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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### 45 CFR Parts 155 and 156

**[CMS–9964–F2]**

**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:** Final rule.

**SUMMARY:** This final rule implements 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 final rule amends existing regulations regarding triggering events and special enrollment periods for qualified employees and their dependents and implements a transitional policy regarding employees' choice of qualified health plans (QHPs) in the SHOP.

**DATES:** These regulations are effective on July 1, 2013.

**FOR FURTHER INFORMATION CONTACT:** Leigha Basini at (301) 492–4307.

**SUPPLEMENTARY INFORMATION:**

### 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'' (also called Health Insurance Marketplaces). Section 1311(b)(1)(B) of the Affordable Care Act contemplates that in each State there will be a SHOP that assists qualified employers 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,[2] sets forth standards for the administration of SHOP Exchanges. In this rule, we finalize provisions proposed in the Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program Notice of Proposed Rule Making,[3] which amends some of the standards established in the Exchange Establishment Rule.

In the Exchange Establishment Rule, we established standards for special enrollment periods for people enrolled through an individual market Exchange, 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). In the proposed rule we proposed and this final rule amends, 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).[4] To further align the SHOP provisions with HIPAA, we also proposed 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 also proposed to make a conforming change to § 156.285(b)(2), so that this section references the SHOP special enrollment periods in a way that 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 proposed and are now finalizing the following transitional policy. For plan years beginning on or after January 1, 2014 and before January 1, 2015, a SHOP will not be required to permit qualified employers to offer their qualified employees a choice of QHPs at a single level of coverage, but will have the option of doing so. Federally-facilitated SHOPs (FF–SHOPs) will not exercise this option, but will instead allow employers to choose a single QHP from the choices available in FF–SHOP 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 care tax credit). We also proposed 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, which we are finalizing in this rule.

### II. Background

#### *A. Legislative Overview*

Section 1311(b) of the Affordable Care Act establishes that there will be a SHOP in each State 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 direct 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

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

[2] Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2014, 78 FR 15410 (March 11, 2013) (to be codified at 45 CFR parts 153, 155, 156, 157, & 158).

[3] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 77 FR 15553 (March 11, 2013) (to be codified at 45 CFR parts 155 & 156).

[4] HIPAA added section 9801(f) to the Internal Revenue Code (the Code), section 701(f) to the Employee Retirement Income Security Act (ERISA), and section 2704(f) to the Public Health Service Act.

National Association of Insurance Commissioners (NAIC), employers, health insurance issuers, trade groups, consumer advocates, 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,[5] 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,[6] to which we responded in the Notice of Benefit and Payment Parameters for 2014 final rule (78 FR 15410). We considered these stakeholder comments in developing this final rule.

*C. Structure of the Final Rule*

The regulations outlined in this final rule will 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.

This final rule finalizes provisions set forth in the March 11, 2013 proposed rule (78 FR 15553).

## III. Provisions of the Proposed Rule and Responses to Public Comments

We received 40 comments to the proposed rule, including comments from consumer advocacy groups, health care providers, employers, health insurers, health care associations, Members of Congress, and individuals. The comments ranged from general support or opposition to the proposed provisions to very specific questions or comments regarding proposed changes. In this section, we summarize the provisions of the proposed rule and discuss and provide responses to the comments. We have carefully considered these comments in finalizing this rule.

[5] 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 & 156).

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

Brief summaries of each proposed provision, a summary of the public comments we received and our responses to the comments are as follows. We received a number of comments that fall outside the scope of these regulations, which we do not address in this final rule.

The following summarizes comments about the rule, in general, or regarding issues not contained in specific provisions:

*Comment:* Two commenters suggested that HHS should revisit § 156.200(g), as finalized in the Notice of Benefit and Payment Parameters for 2014. Section 156.200(g) is a QHP certification requirement linking, or tying, federally-facilitated Exchange and FF–SHOP participation. Generally, the certification requirement applies when an issuer or a member of the same issuer group as the issuer (defined at § 156.20 as a group under common ownership and control, or using a common national service mark) has a share of the small group market in a State with a federally-facilitated Exchange/FF–SHOP that exceeds 20 percent, as determined from the most recent earned premiums data reported to HHS. .Specifically, the certification requirement applies in the following circumstances: We interpret § 156.200(g)(1) to require that issuers that have greater than 20 percent small group market share offer at least one silver-level QHP and one gold-level QHP through the FF–SHOP as a condition of participation in the federally facilitated individual market Exchange.

We also interpret § 156.200(g)(1) to require that issuers that do not have greater than 20 percent market share in a State's small group market, but that are members of an issuer group that has at least one member with greater than 20 percent market share, have to offer the required silver and gold level coverage through the SHOP as a condition of participation in the individual market Exchange.

Under § 156.200(g)(2), issuers that do not offer small group market products in a State, but that are members of an issuer group that has at least one member with greater than 20 percent market share, would not have to offer the required SHOP coverage themselves. Instead, another issuer in that issuer's group would do so, and in light of the fact that we intend the tying provision to fall primarily on issuers with greater than 20 percent market share, we interpret § 156.200(g)(2) to require that the issuer meeting the requirement in these circumstances be an issuer whose small group market share exceeds 20 percent.

The commenters on this certification requirement stated that tying Exchange participation to SHOP participation could lead to higher costs in the SHOPs and may have a disparate effect on larger issuers in the small group market.

*Response:* Section 156.200(g) has been finalized and will apply in the 2014 plan year. HHS intends to evaluate in future years the effect this certification standard is having generally on a State's small group market and specifically on employee choice in SHOPs.

*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)).

When we proposed this policy, we also sought comments on a transitional policy in which a FF–SHOP would allow employers to offer to their employees a single QHP from those offered through the SHOP (77 FR 73184). A few commenters suggested that each FF–SHOP should provide employee choice. Most commenters on this issue, however, supported allowing employers to choose a single QHP option for employees, 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 choosing a single QHP to offer 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. 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).

In light of these concerns, we concluded in the final HHS Notice of Benefit and Payment Parameters for 2014 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.

To respond to these comments we proposed a transition policy until 2015 that allows, but does not require implementation of the employee choice model for all SHOPs. We also proposed that FF–SHOPs should assist qualified employers in offering qualified employees a single QHP choice for plan years beginning during calendar year 2014.

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 also proposed at § 155.705(b)(4) that the premium aggregation function be optional for plan years beginning before January 1, 2015.

Specifically, we proposed 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 received the following comments concerning these proposals.

*Comment:* Many commenters expressed support for the proposed transition policy for both the employer choice requirement of § 155.705(b)(2) and the premium aggregation requirement of § 155.705(b)(4), stating that the transition would provide the additional time needed to build the systems necessary to ensure the success of employee choice and premium aggregation. Other commenters opposed the delay, believing that transitioning to employee choice would undermine the value proposition of the SHOP in any State that exercised this option and reduce enrollment in the SHOP. One commenter suggested that during the transitional policy SHOPs operate under a simplified implementation that does not include a web portal and plan comparison tool.

*Response:* Section 1312 of the Affordable Care Act permits an employer to select a level of coverage and an employee to have the choice of enrolling in any qualified health plan that offers coverage at that level. We have serious concerns that issuers would not be operationally ready to offer QHPs through the SHOP if we implemented employee choice for 2014.

As described in the proposed rule, HHS proposed a transitional period for employee choice and premium aggregation in the SHOP based on comments issuers made about whether issuers could complete the enrollment and accounting system changes required to interact with the SHOP enrollment and premium aggregation systems required by employee choice and whether issuers could meet the deadlines for submission of small group market QHPs.

As finalized at 45 CFR 147.102, the new rating rules for coverage beginning on January 1, 2014 significantly reform rating practices in many States. In comments to the Final Notice of Benefit and Payment Parameters for 2014, issuers expressed concern that implementation of employee choice would complicate SHOP pricing in light of the compressed timeframe for finalizing rates because employee choice may significantly modify the population expected to participate in a plan in a manner that will be difficult for issuers to predict.

In other comments to the Exchange Establishment Rule and Notice of Benefit and Payment Parameters for 2014, issuers also expressed concern with the compressed timeline for completing the modifications to their information technology systems necessitated by employee choice and premium aggregation. For example, many health insurance issuers expect that their accounting and enrollment systems will be the sole system of record. Integrating such a system into a SHOP with employee choice and premium aggregation might require additional modifications to the system, as the system must be synchronized with the SHOP's enrollment and accounting systems and responsibility for determining certain group changes in enrollment and billing might be effectuated by the SHOP instead of the issuer.

Issuers also expressed concern that there would be inadequate time to educate employers, employees, and agents and brokers about how they are expected to interact with the SHOP. For example, issuers noted that they accommodate many of the unique needs of small businesses through changes in enrollment at the time of payment. Under employee choice and premium aggregation, some standardization of these processes is necessary because an employee group may interact with a variety of carriers, each potentially with its own set of rules. Issuers suggested that they needed additional time to educate employers and agents and brokers about these new standardized processes.

We believe that even in SHOPs that elect to transition to employee choice, there is still significant value to the SHOP for small employers when compared to the small group market outside the SHOP and therefore significant value to operating a SHOP under this transitional policy. Employers participating in the SHOP may qualify for a small business health care tax credit of up to 50 percent of the employer paid premium cost of coverage. The SHOP will still provide employers with a streamlined comparison of health plans from multiple health insurance issuers, assistance modeling employee contributions, and real-time premium quotes. These benefits would not be available to employers under simplified implementation suggested by one commenter. Further, plans sold on the SHOP must be certified as QHPs, meaning that they must meet minimum standards in order for issuers to sell them on the SHOP. We believe that because of this strong value proposition, the SHOP may still have robust enrollment despite the adoption of this transitional policy.

*Comment:* Some commenters suggested that HHS further delay full implementation of employee choice and extend the transitional period for up to five years. Two commenters suggested that HHS test employee choice and premium aggregation in a few States to study their effect on the small group market before requiring their implementation in every SHOP.

*Response:* We believe a one-year transitional period best addresses these concerns, as it provides issuers with a year's worth of experience under the new small group rating methodology, gives issuers significantly more time to design and implement the modifications to their systems necessary for employee choice and premium aggregation, and allows additional time for education and outreach about employee choice.

HHS will monitor through any information provided under § 155.720(i)

the effect of implementing employee choice in States that elect to implement it in 2014. This process will provide much of the systematic testing suggested by commenters.

*Comment:* Some commenters suggested that HHS use the additional time afforded to SHOPs to implement employee choice under the proposed rule to further streamline the paperwork and regulatory burden on employers and to streamline other Exchange-related employer reporting requirements.

*Response:* We received comments on the ''Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Options Program'' Paperwork Reduction Act packages through both the 60-day **Federal Register** Notice published on January 29, 2013 (78 FR 6109) and the 30-day **Federal Register** Notice published on July 6, 2012 (77 FR 40061). These comments helped us to reduce the burden of SHOP applications on small employers by streamlining the application form. HHS has used these opportunities to create application questions for determining an employer's size that are easier for an employer to understand. HHS, the Departments of Labor, and the Treasury continue to explore methods to minimize any employer burden.

*Comment:* One commenter requested HHS clarify how the proposed FF–SHOP transitional employee choice policy would affect the ability of employers to offer stand-alone pediatric dental coverage in the FF–SHOP.

*Response:* We do not believe that the transitional employee choice policy would prevent an employer from selecting and offering a single stand-alone dental plan in addition to a QHP.

*Comment:* Some commenters requested that HHS clarify how the transitional employee choice policy would affect the employer contribution methodology for the FF–SHOP that was issued in the Notice of Benefit and Payment Parameters for 2014 and codified at § 155.705(b)(11)(ii), as these commenters suggested the purpose of this contribution model may no longer be pertinent without employee choice, specifically the ability to calculate composite premiums.

*Response:* This rule does not modify the premium contribution methodology codified in § 155.705(b)(11)(ii), which permits either State law or employers to require the FF–SHOP to base contributions on a calculated composite premium for employees. In the case of the FF–SHOP before 2015 operating with the employee choice transitional policy, we now clarify that the benchmark plan selected by the employer will be the single QHP offered by the employer to its employees, simplifying this process for the employer.

*Comment:* One commenter supporting the FF–SHOP transitional employee choice policy questioned how the delay of premium aggregation would affect the collection of user fees from QHP issuers participating in the FF–SHOP.

*Response:* We do not believe this transitional employee choice policy will impact the collection of user fees from QHP issuers participating in the FF–SHOP. We noted in the preamble to the Notice of Benefit and Payment Parameters for 2014 (78 FR 15496) that we anticipate user fees for the FF–SHOP to be collected in the same manner as they will be collected for the FFE. We anticipate collecting user fees by deducting the user fee from the federally-administered Exchange-related program payments. If a QHP issuer does not receive any Exchange-related program payments, the issuer would be billed for the user fee on a monthly basis and receive an invoice as described in the ''Supporting Statement for Paperwork Reduction Act Submissions: Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations'' posted on the CMS Web site in conjunction with the **Federal Register** Notice (77 FR 40061).

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 group health plan or health insurance coverage or after a person becomes a dependent through marriage, birth, adoption, or placement for adoption.[7] 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 proposed 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 section 311 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111–3, enacted on February 4, 2009), we proposed that a qualified employee or dependent of a qualified employee who has lost eligibility for Medicaid or CHIP coverage, 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 proposed striking § 155.725(a)(3) and adding a new paragraph (j) consolidating the proposed SHOP special enrollment provisions in one paragraph. We proposed a provision clarifying that a dependent of a qualified employee is eligible for a special enrollment period only if the employer offers coverage to dependents of qualified employees. We also proposed 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 proposed 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. We received the following comments concerning these proposals.

*Comment:* We received many comments supporting the proposed alignment of the length of special enrollment periods in the SHOP with the small group market at large. Some of these commenters stated that aligning with the existing market standards will reduce confusion, simplify public education, and prevent adverse selection. However, some commenters were concerned that reducing the length of special enrollment periods may not provide sufficient time for an employee to understand and compare the plan or plans offered to the employee. These commenters were particularly concerned that an employee choice model would require additional time for an employee to make an informed decision, as employees would have

[7] See 26 CFR 54.9801–6, 29 CFR 2590.701–6, and 45 CFR 146.117 for regulations regarding special enrollment periods under HIPAA.

many more plans to compare before making a decision.

*Response:* We believe that even with the employee choice model, the existing HIPAA standard for the length of special enrollment periods reduces confusion and balances an employee's need for sufficient time to review his or her plan options while limiting the potential for adverse selection. Today, many employers, agents and brokers, and employees are familiar with the existing HIPAA standard. Maintaining a policy inconsistent with the HIPAA standard would be confusing to many employers, agents and brokers, and employees, as they may rationally expect the market standard to apply inside the SHOP.

Additionally, with the assistance of the SHOP, employees will have online tools that will assist them in easily viewing and comparing information regarding the premium cost and benefits of their plan options. These tools were specifically designed to assist employees in making an informed decision when presented with a large number of plans. Therefore, we believe that the employee choice model does not inherently require that employees have additional time to make a plan selection.

c. Provisions for the Additional Standards Specific to SHOP

In § 156.285, we proposed requiring QHPs in the SHOP to provide the special enrollment periods added to § 155.725. While we received many comments on the proposed special enrollment periods, we received no comments on this conforming amendment. We are finalizing this provision as proposed.

## IV. Provisions of the Final Regulations

This final rule incorporates the provisions of the proposed rule, and we are finalizing these provisions primarily as proposed.

## V. Collection of Information Requirements

This final rule has not imposed new or altered 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.

## 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), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). It is HHS's belief that this final rule does not reach this economic threshold and thus is not considered a major rule.

This final 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 adds a triggering event that creates a special enrollment 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). We do not believe either of these actions would impose any new costs on issuers, employers, enrollees, or the SHOP. In fact, the amendment would create alignment of SHOP regulations with laws for the existing group market and could potentially create efficiencies for QHP issuers.

Finally, this rule provides a transition so that SHOPs 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 CY 2014, qualified employers will offer qualified employees coverage through a single QHP in FF–SHOPs; State-based SHOPs will 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 (78 FR 15410), 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).[8] 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.

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 final 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 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.

[8] 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, March 2012. Available at: *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf.*

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 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,[9] 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, 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.[10] 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. Until 2016, States have the option to reduce this threshold to 50. For this reason, we expect that many employers would meet the SBA standard for small entities. We do not believe that this rule imposes 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 the final rule applies to eligible employees and dependents with coverage through the SHOP, and the triggering event that the final rule applies to eligible individuals and dependents, as well. The rule merely applies 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.

Therefore, we are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this final rule will 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 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 rule does not place any financial mandates on State, local, or tribal governments. It applies a triggering event and special enrollment period to coverage through the SHOP, modifies the duration of certain special enrollment periods, and implements employee choice in the SHOP starting with plan years beginning on or after January 1, 2015. These amendments would affect State governments only 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 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, 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 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 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 implement this policy in plan years starting on or after January 1, 2015.

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 proposed regulation 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.

## X. 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. HHS 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

[9] 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 (December 1, 2010) (codified at 45 CFR part 158).

[10] 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.*

States prior to publication of the rule in the **Federal Register**. This final rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

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

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

■ 1. The authority citation for part 155 continues to read as follows:

**Authority:** Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413.

■ 2. Section 155.705 is amended by revising paragraphs (b)(2) through (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 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:
■ A. Amending paragraph (a)(1) by adding ''and'' at the end of the paragraph.
■ B. Amending paragraph (a)(2) by removing ''; and'' and by adding a period in its place at the end of the paragraph.
■ C. Removing paragraph (a)(3), and
■ D. Adding paragraph (j).

The addition reads 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) Thirty (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) Sixty (60) days from the date of a triggering event described in paragraph (j)(2)(ii) 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: May 13, 2013.

**Marilyn Tavenner,**

*Administrator, Centers for Medicare & Medicaid Services.*

Approved: May 15, 2013

**Kathleen Sebelius,**

*Secretary, Department of Health and Human Services.*

[FR Doc. 2013–13149 Filed 5–31–13; 11:15 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF COMMERCE

### National Oceanic and Atmospheric Administration

### 50 CFR Part 300

**[Docket No. 120814337–3488–02]**

**RIN 0648–BC44**

## International Fisheries; Pacific Tuna Fisheries; Fishing Restrictions in the Eastern Pacific Ocean

**AGENCY:** National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

**ACTION:** Final rule.

**SUMMARY:** NMFS is issuing regulations under the Tuna Conventions Act of 1950 to implement Resolution C–12–09 of the Inter-American Tropical Tuna Commission (IATTC) by establishing limits on commercial retention of Pacific bluefin tuna by U.S. fishing vessels operating in the Eastern Pacific Ocean (EPO) in 2013. This action is necessary for the United States to satisfy its obligations as a member of the IATTC and to limit fishing on the stock.

**DATES:** This rule becomes effective July 5, 2013 through December 31, 2013.

**ADDRESSES:** Copies of the proposed and final rules, the Environmental Assessment, the Finding of No Significant Impact, and the Regulatory Impact Review for this action are available via the Federal e-Rulemaking portal, at *http://www.regulations.gov,* and are also available from the Regional Administrator, Rodney R. McInnis, NMFS Southwest Regional Office, 501 W. Ocean Boulevard, Suite 4200, Long Beach, CA 90802. Written comments regarding the burden-hour estimates or other aspects of the collection-of-information requirements contained in this final rule may be submitted to NMFS Southwest Regional Office and by email to *OIRA_Submission@omb.eop.gov,* or fax to (202) 395–7285.

**FOR FURTHER INFORMATION CONTACT:** Heidi Taylor, NMFS SWR, 562–980–4039.

**SUPPLEMENTARY INFORMATION:** On December 12, 2012, NMFS published a proposed rule in the **Federal Register** (76 FR 560790) to implement Resolution C–12–09 of the IATTC by revising regulations at 50 CFR part 300, subpart C. The proposed rule was open to public comment through January 11, 2012. In addition, a public hearing was held in Long Beach, CA on January 11, 2012.

### Background on the IATTC

The United States is a member of the IATTC, which was established under the 1949 Convention for the Establishment of an Inter-American Tropical Tuna Commission. The full text of the 1949 Convention is available at: *http://www.iattc.org/PDFFiles/IATTC_convention_1949.pdf.* The Antigua Convention, which was negotiated to strengthen and replace the 1949 Convention establishing the IATTC, entered into force in 2010. The United States has not yet ratified the Antigua Convention. The IATTC serves as an international arrangement to ensure for conservation and management of highly migratory species of fish in the Convention Area (defined as the waters of the EPO). Since 1998, conservation resolutions adopted by the IATTC have further defined the Convention Area as the area bounded by the coast of the Americas, the 50° N. and 50° S. parallels, and the 150° W. meridian. The IATTC has maintained a scientific research and fishery monitoring program for many years, and regularly assesses the status of tuna and billfish stocks in the EPO to determine appropriate catch limits and other measures deemed necessary to prevent overexploitation of these stocks and to promote sustainable fisheries. Current IATTC membership includes: Belize, Canada, China, Chinese Taipei (Taiwan), Colombia, Costa Rica, Ecuador, El Salvador, the European Union, France, Guatemala, Japan, Kiribati, the Republic of Korea, Mexico, Nicaragua, Panama, Peru, the United States, Vanuatu, and Venezuela. Bolivia and the Cook Islands are cooperating non-members.

### International Obligations of the United States Under the Convention

As a Contracting Party to the 1949 Convention and a member of the IATTC, the United States is legally bound to implement resolutions of the IATTC. The Tuna Conventions Act (16 U.S.C. 951–962) directs the Secretary of Commerce, after approval by the Secretary of State, to promulgate such regulations as may be necessary to implement resolutions adopted by the IATTC. The authority to promulgate such regulations has been delegated to NMFS.

### IATTC Resolutions in 2012

At its 83rd Meeting, in June 2012, the IATTC adopted Resolution C–12–09, Conservation and Management Measures for Bluefin Tuna in the EPO. All active resolutions and recommendations of the IATTC are available on the following Web site: *http://iattc.org/ResolutionsActiveENG.htm.*

The main objective of Resolution C–12–09 is to conserve Pacific bluefin tuna (*Thunnus orientalis*) by establishing limits on the commercial catches of Pacific bluefin tuna in the EPO. Before Resolution C–12–09, the IATTC had not adopted catch limits for Pacific bluefin tuna in the EPO. The IATTC recognizes the need to reduce fishing mortality of Pacific bluefin tuna throughout its range. Accordingly, Resolution C–12–09 included both a cumulative catch limit of 10,000 metric tons for all commercial fishing vessels of all IATTC member countries and cooperating non-member countries (CPCs) fishing in the EPO for 2012 and 2013 combined, and an annual catch limit of 500 metric tons for each CPC with a historical record of Eastern Pacific bluefin catch to allow these nations some opportunity to catch Pacific bluefin tuna if the cumulative limit is reached. The IATTC emphasizes that the measures in Resolution C–12–09 are intended as an interim means for assuring viability of the Pacific bluefin tuna resource. Future conservation