

§ 155.625

after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months remains effective.

§ 155.625 Options for conducting eligibility determinations for exemptions.

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

(1) Directly or through contracting arrangements in accordance with § 155.110(a); or

(2) By use of the HHS service under paragraph (b) of this section.

(b) *Use of HHS service.* Notwithstanding the requirements of this subpart, the Exchange may adopt an exemption eligibility determination made by HHS.

(c) *Administration of hardship exemption based on affordability.* States may choose to administer the hardship exemption under § 155.605(d)(2) only and delegate to HHS all other exemption determinations generally administered by HHS.

[79 FR 30349, May 27, 2014, as amended at 81 FR 12346, Mar. 8, 2016]

§ 155.630 Reporting.

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

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

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

§ 155.635 Right to appeal.

(a) For an application submitted before October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 155.610(i).

(b) For an application submitted on or after October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how

45 CFR Subtitle A (10–1–23 Edition)

to file an appeal in any notification issued in accordance with §§ 155.610(i) and 155.625(b)(2)(i).

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

SOURCE: 77 FR 18464, Mar. 27, 2012, unless otherwise noted.

§ 155.700 Standards for the establishment of a SHOP.

(a) *General requirement.* (1) For plan years beginning before January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(2) For plan years beginning on or after January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans.

(b) *Definition.* For the purposes of this subpart:

Group participation rate means the minimum percentage of all eligible individuals or employees of an employer that must be enrolled.

SHOP application filer means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by other law.

[77 FR 18464, Mar. 27, 2012, as amended at 78 FR 54141, Aug. 30, 2013; 80 FR 10868, Feb. 27, 2015; 83 FR 17064, Apr. 17, 2018]

§ 155.705 Functions of a SHOP for plan years beginning prior to January 1, 2018.

(a) *Exchange functions that apply to SHOP.* The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with § 155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) *Unique functions of a SHOP.* The SHOP must also provide the following unique functions:

(1) Enrollment and eligibility functions. The SHOP must adhere to the requirements outlined in subpart H.

(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, unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section.

(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) Unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section, 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 provide a qualified employer the choice to make available to qualified employees a single QHP.

(iv) Unless the Secretary makes an election pursuant to paragraph (b)(3)(vi) of this section, 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.

(v) 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 stand-alone dental plans available to qualified employees and their dependents:

(A) The employer may choose to make available a single stand-alone dental plan.

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in § 156.150(b)(2) of this subchapter.

(vi) For plan years beginning in 2015 only, the SHOP may elect to provide employers only with the option set forth at paragraph (b)(3)(ii)(B) of this section, or in the case of a Federally-facilitated SHOP, only with the option set forth at paragraph (b)(3)(iv)(B) of this section, only if the State Insurance Commissioner submits a written recommendation to the SHOP adequately explaining that it is the State Insurance Commissioner's expert judgment, based on a documented assessment of the full landscape of the small group market in his or her State, that not implementing employee choice would be in the best interests of small employers and their employees and dependents, given the likelihood that implementing employee choice would cause issuers to price products and plans higher in 2015 due to the issuers' beliefs about adverse selection. A State Insurance Commissioner's recommendation must be based on concrete evidence, including but not limited to discussions with those issuers expected to participate in the SHOP in 2015.

§ 155.705

(vii) For plan years beginning in 2015 only, a State Insurance Commissioner should submit the recommendation specified in paragraph (b)(3)(vi) of this section, and the SHOP should make a decision based on that recommendation sufficiently in advance of the end of the QHP certification application window such that issuers can make informed decisions about whether to participate in the SHOP. In a Federally-facilitated-SHOP, State Insurance Commissioners must submit to HHS the recommendation specified in paragraph (b)(3)(vi) of this section on or before June 2, 2014, and HHS will make a decision based on any recommendations submitted by that deadline before the close of the QHP certification application window.

(viii) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make QHPs available to qualified employees and their dependents described in paragraphs (b)(3)(viii)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make QHPs available to qualified employees and their dependents as described in paragraph (b)(3)(viii)(C) of this section.

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section;

(B) The employer may choose a single QHP; or

(C) The employer may offer its qualified employees a choice of all QHPs offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in section 1302(d)(1) of the Affordable Care Act and implemented in §156.140(b) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would

45 CFR Subtitle A (10–1–23 Edition)

have on the small group market and consumers.

(ix) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make stand-alone dental plans available to qualified employees and their dependents described in paragraphs (b)(3)(ix)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make stand-alone dental plans available to qualified employees and their dependents as described in paragraph (b)(3)(ix)(C) of this section.

(A) The employer may choose to make available a single stand-alone dental plan;

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in §156.150(b)(2) of this subchapter; or

(C) The employer may offer its qualified employees a choice of all stand-alone dental plans offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in §156.150(b)(2) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(x) States operating a State-based Exchange utilizing the Federal platform for SHOP enrollment functions will have the same employer choice models available as States with a Federally-facilitated SHOP, except that a State with a State-based Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering the employer choice models specified in paragraphs (b)(3)(viii)(C) and (b)(3)(ix)(C) of this section in that State, provided that the State notifies HHS of that decision in

advance of the annual QHP certification application deadline, by a date to be established by HHS.

(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 except as provided for in paragraph (b)(4)(ii)(A) of this section; 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) The SHOP may establish one or more standard processes for premium calculation, premium payment, and premium collection.

(A) The SHOP may, upon an election by a qualified employer, enter into an agreement with a qualified employer to facilitate the administration of continuation coverage by collecting premiums for continuation coverage enrolled in through the SHOP directly from a person enrolled in continuation coverage through the SHOP consistent with applicable law and the terms of the group health plan, and remitting premium payments for this coverage to QHP issuers. A Federally-facilitated SHOP may elect to limit this service to the collection of premiums related to continuation coverage required under 29 U.S.C. 1161, *et seq.*

(B) Qualified employers in a Federally-facilitated SHOP must make premium payments according to a timeline and process established by HHS:

(1) In a Federally-facilitated SHOP, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins.

(2) In a Federally-facilitated SHOP, when coverage is effectuated retroactively, payment for the first month's coverage and all months of the retroactive coverage must be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage. If payment is received on or before the 20th day of a month, coverage will be effectuated upon the first day of the following month retroactive to the effective date of coverage. If payment is received after the 20th day of a month, coverage will be effectuated upon the first day of the second following month retroactive to the effective date of coverage, provided that the payment includes the premium for the intervening month.

(C) For a Federally-facilitated SHOP, the premium for coverage lasting less than 1 month must equal the product of:

(1) The premium for 1 month of coverage divided by the number of days in the month; and

(2) The number of days for which coverage is being provided in the month described in paragraph (b)(4)(ii)(C)(1) of this section.

(iii) *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.

(5) *QHP Certification.* With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in § 156.285 of this subchapter.

(6) *Rates and rate changes.* The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is no more frequently than quarterly.

(A) In a Federally-facilitated SHOP, rates may be updated quarterly with effective dates of January 1, April 1, July 1, or October 1 of each calendar year, beginning with rates effective no sooner than July 1, 2014. The updated rates must be submitted to HHS at least 60 days in advance of the effective date of the rates.

(B) [Reserved]

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) *QHP availability in merged markets.* If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting level of coverage requirements described in section 1302(d) of the Affordable Care Act.

(8) *QHP availability in unmerged markets.* If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) *SHOP expansion to large group market.* If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) *Participation rules.* Subject to §147.104 of this subchapter, the SHOP may authorize a uniform group participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) For plan years beginning before January 1, 2016, subject to §147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as

Medicare, Medicaid, or TRICARE. For purposes of this calculation, qualified employees who are former employees will not be counted.

(ii) For plan years beginning on or after January 1, 2016, subject to §147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of full-time employees accepting coverage offered by a qualified employer plus the number of full-time employees who, at the time the employer submits the SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of full-time employees offered coverage.

(iii) Notwithstanding paragraphs (b)(10)(i) and (ii) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) *Premium calculator.* In the SHOP, the premium calculator described in §155.205(b)(6) must facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost sharing reductions.

(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage.

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) When the employer offers a single plan to qualified employees, the employer must use a fixed contribution methodology under which the employer contributes a fixed percentage of the plan's premium for each qualified employee and, if applicable, for each dependent of a qualified employee. The employer's contribution is calculated

Dept. of Health and Human Services

§ 155.706

based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(B) When the employer offers a choice of plans to qualified employees, the employer may use a fixed contribution methodology or a reference plan contribution methodology. Under the fixed contribution methodology, the employer contributes a fixed percentage of the premiums for each qualified employee and, if applicable, for each dependent of a qualified employee, across all plans in which any qualified employee, and, if applicable, any dependent of a qualified employee, is enrolled. Under the reference plan contribution methodology, the employer will select a plan from among the plans offered by the employer as described in paragraphs (b)(2) and (3) of this section to serve as a reference plan on which contributions will be based, and then will define a percentage contribution toward premiums under the reference plan; the resulting contribution amounts under the reference plan will be applied toward any plan in which a qualified employee or, if applicable, any dependent of a qualified employee, is enrolled, up to the lesser of the contribution amount or the total amount of any premium for the selected plan before application of a tobacco surcharge, if applicable. The employer's contribution is calculated based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage. To the extent permitted by other applicable law, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP may permit an employer to define a different percentage contribution for full-time employees from the percentage contribution it defines for non-full-time employees, and it may permit an employer to define a different percentage contribution for dependent coverage for full-time employees from the percentage contribution it

defines for dependent coverage for non-full-time employees.

(D) A Federally-facilitated SHOP may permit employers to base contributions on a calculated composite premium for employees, for adult dependents, and for dependents below age 21.

(c) *Coordination with individual market Exchange for eligibility determinations.* A SHOP must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to §155.100(a)(2).

(d) *Duties of Navigators in the SHOP.* In States that have elected to operate only a SHOP pursuant to §155.100(a)(2), at State option and if State law permits the Navigator duties described in §155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

(e) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.706 is applicable for plan years beginning on or after January 1, 2018.

[77 FR 18464, Mar. 27, 2012, as amended at 78 FR 15533, Mar. 11, 2013; 78 FR 33239, June 4, 2013; 78 FR 54141, Aug. 30, 2013; 78 FR 79620, Dec. 31, 2013; 79 FR 13838, Mar. 11, 2014; 79 FR 30349, May 27, 2014; 79 FR 59138, Oct. 1, 2014; 80 FR 10868, Feb. 27, 2015; 81 FR 12346, Mar. 8, 2016; 83 FR 17064, Apr. 17, 2018]

§ 155.706 Functions of a SHOP for plan years beginning on or after January 1, 2018.

(a) *Exchange functions that apply to SHOP.* The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with §155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under §155.240.