii) to read as follows:

§ 147.104 Guaranteed availability of
coverage.

* * * * *

(b) * * *

(1) * * *

(i) * * *

With respect to coverage in
the small group market, and in the large
group market if such coverage is offered
in a Small Business Health Options
Program (SHOP) in a state, coverage
must become effective consistent with
the dates described in § 155.725(a)(2) of
this subchapter, except as provided in
paragraph (b)(1)(iii) of this section.

(ii) Coverage must become
effective consistent with the dates
described in § 155.410(c) and (f) of this
subchapter, except as provided in
paragraph (b)(1)(iii) of this section.

(iii) Exception in certain effective
dates of coverage. Only with respect to
coverage offered outside of an Exchange
or SHOP, for a plan selection received
by an issuer on or before December 15,
2013, the issuer must ensure a coverage
effective date of January 1, 2014, and for
a plan selection received by an issuer
between the 16th and 31st of the month
of December 2013, an issuer generally
must ensure a coverage effective date of
February 1, 2014. The preceding
sentence does not prevent an issuer
from aligning the plan selection and
coverage effective dates with those
required by the Exchange or SHOP, as
applicable, in the applicable state,
consistent with § 155.410(c) of this
subchapter.

* * * * *

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

3. 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
18033, 18041–18042, 18051, 18054, 18071,
and 18081–18083).
4. Section 155.410 is amended by revising paragraph (c)(1) to read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(c) * * * *

(1) Regular effective dates. For a QHP selection received by the Exchange from a qualified individual—

(i) On or before December 23, 2013, the Exchange must ensure a coverage effective date of January 1, 2014.

(ii) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month.

(iii) Between the sixteenth and last day of the month for any month between January 2014 and March 31, 2014 or between the twenty-fourth and the thirty-first of the month of December 2013, the Exchange must ensure a coverage effective date of the first day of the second following month.

(iv) Notwithstanding the requirement of paragraph (c)(1)(i) of this section, an Exchange or SHOP operated by a State may require a January 1, 2014 effective date for plan selection dates later than December 23, 2013; a SHOP may also establish plan selection dates as early as December 15, 2013 for enrollment in SHOP QHPs for a January 1, 2014 coverage effective date.

(v) Notwithstanding the regular effective dates set forth in this section, an Exchange may allow issuers to provide for a coverage effective date of January 1, 2014 for plan selections received after December 23, 2013 and on or before January 31, 2014, if a QHP issuer is willing to accept such enrollments.

* * * * *

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

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


6. Section 156.265 is amended by revising paragraph (d) to read as follows:

§ 156.265 Enrollment process for qualified individuals.

* * * * *

(d) Premium payment. Regarding premium payment, a QHP issuer—

(1) Must, follow the premium payment process established by the Exchange in accordance with § 155.240.

(2) Must, for QHPs offered through a Federally-facilitated Exchange, establish the date by which a qualified individual that has selected a QHP within the enrollment period dates in § 155.410(b) of this subchapter must make a premium payment in order to effectuate coverage by the applicable coverage effective date, provided that—

(i) The payment date is no earlier than the day before the coverage effective date.

(ii) The payment date policy is applied consistently to all applicants in a non-discriminatory manner.

* * * * *

Dated: December 4, 2013.

Marilyn Tavenner,
Administrator, Centers for Medicare & Medicaid Services.

Approved: December 5, 2013.

Kathleen Sebelius,
Secretary, Department of Health and Human Services.

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