

marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage.

Finally, we solicited comment about how to prevent potential gaming of guaranteed availability rights and about strategies to minimize the risk of adverse selection.

Comment: Several commenters asked that the term “offer” in section 2702 be interpreted to mean “actively marketed,” so that issuers would not be required to reopen closed blocks of business. Commenters expressed concern about having to develop enrollment materials for closed products. In addition, some commenters were concerned that this requirement would make it difficult for issuers to bring existing products into compliance with the Affordable Care Act in a manner that minimizes consumer confusion, and ultimately prompt some issuers to terminate closed products. Some commenters argued that the requirement is not necessary because starting in 2014, individuals will have choices beyond closed blocks, alleviating many of the concerns about closed blocks in today’s market. Other commenters requested flexibility for states to determine the best policy for addressing closed blocks.

Response: Section 2702 provides that each health insurance issuer that offers health insurance coverage in the group or individual market in a state must accept every employer or individual in the state that applies for such coverage. We have interpreted the term “offer” as used throughout the title XXVII requirements of the PHS Act as added by the Affordable Care Act (which apply to “a health insurance issuer offering health insurance coverage”) to refer to an issuer offering both new as well as existing coverage. Accordingly, this final rule does not interpret the term “offer” in section 2702 to mean “actively marketing.” We note that while this provision requires an issuer to accept any individual or employer that applies for coverage, it does not require closed blocks to be actively marketed. Furthermore, we clarify that only non-grandfathered plans are subject to guaranteed availability.

Comment: Several commenters remarked on the application of the guaranteed availability requirements to coverage sold through bona fide associations.

Response: We refer readers to section II.F.2. of the preamble for discussion of this issue.

Comment: We received a few comments about the proposal that

issuers would be allowed to decline to offer coverage to small employers for failure to satisfy minimum contribution or group participation requirements under state law or the SHOP standards. Several commenters expressed support for the policy and recommended extending it to the large group market. One commenter emphasized that minimum participation and contribution standards must be reasonable and not burdensome to the point that small employers are discouraged from offering coverage.

Response: Upon further consideration of this issue, we have determined that small employers cannot be denied guaranteed availability of coverage for failure to satisfy minimum participation or contribution requirements. As in the case of the bona fide association exception discussed above, while Congress left in place an exception for failure to meet contribution or participation requirements under the guaranteed renewability requirement in section 2703(b), it provided no such exception from the guaranteed availability requirement in section 2702. To the contrary, language in the guaranteed availability provision for group health plans that was in place before the Affordable Care Act was not included in section 2702. Accordingly, the proposed approach would conflict with the guaranteed availability provisions in section 2702 of the PHS Act. Moreover, permitting issuers to deny coverage altogether to a small employer with between 50 and 100 employees based on a failure to meet minimum participation or contribution requirements could subject such employer to a shared responsibility payment under section 4980H of the Code for a failure to offer coverage to its employees.

While section 2702 contains no exception to guaranteed availability based on a failure to meet contribution or minimum participation requirements, section 2702(b)(1) permits an issuer to limit enrollment in coverage to open and special enrollment periods. Under our authority in section 2702(b)(3) to define “open enrollment periods,” we are providing in this final rule that, in the case of a small employer that fails to meet contribution or minimum participation requirements, an issuer may limit its offering of coverage to an annual open enrollment period, which we set forth in this final rule as the period beginning November 15 and extending through December 15 of each year. As such, the group market will have continuous open enrollment, except for small employers that fail to meet contribution or minimum

participation requirements, for which the enrollment period may be limited to the annual enrollment period described above, from November 15 through December 15. This approach addresses concerns about adverse selection in a manner that is consistent with the statutory provisions. We do not extend this provision to the large group market because large employers generally do not present the same adverse selection risk as small employers.

Comment: Several commenters voiced concerns about the potential for individuals with histories of non-payment to game guaranteed availability. Some commenters suggested that we take action to both prevent individuals with histories of non-payment from taking advantage of guaranteed availability and to prevent individuals from dropping in and out of coverage based on medical need. Other commenters, including the NAIC, recommended that states have the flexibility to develop an environment that will discourage adverse selection and suggested that there are a number of tools available to states to limit adverse selection. Some of the tools identified by commenters included: (1) Allowing issuers to require pre-payment of premiums each month; (2) allowing issuers to require payment of all outstanding premiums before enrollees can re-enroll in coverage after termination due to non-payment of premiums; (3) allowing late enrollment penalties or surcharges (similar to those in Medicare Parts B and D); (4) allowing issuers to establish waiting periods or delayed effective dates of coverage; (5) allowing issuers to offset claims payments by the amount of any owed premiums; (6) allowing issuers to prohibit individuals who have canceled coverage or failed to renew from enrolling until the second open enrollment period after their coverage ceased (unless they replace coverage with other creditable coverage); (7) restricting product availability (for example, to a catastrophic, bronze, or silver level plan) outside of enrollment periods to prevent high-risk individuals from enrolling in more generous coverage when medical needs arise; and (8) allowing individuals to move up one metal level each year through the Exchange shopping portal.

Response: We appreciate the various strategies suggested by commenters and agree that states have flexibility to implement policies to address adverse selection. We encourage states to consider approaches to discourage adverse selection while ensuring consumers’ guaranteed availability rights are protected since state policies

premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the state. If a state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (c)(1) of this section will apply in that state.

(3) *Application to small group market.* In the case of the small group market, the total premium charged to the group is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable. Nothing in this section precludes a state from requiring issuers to offer, or an issuer from voluntarily offering, to a group premiums that are based on average enrollee amounts, provided that the total group premium is the same total amount derived in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable.

(d) *Uniform age bands.* The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section:

(1) *Child age bands.* A single age band for individuals age 0 through 20.

(2) *Adult age bands.* One-year age bands for individuals age 21 through 63.

(3) *Older adult age bands.* A single age band for individuals age 64 and older.

(e) *Uniform age rating curves.* Each state may establish a uniform age rating curve in the individual or small group market, or both markets, for rating purposes under paragraph (a)(1)(iii) of this section. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with § 147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(f) *Special rule for large group market.* If a state permits health insurance issuers that offer coverage in the large group market in the state to offer such coverage through an Exchange starting in 2017, the provisions of this section applicable to coverage in the small group market apply to all coverage offered in the large group market in the state.

(g) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(h) *Grandfathered health plans.* This section does not apply to grandfathered health plans in accordance with § 147.140.

■ 6. A new § 147.103 is added to part 147 to read as follows:

§ 147.103 State reporting.

(a) *2014.* If a state has adopted or intends to adopt for the 2014 plan or policy year a standard or requirement described in this paragraph, the state must submit to CMS information about such standard or requirement in a form and manner specified in guidance by the Secretary no later than March 29, 2013. A state standard or requirement is described in this paragraph if it includes any of the following:

(1) A ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older, pursuant to § 147.102(a)(1)(iii).

(2) A ratio narrower than 1.5:1 in connection with establishing rates for individuals who use tobacco legally, pursuant to § 147.102(a)(1)(iv).

(3) Geographic rating areas, pursuant to § 147.102(b).

(4) In states that do not permit rating based on age or tobacco use, uniform family tiers and corresponding multipliers, pursuant to § 147.102(c)(2).

(5) A requirement that that issuers in the small group market offer to a group premiums that are based on average enrollee amounts, pursuant to paragraph § 147.102(c)(3).

(6) A uniform age rating curve, pursuant to § 147.102(e).

(b) *Updates.* If a state adopts a standard or requirement described in paragraph (a) of this section for any plan or policy year beginning after the 2014 plan or policy year (or updates a standard or requirement that applies for the 2014 plan or policy year), the state must submit to CMS information about such standard in a form and manner specified in guidance by the Secretary.

(c) *Applicability date.* The provisions of this section apply on March 29, 2013.

■ 7. A new § 147.104 is added to part 147 to read as follows:

§ 147.104 Guaranteed availability of coverage.

(a) *Guaranteed availability of coverage in the individual and group market.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.

(b) *Enrollment periods.* A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) *Open enrollment periods—(i) Group market.* A health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurance issuer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as defined in § 147.106(b)(3), pursuant to applicable state law and, in the case of a QHP offered in the SHOP, as permitted by § 156.285(c) of this subchapter. 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(h) of this subchapter.

(ii) *Individual market.* A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in § 155.410(b) and (e) of this subchapter. Coverage must become effective consistent with the dates described in § 155.410(c) and (f) of this subchapter.

(2) *Limited open enrollment periods.* A health insurance issuer in the individual market must provide a limited open enrollment period for the events described in § 155.420(d) of this subchapter, excluding paragraphs (d)(3) (concerning citizenship status), (d)(8) (concerning Indians), and (d)(9) (concerning exceptional circumstances). In addition, a health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(3) *Special enrollment periods.* A health insurance issuer in the group and individual market must establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.

(4) *Length of enrollment periods.* With respect to the group market, enrollees must be provided 30 calendar days after