DELAWARE'S MOTOR VEHICLE EMISSION BUDGETS FOR THE 1997 ANNUAL $PM_{2.5}$ NAAQS

Type of control strategy SIP	Year	VOC	NO_X
Attainment Plan (Milestone Year)	2009	257	8,448
Attainment Plan (Out Year)	2012	199	6,273

[FR Doc. 2013–29803 Filed 12–16–13; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147, 155 and 156

[CMS–9945–IFC]

RIN 0938–AS17

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

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

ACTION: Interim final rule with comment period.

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

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

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

ADDRESSES: In commenting, please refer to file code CMS–9945–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9945–IFC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9945–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this interim final rule, we refer to the two statutes collectively as the ''Affordable Care Act.''

As of October 2013, for coverage starting as soon as January 1, 2014, qualified individuals and qualified employers have been able to enroll in QHPs—private health insurance that has been certified as meeting certain standards—through competitive marketplaces called ''Exchanges'' or ''Health Insurance Marketplaces.'' The word ''Exchanges'' refers to both State Exchanges, also called State-based

Exchanges, and Federally-facilitated Exchanges, or ''FFEs.'' In this interim final rule, we use the terms ''State Exchange'' or ''FFE'' when we are referring to a particular type of Exchange. When we refer to ''FFEs,'' we are also referring to State Partnership Exchanges, which are a form of FFE. We use the term ''State-based SHOPs'' to refer to Small Business Health Options Programs (SHOPs) operated by a state and ''FF–SHOPs'' to refer to a SHOP operated by CMS.

On March 27, 2012, we published a final rule entitled Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310),[1] hereinafter referred to as the Exchange Establishment Rule. Section 155.410(c) of the Exchange Establishment Rule established the effective coverage dates with respect to the date by which a qualified individual selects a QHP, and outlined basic enrollment processes for issuers. For a January 1, 2014 effective coverage date, § 155.410(c) provides that a qualified individual must select a QHP on or before December 15, 2013. Through cross references in § 155.725(a)(2) to § 156.260(a)(1) to § 155.410(c), the same coverage effective dates are applied to the SHOP. Through cross references in § 147.104, the coverage effective dates are extended to all non-grandfathered health insurance coverage offered in the individual and small group markets.[2] Section 156.265 establishes enrollment processes that QHP issuers must follow for qualified individuals, and requires QHP issuers to follow the premium payment process established by the Exchange. However, this section did not establish a date by which a premium must be paid to effectuate enrollment.

We issued a draft guidance document titled ''Federally-facilitated Marketplace Enrollment Operational Policy and Guidance'' [3] (''Draft Enrollment Guidance'') on October 3, 2013, that specifies procedural guidance for the FFE regarding the enrollment process, including the premium payment process, some of which is impacted by this interim final rule and is referenced as appropriate throughout the preamble.

[1] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310 (March 27, 2012).

[2] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 FR 13406 (February 27, 2013), hereinafter referred to as the Market Reform Rule.

[3] Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_OperationsPolicyandGuidance_5CR_100313.pdf.*

Since the publication of the Exchange Establishment Rule and the Draft Enrollment Guidance, there have been unforeseen barriers to enrollment in the Exchanges. This interim final rule includes policy changes aimed at allowing additional enrollment opportunities for qualified individuals and qualified employers seeking January 1 coverage. Policy clarifications regarding premium payment are also included.

II. Provisions of the Interim Final Rule

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

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

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

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

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

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

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

In § 155.410(c)(1)(iii), a conforming amendment is made to the regulatory text so that standard coverage effective dates apply only to plan selections starting after January 16, instead of the previously stated December 16. This means that the schedule of coverage effective dates based on plan selection will generally resume as previously established in § 155.410 in the Exchange Establishment Rule starting for plan selections made on December 24, 2013 or later. For example, if a plan selection is made between December 24, 2013 and January 15, 2014, the coverage effective date will be no later than February 1, 2014, unless the issuer elects to make the coverage effective earlier. If a plan selection is made between January 16 and January 31, of 2014, the coverage effective date will be March 1, 2014. We note that, generally, the dates by which an Exchange must ensure coverage based on the date of plan selection are considered the latest date for effectuation; nothing prohibits an issuer from establishing coverage effective

dates earlier than those listed in § 155.410(c).

In § 155.410(c)(1)(iv), this interim final rule permits a State Exchange or a State-based SHOP to establish later plan selection dates for coverage that must be effective on January 1, 2014. Given the varying experiences of State Exchanges and SHOPs, we believe that this flexibility would avoid any inconsistencies with those states that may have already extended the plan selection date and that may have different procedural requirements regarding the consumer payment date from those applicable in the FFEs and FF–SHOPs. Section 155.410(c)(1)(iv) also provides that a SHOP can require plan selection by as early as December 15, 2013 to ensure coverage effective January 1, 2014, as we understand that some State-based SHOPs have already established their own deadlines for QHP selection or may wish to align plan selection dates with the rest of the small group market.

The FF–SHOPs will require issuers to ensure a January 1, 2014 coverage date for plan selections received on or before December 23, 2013, which differs from date by which plan selections must be received in the small group market outside the FF–SHOPs to ensure a January 1, 2014 coverage effective date. In states with an FF–SHOP, we expect issuers to allow a small employer to enroll employees in a SHOP QHP on or before December 23, 2013 for a January 1, 2014 coverage effective date if the employer has indicated that it is seeking SHOP coverage. If the employer indicates that it is seeking SHOP coverage, the employer would need to ensure that issuer has received all employee enrollment forms for those employees not waiving coverage on or before December 23, 2013. Employers may indicate their desire to seek SHOP coverage by selecting a SHOP QHP, or by following any issuer guidance on how to make the indication.

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

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

Accordingly, this interim final rule adds regulatory text at § 156.265(d)(2) to establish that a QHP issuer in an FFE must establish the date by which a qualified individual who has selected a QHP within the initial open enrollment period must make a premium payment in order to effectuate coverage by the applicable coverage effective date, provided that payment dates are no earlier than the last day before the coverage effective date and are consistently applied to all applicants in a non-discriminatory manner. We note that this payment date policy applies only for the initial open enrollment period; we intend to address payment policies applicable beyond the initial open enrollment period in future rulemaking. In addition, this policy applies specifically to the FFEs. State Exchanges can establish their own payment policies.

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

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

We note that this interim final rule also does not require the full premium to be paid to effectuate coverage. For example, the Draft Enrollment Guidance stated that, in the individual market FFEs, QHP issuers could implement a premium payment threshold policy. QHP issuers electing to establish such a policy may effectuate enrollment when the enrollee pays an amount less than the total amount owed by the enrollee but greater than the threshold amount established by the issuer. This rule provides flexibility to QHP issuers in the FFEs to set payment dates, which can include a single payment date for the full premium or an initial payment date for a threshold amount of the premium with subsequent payment dates for the remaining amounts. Payment dates and other enrollment procedures would need to be consistently applied in a non-discriminatory manner for all FFE enrollees. We note that, while issuers may permit less than full payment of the applicable premium prior to effectuating coverage, the grace period described in § 156.270(d) for enrollees receiving advance payments of the premium tax credit still requires that at least one full month's premium has been paid.

Even if an issuer sets a payment date for a January 1, 2014 coverage effective date beyond December 31, 2013, the coverage must take effect January 1, 2014 as long as the plan selection is made by the applicable date, as set forth in § 155.410(c) as amended by this interim final rule, and payment is made by the issuer-established date, regardless of when the enrollment confirmation transaction is sent to the FFE. For QHP issuers in the FFEs that accept payments after January 1 for a coverage effective date of January 1, 2014, we note that this rule does not establish specific standards related to the communication with consumers regarding the distribution of welcome materials and insurance cards and the way in which coverage for any services rendered before the enrollment is fully processed. However, we note that an

effective coverage date of January 1, 2014 means that the individual must receive coverage for any services received on or after that date, even if the payment and enrollment are not processed by that time.

C. Other Policies to Smooth Transitions

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

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

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

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

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

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

However, we are also cognizant that new enrollees may be unfamiliar with what is covered in their new plan's formulary and the drug exceptions process. Also, some enrollees whose drugs are covered by a QHP issuer's formulary may need to obtain prior authorization or go through step therapy in order to have coverage for the drug. Since new QHP enrollees may need more immediate coverage for drugs they have been prescribed and are currently taking, we strongly urge QHP issuers to temporarily cover non-formulary drugs (including drugs that are on a QHP issuer's formulary but require prior authorization or step therapy) as if they were on formulary (or without imposing prior authorization or step therapy requirements) during the first 30 days of coverage, starting on January 1, 2014. While not required, we encourage this approach because this policy would accommodate the immediate needs of QHP enrollees, while allowing the issuer and/or the enrollee sufficient time to go through the prior authorization and/or drug exception processes.

[4] Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, published in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule).

[5] Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.*

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

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

Additionally, section 553(d) of the APA (5 U.S.C. 553(d)) ordinarily requires that a final rule be effective not less than 30 days from the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if otherwise provided by an agency for good cause found and published with the rule. For the reasons set forth below, we also find good cause to waive the 30-day delay in effective date as unnecessary, impracticable and contrary to the public interest.

In this case, given the short timeframe under which this change must be implemented, delaying the promulgation and effectiveness of these rules would inhibit the ability of Exchanges and QHP issuers to effectuate the extended opportunity to enroll in a QHP. Exchanges may need to make system and process adjustments immediately, to ensure that consumers have the additional flexibility to submit applications and select a plan. We consider providing additional time to enroll to be a benefit to consumers. The need to provide additional opportunities for consumers to enroll was not clear until a date by which a 30-day comment period and 30-day delay of the effective date would make it impossible to implement on time. If we were to open the policy for 30 days of public comments and a 30-day delay of effective date, the policy would not be effective until well beyond January 1, 2014, which would be contrary to the public interest.

We note that the Exchange Establishment Rule at § 155.410(c)(2) provided that an Exchange could establish shorter coverage effective date timeframes (such as December 23 for coverage effective January 1) if, among other requirements, the Exchange can demonstrate that all participating QHP issuers agree to such timeframes. This condition would likely be an obstacle if CMS were seeking to establish the December 23, 2013 date under the current regulations. However, CMS has the legal authority to, by rulemaking, amend the regulation as necessary to impose the requirement that issuers accept enrollments as late as December 23 for coverage effective January 1. Further, this interim final rule does not introduce substantially different policies, but instead alters operational cutoff dates by about one week.

Given the unusual circumstances and for the reasons outlined above, CMS finds good cause under the APA, 5 U.S.C. 553(b)(B), to waive the 30 day comment period in notice-and-comment rulemaking and to waive the 30-day delay in effective date and proceed directly with the issuance of an interim final rule with an immediate effective date.

IV. Collection of Information Requirements

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

V. Regulatory Impact Analysis

We have examined the impact of this interim 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 CMS's belief that this interim final rule does not reach this economic threshold and thus is not considered a major rule.

Since the publication of the Exchange Establishment Rule, there have been unforeseen barriers to enrollment in Exchanges. This interim final rule provides flexibility to the regulations regarding plan selection and the effective date of coverage in order to allow additional opportunities for qualified individuals and qualified employers seeking coverage with an effective date of coverage on January 1, 2014. This rule also clarifies that QHP issuers in the FFEs can establish payment dates no earlier than the day before the effective date of coverage. We believe that this regulation will benefit potential enrollees by giving them more time to select a QHP and have their coverage become effective by January 1, 2014. We do not believe these actions would impose any significant new costs on issuers.

A. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601, et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the rule on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as—(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of ''small entity.'' CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Small businesses are those with sizes below thresholds established by the SBA. For the purposes of the regulatory flexibility analysis, we expect the following types of small entities to be affected by this interim final rule: (1) QHP issuers.

As discussed in Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule,[6] few, if any, issuers are small enough to fall below the size thresholds for small business established by the SBA. In that rule, we used a data set created from 2009 NAIC Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, CMS used total Accident and Health earned premiums as a proxy for annual receipts. We estimated that there are 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage.[7] However, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

Therefore, we are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this interim final rule will not have a significant economic impact on a substantial number of small entities.

B. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule (and subsequent final rule) that includes any federal mandate that may result in expenditures in any one year by a state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million 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

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

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

stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

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

C. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on state and local governments, preempts state law, or otherwise has Federalism implications. There may be minor additional costs for States to make system and process adjustments before December 16, 2013, to ensure that consumers have the additional flexibility to submit applications and select a plan. This rule does not impose any costs on state or local governments not otherwise imposed by already-finalized provisions of the regulations implementing the Affordable Care Act.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy-making discretion of the states, CMS has engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the NAIC, and consulting with state insurance officials on an individual basis. We believe that this rule does not impose substantial direct costs on state and local governments, preempt state law, or otherwise have federalism implications. We are amending the date by which a plan may be selected for coverage effective January 1, 2014.

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

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

D. Congressional Review Act

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

List of Subjects

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 155

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

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR parts 147, 155, and 156 as set forth below:

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

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

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

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

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(1) * * *

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

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

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

* * * * *

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

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

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

■ 4. Section 155.410 is amended by revising paragraph (c)(1) to read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(c) * * *

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

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

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

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

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

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

* * * * *

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

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

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).

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

§ 156.265 Enrollment process for qualified individuals.

* * * * *

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

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

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

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

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

* * * * *

Dated: December 4, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: December 5, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–29918 Filed 12–12–13; 4:15 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[WC Docket No. 13–39; FCC 13–135]

Rural Call Completion

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document the Federal Communications Commission (Commission) improves its ability to monitor problems with completing calls to rural areas, and enforce restrictions against blocking, choking, reducing, or restricting calls. The Report and Order applies the new rules to providers of long-distance voice service that make the initial long-distance call path choice for more than 100,000 domestic retail subscriber lines, counting the total of all business and residential fixed subscriber lines and mobile phones and aggregated over all of the providers' affiliates (referred to herein as ''covered providers''). In most cases, this is the calling party's long-distance provider. Covered providers include LECs, interexchange carriers (IXCs), commercial mobile radio service (CMRS) providers, and VoIP service providers. These rules do not apply to intermediate providers. Covered providers must file quarterly reports and retain the call detail records for at least six calendar months. The Report and Order also allows qualifying providers to certify that they meet the conditions for a Safe Harbor that would reduce reporting and retention obligations. In addition, the Commission has delegated to the Wireline Competition Bureau, in consultation with the Enforcement Bureau, the authority to act on requests from qualified providers for waiver of these rules. The Report and Order also adopts a rule prohibiting all originating and intermediate providers from causing audible ringing to be sent to the caller before the terminating provider has signaled that the called party is being alerted.

DATES: Effective January 16, 2014 except for § 64.2201 of the Commission's rules, which will become effective January 31, 2014, and §§ 64.2103, 64.2105, and 64.2107 and the information collection in paragraph 67 of this Report and Order, which contains information collection requirements that have not been approved by Office of Management and Budget. The Federal Communications Commission will publish a document in the **Federal Register** announcing the effective date of §§ 64.2103, 64.2105, and 64.2107.

FOR FURTHER INFORMATION CONTACT: Gregory D. Kwan, Competition Policy Division, Wireline Competition Bureau, at (202) 418–1191.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order in WC Docket No. 13–39, FCC 13–135, released on November 8, 2013. The complete text of this document is available for public inspection during regular business hours in the FCC Reference Information Center, Room CY–A257, 445 12th Street SW., Washington, DC 20554. It is also available on the Commission's Web site at *http://www.fcc.gov*. This summarizes only the Report and Order in WC Docket No. 13–39; A summary of the Commission's Further Notice of Proposed Rulemaking in WC Docket No. 13–39 is published elsewhere in this issue of the **Federal Register**.

Synopsis of Report and Order

I. Introduction

1. In this Order, we adopt rules to address significant concerns about completion of long-distance calls to rural areas. Doing so will help ensure that long-distance calls to all Americans, including rural Americans, are completed. The record in this proceeding leaves no doubt that completion rates for long-distance calls