UBA ACAAdvisor

Patient Protection and Affordable Care Act (ACA)

Provisions Affecting Employee Benefits

Updated May 26, 2016

The information provided in this document is not intended be exhaustive or to advise Plan Sponsors, Employers, or Benefits Advisors how they may comply with any provisions of the referenced legislation or related legislation or regulations, nor it is otherwise intended to, or be considered to impart any legal advice. If you have any questions about how to comply with this or any other law or regulation, we recommend that you consult legal counsel.

UBA United Benefit Advisors

Table of Contents

Acronyms Used in this Document

ACA	Affordable Care Act
ACO	Accountable care organization
AHFS	American Hospital Formulary Service
AHRQ	Agency for Healthcare Research and Quality
ALE	Applicable large employer
AMT	Alternative minimum tax
Archer MSA	Archer medical savings account
BHP	Basic Health Program
BMI	Body mass index
CAC	Certified Application Counselor
CBA	Collective bargaining agreement
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare and Medicaid Services
Code	Internal Revenue Code
CO-OP	Consumer Operated and Oriented Plan
CPI	Consumer price index
CPI-U	Consumer price index for all urban consumers
DOL	U.S. Department of Labor
DME	Durable medical equipment
DRG	Diagnosis-related group
DSH	Disproportionate share hospital
EBSA	Employee Benefits Security Administration
ECE	Entity claiming exception
ECP	Essential community provider
EHB	Essential health benefit
ERRP	Early Retiree Reinsurance Program
FDA	Food and Drug Administration
FEHB	Federal Employees Health Benefits program
FFE	Federally-facilitated exchange
FFM	Federally Facilitated Marketplace
FFS	Fee for service
FLSA	Fair Labor Standards Act
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSA	Flexible spending account
FTE	Full-time employee Full-time equivalent employee
GAO	Government Accounting Office
GDP	Gross domestic product
GINA	Genetic Information Nondiscrimination Act of 2008
HCSM	Health Care Sharing Ministry
HDHP	High deductible health plan
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIP	Health insurance provider
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
HRA	Health reimbursement arrangement
HRSA	Health Resources and Services Administration
HSA	Health savings account
ICD-10	*International Statistical Classification of Diseases and Related Health Problems*, 10th revision
IRO	Independent review organization
MAGI	Modified adjusted gross income
MCO	Managed care organization
MEWA	Multiple employer welfare arrangement
MLR	Medical loss ratio
MSA	Metropolitan statistical area
NAIC	National Association of Insurance Commissioners
NIH	National Institutes of Health
NQDC	Non-qualified deferred compensation
OPM	Office of Personnel Management

PACE Act	Protecting Affordable Coverage for Employees Act
PCIP	Pre-Existing Condition Insurance Plan
PDP	Prescription drug plan
PHSA	Public Health Service Act
PIHP	Prepaid Inpatient Health Plans
PPS	Prospective Payment System
PQRI	Physician Quality Reporting Initiative
QHP	Qualified health plan
SBC	Summary of Benefits and Coverage
SERFF	System for Electronic Rate and Form Filing
SMM	Summary of Material Modifications
SSI	Supplemental Security Income
STVHCC	Surface Transportation and Veterans Health Care Choice Improvement Act
URRT	Unified Rate Review Template
USPC	U.S. Pharmacopeial Convention
USPSTF	U.S. Preventive Services Task Force
VEBA	Voluntary employees' beneficiary association

Employer Coverage Requirements and Penalties

Coverage Requirements

If a large employer does not offer minimum essential coverage that is both "minimum value" and "affordable," a "free rider" or "play or pay" tax penalty may be assessed. (The definitions of "minimum value" and "affordable" are in the "Play or Pay" Penalty Tax section immediately below.)

The mandate applies only to employers with an average of at least 50 full-time employees during the preceding calendar year.

- Transition relief provided in the final regulation allows employers with 50 to 99 full-time or full-time equivalent employees to delay compliance to January 1, 2016, if the employer certifies that, during the period beginning on February 9, 2014, and ending on the last day of the plan year that begins in 2015, the employer:
  - Has not reduced the size of its workforce or the overall hours of service of its employees so that it could qualify for this delay, and
  - Has not eliminated or materially reduced any coverage it had in effect on February 9, 2014. A material reduction means that:
    - The employer's contribution is less than 95% of the dollar amount of its contribution for single-only coverage on February 9, 2014, or is a smaller percentage than the employer was paying on February 9, 2014;
    - A change was made to the benefits in place on February 9, 2014, that caused the plan to fall below minimum value; or
    - The class of employees or dependents eligible for coverage on February 9, 2014, has been reduced.
- Transition relief provided in final regulations on employer shared responsibility provide that six consecutive months, rather than the full 2014 calendar year, may be used to determine if the employer has averaged at least 100 full-time employees during 2014.
- Transition rules in final rules provide that employers with a non-calendar year plan in effect on December 27, 2012, and that have not moved to a plan year that starts later in the calendar year are not subject to penalties until the start of the 2015 plan year (a) with respect to employees eligible for coverage on February 9, 2014, and (b) with respect to those not eligible on February 9, 2014, if either 25% of all employees were covered on that date, 33% of full-time employees were covered on that date, coverage was offered to one-third of all employees during the most recent open enrollment or coverage was offered to one-half of full-time employees, if affordable, minimum value coverage is offered to all full-time employees by the start of the 2015 plan year.
- "Full-time employee" is defined as any employee working, on average, at least 30 hours per week with respect to any month. The calendar month measure for full-time status is 130 hours.
- Employers are required to add the number of hours worked by part-time employees in the month and divide by 120. This number is added to the number of full-time employees.
  - Part-time employees are considered solely for the purpose of determining if an employer has an average of 50 (or 100) or more full-time employees and is therefore subject to the employer responsibility and penalty provisions.

Effective January 1, 2015, for employers with 100 or more full-time or full-time equivalent employees and a calendar year plan. Non-calendar year plans that satisfy transition requirements may wait until the start of the 2015 plan year to comply. Employers with 50 – 99 employees may delay compliance to 2016 if certain other transition requirements are met.

Original effective date of January 1, 2014

On July 2, 2013, the Treasury and the White House blogged that employer reporting, and therefore this requirement, will be delayed until 2015. Details are pending. IRS Notice 2013-43, issued July 9, 2013, confirmed the delay.

  - However, any penalties would be assessed only on behalf of *full-time* employees who work, on average, 30 or more hours per week with respect to the month.

- The employer is ***not*** considered to exceed 50 (or 100) full-time employees if the workforce exceeds 50 (or 100) full-time employees solely due to seasonal employees working for 120 days or fewer during the calendar year. Employers that wish to use this rule must count employees for the entire 2014 calendar year.
- "Seasonal worker" means a worker who performs labor or service on a seasonal basis as defined by the DOL. This includes retail workers employed exclusively during the holiday seasons.
- An offer of coverage may be made on behalf of an employer (such as by a Taft-Hartley plan or a PEO).
- The final regulation was published February 10, 2014. A helpful IRS FAQ is available.

In determining the employer's size, all entities treated as a single employer under the aggregation rules are treated as one employer.

In situations where the employer did not exist in the preceding year, employer size is determined based on the average number of employees that it is reasonably expected to employ **and does employ** in the current calendar year.

See Appendix 1: Employee Mandate Flow Chart.

See Appendix 2: Employee Information Needed.

"Play or Pay" Penalty Tax

If an employer does ***not*** offer minimum essential coverage that is both "minimum value" and "affordable" to full-time employees (and dependents) and:

- Employs more than 50 "full-time equivalent" employees during the preceding calendar year [for 2015 the threshold generally is 100 "full-time equivalent" employees] *and*
- One or more employees receives a premium assistance tax credit or cost-sharing reduction and buys coverage through an exchange

the employer must pay a non-tax deductible fine:

If *no* coverage is offered, or coverage does not qualify as minimum essential, $2,000 ($2,080 in 2015, $2,160 in 2016) per year (calculated monthly) times the number of full-time employees (part-time employees do not factor into penalty calculations); however:

- Employer subtracts the first 30 full-time workers from payment calculation [for 2015 80 workers are subtracted from the calculation]
- An employer is not subject to the $2,000 ($2,080 in 2015, $2,160 in 2016) no offer penalty if it offers minimum essential coverage to at least 95% of its full-time employees (or to all but five employees if greater) and their dependent children until the end of the month in which they reach age 26 [for 2015 minimum essential coverage only needs to be offered to 70% of full-time employees and dependent children who are not currently covered do not need to be offered coverage until 2016]. Stepchildren and foster children do not need to be offered coverage to satisfy play or pay, but likely must be covered to satisfy the dependent to age 26 requirement. Spouses do not ever have to be offered coverage.

Effective January 1, 2015 for employers with 100 or more full-time or full-time equivalent employees and a calendar year plan. Non-calendar year plans that satisfy transition requirements may wait until the start of the 2015 plan year to comply. Employers with 50 – 99 employees may delay compliance to 2016 if certain other transition requirements are met.

Originally effective January 1, 2014

On July 2, 2013 the Treasury and the White House blogged that employer reporting, and therefore this requirement, will be delayed until 2015. IRS Notice 2013-43, issued July 9, 2013, confirmed the delay.

- The employer will be subject to the $3,000 ($3,120 in 2015, $3,240 in 2016) penalty if an excluded full-time employee receives a premium tax credit
- If minimum essential coverage ***is*** offered but it is not "minimum value" ***and*** "affordable", the fine is the *lesser of*:
  - $3,000 ($3,120 in 2015, $3,240 in 2016) per year (calculated monthly) for each full-time employee receiving a premium assistance tax credit or cost-sharing subsidy through the exchange, **or**
  - $2,000 ($2,080 in 2015, $2,160 in 2016) per year (calculated monthly) times the number of full-time employees (employer subtracts the first 30 full-time workers from this payment calculation).

"Full-time equivalent employees" – Total *part-time* hours (less than 30) for the month divided by 120 (plus number of "normal" full-time employees – 30 hours per week or more)

"Minimum value" coverage – Plan design is expected to pay at least 60% of allowed charges *and* meet minimum benefit standards. Bronze level plans both in and out of the exchanges are deemed to be minimum value.

“Minimum essential coverage” – see the definition under “Individual Mandate” in this Summary.

A final regulation published February 25, 2013 largely follows the proposed rule: Essential Health Benefits, Actuarial Value & Accreditation - Final Rule. The final rule provides that:

- Individual and small group plans must cover the 10 essential health benefits at the prescribed “metal” levels (90%, 80%, 70% or 60%; a catastrophic option is available for those under age 30) and with allowed cost sharing levels
  - An actuarial value calculator to validate the metal levels is included
  - Each state will have its own essential health benefits (EHBs), based on a selected benchmark plan (see REGTAP | Registration for Technical Assistance Portal for information on how to determine a particular state’s benchmark.)
- The 2015 actuarial value calculator is identical to the 2014 version, except for the out-of-pocket and deductible adjustments. Both are available through HHS
- The final 2016 AV methodology and a link to the calculator [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-011514.xlsm] were released on January 16, 2015.Self-funded and large group plans will need to provide an actuarial benefit of at least 60% to be considered “minimum value” (the requirement to cover certain “core benefits” has been dropped). However, per IRS Notice 2014-69 a plan must include benefits for inpatient hospital and physicians services to meet minimum value.
  - The final rule includes a proposed minimum value calculator similar to the actuarial value calculator for insured plans, but which uses data from self-funded plans’ standard population and does not mandate coverage for the EHBs. Unique designs that are not suitable for either method could engage a certified actuary to make the calculation.
  - Plans that cover EHBs beyond core benefits would be allowed to engage a certified actuary to determine the value of the benefit and add it to the result derived from the calculator
- Current year employer contributions to an HSA or integrated HRA that may be used for cost-sharing or premiums would be considered a first dollar benefit for valuation purposes

- Plans must use the HHS AV calculator unless the plan design is incompatible. Information on what makes a design incompatible is available in this FAQ

On September 1, 2015, the Department of the Treasury issued a supplemental notice of proposed rule making that would modify its current rule regarding the ACA minimum value standards to ensure that to meet minimum value requirements, a group health plan must meet or exceed an actuarial standard value of at least 60 percent and provide substantial coverage of inpatient hospital services and physician services. The purpose of the proposal is to incorporate the substance of the earlier HHS rules into IRS regulation.

Under the proposed rule, the actuarial value standard would apply as of December 31, 2013.

The requirement to cover substantial inpatient and physician services would apply for plan years beginning on or after November 3, 2014, for purposes of determining an individual employee's premium tax credit eligibility.

November 3, 2014, will also be the date used for determining employer shared responsibility (play or pay) penalties, except for the requirement of coverage for substantial hospital or physician services, which will not apply until the end of plan years beginning on or after March 1, 2015, so long as the employer met the exception requirements outlined in 2014 (see above). The IRS also clarified that a binding written commitment "exists when an employer is contractually required to pay for an arrangement and a plan begins enrolling employees when it begins accepting employee elections to participate in the plan.

The IRS also noted that in regard to these rules "plan year" refers to the plan year in effect under the terms of the plan on November 3, 2014.

A proposed rule published May 3, 2013, includes three safe harbor plan designs:

- A plan with a $3,500 integrated medical and drug deductible, 80% cost-sharing, and a $5,000 maximum out-of-pocket limit
- A plan with a $4,500 integrated medical and drug deductible, 70% cost sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% medical cost sharing, a $10/$20/$50 copay tiered drug plan, and a 75% coinsurance for specialty drugs

In December 2015, the Internal Revenue Service (IRS) issued a final rule that clarifies various topics relating to minimum value and premium tax credit eligibility provisions. The rule finalizes regulations that were proposed years earlier. The final rule clarified language relating to the calculation of a taxpayer’s household income, which includes the modified gross adjusted income of the taxpayer and the members of their family who are required to file an income tax return. The final rule provides that when a parent makes an election, household income includes the child’s gross income on the parent’s return. Premium tax credit eligibility is based on the child’s modified adjusted gross income (MAGI), which might not be the same as the amount reported as gross income.

The final rule also provides guidance on continuation coverage post-employment. Individuals who are offered coverage post-employment (through COBRA or retiree coverage) will not be disqualified from a premium tax credit eligibility unless they enroll in the coverage. If an individual who is still an employee is offered COBRA coverage (typically due to a reduction in hours) that is affordable and minimum value, he or she will not be eligible for premium tax credits.

Children who are enrolled mid-month due to birth, adoption, placement by court order, or placement for adoption or foster care, will be treated as being enrolled from the first day of the month for purposes of premium tax credit eligibility.

The final rule on Employer Shared Responsibility includes three affordability safe harbors that employers may use. "Affordable" coverage means that employee contributions to the lowest cost plan available to the employees (for self-only coverage) must not exceed 9.5% (9.56% in 2015, 9.66% in 2016) of any of these safe harbors:

- The employee's W-2 wages (Box 1)
  - Application of the safe harbor would be determined at the end of the calendar and on an employee-by-employee basis.
  - An employer also could use the safe harbor prospectively, at the beginning of the year, by structuring its plan and operations to set the employee contribution at a level so that the employee contribution for each employee would not exceed 9.5% (9.56% in 2015, 9.66% in 2016) of that employee's W-2 wages for that year.
- The rate of pay safe harbor, using he employee's monthly wages at the start of the year
  - For hourly employees, the hourly rate would be multiplied by 130 to determine the monthly wage. If the hourly rate decreases the employer would move to a monthly calculation.
  - For salaried employees, the monthly wage would be used. The monthly wage may not be decreased during the year if this safe harbor is used.
- FPL for a single person as of the start of the plan year. The employer may use the FPL in effect during the prior 6 months.

The safe harbor would only apply for purposes of the employer shared responsibility provision, and would not affect employees' eligibility for health insurance premium tax credits, which would continue to be based on the affordability of employer-sponsored coverage for a single person relative to an employee's household income.

An employer may use different safe harbors for different classes of employees.

The proposed rule on minimum value provides that when determining affordability, all wellness incentives except for those for non-use of tobacco must be disregarded. Current year HRA contributions that may only be used for premiums may be applied when determining affordability.

The final rule on employer shared responsibility also provides that:

- "Employee" means a common law employee.
- All hours for which an employee is paid (e.g., vacation, holiday) are considered hours worked.
- Hourly employees' actual hours must be used. For salaried employees, employers may use actual hours, daily equivalencies (1 hour of service = an 8-hour day worked) or weekly equivalencies (1 hour of service = a 40-hour week was worked).
- Hours worked in the U.S. are counted (whether by a citizen or lawful resident).
- Hours worked by "bona fide volunteers" are excluded. A bona fide volunteer is an employee of a governmental entity or an organization that is tax-exempt under Section 501(c) of the Internal Revenue Code if the employee's compensation from that organization is limited to:
  - Reimbursement for, or a reasonable allowance for, expenses

  - Reasonable benefits, including length of service awards, and nominal fees customarily paid by similar entities to their volunteers

- Employers may use any reasonable method of calculating hours for employees with difficult or complex schedules. A safe harbor of 2.25 hours for each hour of classroom, time plus 1 hour for each hour of non-classroom time is a safe harbor for adjunct faculty.
- An employee who terminates but is rehired within 13 weeks (within 26 weeks if an employee of an educational institution) must have coverage resume on his date of rehire to avoid penalties. A special rule is available for employees initially employed for less than 13 (or 26) weeks.
- An employer may measure an employee's hours on a current monthly basis. An employer may count using weeks, rather than calendar months, if it prefers.
- An employer may use lookback measurement periods and subsequent stability periods to reduce fluctuations in "full-time" status. The rules are complex, but in general:
  - For ongoing employees, the employer may use a measurement (lookback) period of 3 to 12 months to determine whether the employee averages 30 hours per week. The measurement period must be matched by a stability period of at least the same length (but not more than 12 months) during which the employee will be deemed to work the same average hours as he did during the measurement period. New employees who are reasonably expected to work 30 or more hours per week are treated similarly.
  - For new seasonal and variable-hours employees, the employer may use a measurement (lookback) period of up to 12 months to determine whether the employee averages 30 hours per week. The measurement period must be matched by a stability period of at least the same length during which the employee will be deemed to work the same average hours as he did during the measurement period. Additionally, if the employee is found to be full-time during the measurement, the employee must be considered full-time during a stability period of at least 6 months. A variable-hours employee is one whose hours fluctuate. A seasonal employee is one who is hired for a season (or seasons) that are not expected to exceed 6 months per year.
  - Different periods and different methods (lookback or monthly) may be used for hourly and salaried, collectively bargained and non-collectively bargained, different bargaining units, and different states. Use of the lookback method may not be limited to variable and seasonal employees.

Penalties do not apply during the first 3 calendar months of full-time employment (or during the initial measurement period for variable hours and seasonal employees).

For entities treated as a single employer under the aggregation rules, the 30 full-time worker reduction [the reduction is 80 in 2015] used to calculate penalties may only be used once, with the 30 worker reduction to be allocated proportionately based on each entity's number of employees. This is the case even if the penalty only applies to some of the members of the group.

An employer is only responsible for its own employees (so if Employer A is in a controlled/affiliated services group, and Employer A offers coverage but Employer B does not, Employer A will not be subject to the penalty and Employer B will be).

The penalty is indexed based upon the premium adjustment percentage, rounded down to the nearest $10. (The premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the

Secretary of HHS) no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013.

Treasury may make this payment due annually, monthly or on any other periodic basis. It is expected to be an annual payment, following the due date for individual federal income tax returns.

This penalty is also referred to as the "free rider" or "employer-shared responsibility" penalty.

The Surface Transportation and Veterans Health Care Choice Improvement Act (STVHCC) of 2015 was signed into law by President Obama on July 31, 2015. The STVHCC allows employers (effective months beginning after December 31, 2013), solely for purposes of determining ALE status, to disregard in any month an employee that has medical coverage for that month through TRICARE or under a federal health care program through the Department of Veterans Affairs. Employers who offer health coverage, regardless of their size, should offer health coverage to all eligible employees who have TRICARE or health coverage through the Department of Veterans Affairs. The STVHCC only affects the way an employer counts employees for determining ALE status under the ACA.

Employee "Free Choice" Voucher Requirement

This section has been repealed. See Appendix 17, Repealed Provisions, for details.

Small Employer Tax Credits

Eligibility

Small employers are those with no more than 25 full-time equivalent (FTE) employees *and* having not greater than $50,000 in average annual wages.

An agency or instrumentality of a governmental (including tribal) entity is ***not*** a qualified employer unless it is an organization described in Internal Revenue Code (Code) Section 501(c) that is exempt from tax under Code Section 501(a).

Controlled group and affiliated service group rules apply for purposes of determining qualified employer status and wage levels applicable to the credit determination.

An employer must make a non-elective contribution of at least 50% of the single premium on behalf of each employee enrolled in a "qualified" (see definition of "qualified" below) health plan in an amount equal to a uniform percentage (exception: employers contributing more to older employee coverage). Alternative methods of meeting the 50% contribution requirement are available for employers that offer multiple options, use list bills, or contribute to family coverage. Any state-imposed maximum contribution may be honored for specific employees without necessitating similar adjustments for the balance of the employees.

Any premium paid pursuant to a salary reduction arrangement under a Section 125 cafeteria plan is ***not*** treated as paid by the employer.

Generally, if a state makes payments to an insurer to pay a portion of the premium of an employee covered under an employer-sponsored plan ***and*** such payments are contingent on the maintenance of an employer-sponsored plan, the state payments are treated as employer contributions when determining the 50% minimum contribution requirement and the premium credit due.

Employers are ***not*** required to have coverage in-force for all of 2010.

Transition rules for tax years beginning in 2010: The uniform percentage requirement is waived if the employer pays at least 50% of the premium for each enrolled employee.

Note: Eligible small businesses that do not yet provide insurance can start providing insurance and claim the credit for 2011 forward.

See IRS FAQ on the Small Business Health Care Tax Credit and FAQ on Determining FTEs and Average Annual Wages.

The National Federation of Independent Business has provided an easy-to-use health insurance tax credit calculator to help determine tax credit eligibility.

Qualified Coverage: Phase I (2010-2013)

"Qualified health insurance coverage" consists of products that provide:

- Medical care coverage for hospital and medical services as defined by IRC § 9832(b)(1), including nursing home care and home health care

Effective March 23, 2010

Retroactive for premiums paid in taxable years beginning on or after January 1, 2010

- Dental coverage
- Vision coverage
- Long-term care
- Specified disease or illness coverage
- Hospital indemnity or other fixed-indemnity coverage
- Medicare supplement coverage
- Certain other supplemental coverage

Generally, this includes coverage purchased from an insurance company licensed under state law. Self-funded plans, HRAs, HSAs, and flex contributions are ineligible.

This does ***not*** include excepted benefits such as coverage for:

- Accident only
- Disability income insurance
- Liability insurance (including general liability and auto liability)
- Coverage issued as a supplement to liability coverage
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for onsite medical clinics
- Other coverage under which medical care is secondary or incidental to other insurance benefits

Although seasonal employees who work less than 120 days per year are excluded for purposes of counting hours and wages, any contribution made to provide a seasonal employee with coverage is eligible for the credit.

Qualified Coverage: Phase II (2014 and beyond)

Only qualified health plans offered through the exchange are eligible for the tax credit. If no SHOP is available, as has occurred in certain parts of Iowa, Washington, and Wisconsin, the credit is available if the employer purchases coverage that meets the other requirements. Notice 2015-8 and Notice 2014-6 provide details.

Note: The filing deadlines for the credit are either September 15 for corporations or partnerships and October 17 for other small business filers.

- Small businesses that have already filed and want to claim the credit can amend their returns using IRS Form 1120X for corporations or IRS Form 1040X for other small businesses.
- Eligible tax-exempt organizations can claim the credit on Form 990-T.

Proposed rules were issued by the IRS on August 26, 2013: Small Employer Tax Credit - Proposed Rule

A Final Rule was published on June 30, 2014.

The IRS has posted information about the credit, including a calculator and FAQs.

Type of Tax Credit

For tax-exempt organizations, this type of credit is refundable, so long as it does not exceed its total income tax withholding and Medicare tax liability for the year.

For all other qualifying employers, the credit will be in the form of a general business credit as provided for in IRC § 38(b), and may be claimed in full against both regular and alternative minimum tax (AMT) liabilities. It can be carried back **five years** or carried forward 20 years (for 2010, the credit can only be carried forward). Any portion of the credit not claimed during the 20 year carry-forward can be claimed as a deduction in the next tax year.

The credit is limited by the for-profit employer's actual tax liability.

Employers receiving credits are denied any deduction for health insurance costs equal to the credit.

Effective March 23, 2010

Retroactive for premiums paid in taxable years beginning on or after January 1, 2010

Credit Amount

Phase I (2010-2013)

Credit amount is up to 35% of "employer costs" (25% if tax exempt) with sliding scale for firm size and wages. Due to sequestration, the refund will be reduced by 8.7% until the earlier of September 30, 2013, or Congressional action.

"Employer costs" are the ***lesser of***:

- Aggregate amount of non-elective employer contributions to health insurance coverage during the tax year
- Aggregate amount of non-elective contributions an employer would have made if employees were enrolled in a health plan with premiums equal to the average small group premium (as determined by HHS) for the small group market in a given state.

Tax-exempt employer credits are the ***lesser of***:

- Credit allowed as defined by general rules above
- Total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year, and the employer share of Medicare tax on employees' wages.

Phase II (2014 and beyond)

Credit amount is up to 50% of "employer costs" (35% if tax-exempt) with sliding scale for firm size and wages.

- Only qualified health plans offered through the exchange are eligible for the tax credit. In the federal SHOP, and several state SHOPs, the process is to purchase coverage through a broker or insurer and then apply for the credit through the exchange.
- Tax credit is limited to first two consecutive years of coverage (not taking into account years before 2014)
- Non-calendar year plans may claim the 50% credit for all of 2014 if they offer coverage in both 2013 and 2014

Effective March 23, 2010

Retroactive for premiums paid in taxable years beginning on or after January 1, 2010

"Employer costs" are the *lesser of*:

- Aggregate amount of non-elective employer contributions to selected qualified health plan during the tax year
- Aggregate amount of contributions an employer would have made if employees enrolled in a qualified health plan that had a premium equal to the average small group premium (as determined by HHS) for the small group market in the rating area in which the employee enrolls for coverage.

Tax-exempt employer credits are the *lesser of*:

- Credit allowed as defined by general rules above
- Total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year, and the employer share of Medicare tax on employees' wages.

Amounts paid for the tobacco surcharge are not included in the premium for applying the uniform percentage requirement and are not eligible for premium tax credits. Employer contributions for employees who participate in wellness programs are not taken into account for determining the uniform contribution requirement (employers must contribute not less than 50% of premiums even for employees who do not participate) but are taken into account in determining the amount of the tax credit. If state law requires employers to make higher contributions for low wage employees, the employer does not have to increase contributions for all other employees to meet the uniformity requirement if the 50% requirement is otherwise met for all.

The employer will receive the full federal credit as long as the credit doesn't surpass the employer's net contribution to health (and if offered, dental and vision) coverage.

Organizations will use the IRS Form 8941 to calculate the credit. Non-profits may claim the credit (against certain payroll taxes) on IRS Form 990-T. For-profits claim the credit on IRS Form 3800.

A tax credit estimator is available.

See Appendix 3: Small Business Tax Credit Tables

See Appendix 4: Small Group Market Averages By State

Credit Phase Out Schedule

Eligibility for the maximum ("full") Small Employer Tax Credit:

- 10 or less full-time equivalent (FTE) employees ***and***
- $25,000 or less in average annual wages.
- After 2013, the $25,000 limit is indexed by the cost of living adjustment.

The 2015 limit is $25,800. The 2014 limit is $25,400.

The credit (before any reduction) is multiplied by the following to get the reduction amount:

- When the employer has more than 10 FTEs, the number of FTEs in excess of 10 divided by 15; plus
- When average annual wages are in excess of $25,000, the excess divided by $25,000.

Effective March 23, 2010

Retroactive for premiums paid in taxable years beginning on or after January 1, 2010

Note: If the employer has both more than 10 FTEs and average annual wages greater than $25,000, the reduction is the sum of amount of both reductions.

See Appendix 5: Small Business Tax Credit Reduction Tables

Calculating Wages and Full-Time Equivalent (FTE) Employees

Effective March 23, 2010

Retroactive for premiums paid in taxable years beginning on or after January 1, 2010

Full-time equivalent (FTE) employees are determined by dividing the total number of hours of service for which wages are paid by the employer (including paid vacation, holidays, sick days, etc.) for the taxable year by 2,080, and then rounding down to the next lowest whole number.

- If an employee works in excess of 2,080 hours, then any such excess is ***not*** taken into account for calculating FTEs.
- Leased employees are included in FTE and wage calculations if they have worked for the employer for at least one year.
- Wages of union employees are included, even if they obtain benefits through a union (Taft-Hartley) plan.
- Hours of employees in the coverage waiting period are included.

Average annual wages are determined by dividing the aggregate amount of wages paid by the employer during the taxable year by the number of FTEs, then rounding *down* to the nearest multiple of $1,000.

Ineligible employees for FTE and wage calculations:

- Seasonal employees working for 120 days or less
- Self-employed individuals
- Any 2% shareholders of an S corporation
- Any 5% owner of an eligible small business
- Dependents, other household members, and specified family members with certain relationships to above three bullets (e.g., dependent, sister, brother, in-laws, aunts, uncles, etc.)

As alternatives to *actual* hours of service used to determine hours of service, an employer may use simple rules of convenience to estimate hours based on:

- Days of service – assume 8 hours of service for any day for which the employee would be required to be credited with at least one hour of service according to the "actual" service rules
- Weeks of service – assume 40 hours of service for any week for which the employee would be required to be credited with at least one hour of service according to the "actual" service rules

Controlled group and affiliated service group rules apply for purposes of determining qualified employer status and wage levels applicable to the credit determination.

Instructions are available.

Plan Coverage Provisions – Plan Design

Coverage of Preventive Care

Mandates coverage of specific preventive services with **no** cost-sharing *if provided by an in-network provider* for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans

Note: If an in-network ambulatory facility has no co-pay, a co-pay may be applied to an in-network outpatient hospital facility.

The services that must be covered at minimum include:

- Evidence-based items or services with a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved
- For infants, children, and adolescents: evidence-informed preventive care and screenings identified in the comprehensive guidelines supported by the Health Resources and Services Administration
- For women, additional preventive care and screenings identified in comprehensive guidelines supported by the Health Resources and Services Administration
- For women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current, other than those issued in or around November 2009
- Per FAQ XIX, tobacco use counseling and intervention, to include:
  - Screening for tobacco use; and,
  - For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

The entire list from which this summary was derived can be found on the U.S. Preventive Services Task Force website.

Plan years beginning on or after September 23, 2010

(Not applicable to grandfathered plans.)

HHS released new guidelines that are in addition to the rules released previously. The new guidelines include:

- Well-woman visits
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- Human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening and counseling

New health plans and non-grandfathered plans must include these services without cost sharing for insurance policies with plan years beginning on or after August 1, 2012.

Starting with the first plan year beginning on or after September 24, 2014, preventive care must include risk-reducing medications like tamoxifen and raloxifene for women at high risk of breast cancer.

Non-profit religious organizations will not be required to offer, contract, pay for, or refer for contraceptive coverage. The religious organization will self-certify its objection to its insurer or administrator (using a different form than was used previously). The insurer or administrator would be obligated to offer coverage at no cost to interested members (but not through a separate policy, as had been proposed). The insurer or administrator must provide a notice to participants, separate from the application materials, but at about the same time, describing the availability of no-cost contraceptive coverage. The insurer will be expected to pay the cost directly (HHS states that as contraceptives are less expensive than maternity claims, this will be cost neutral). Administrators may obtain reimbursement as an offset to the federally facilitated exchange (FFE) fee.

Final Rule: Women's Preventive Services Coverage

Self-certification form

Model notice of availability of separate payments for contraceptive services

On August 22, 2014, HHS issued an interim final rule and an alternative model notice that non-profit eligible religious organizations that have objections to covering some or all types of contraception may use to notify HHS of their concern. Under this alternative, HHS will directly arrange for the insurer or TPA to provide no-cost contraceptive coverage to participants.

June 30, 2014, the U.S. Supreme Court issued a decision in *Burwell v. Hobby Lobby et. al.* that exempts closely held corporations that have a strong religious objection to covering contraceptives from this requirement because HHS should be able to find a less intrusive method for providing this coverage to employees of employers like Hobby Lobby. On August 22, 2014 HHS, issued a proposed rule that would give closely-held corporations with religious objections to covering contraception the ability to obtain an exemption using the same process as religious organizations are currently using. The proposed rule seeks comments on how an entity can qualify as a closely-held corporation with a religious objection to covering contraceptives.

On July 17, 2014, the DOL issued a FAQ that reminds closely held corporations that plan to discontinue coverage of some or all contraceptives mid-year because of a religious objection to providing that coverage that an SMM must be provided to plan participants within 60 days after the change becomes effective.

The Preventive Services Task Force may update its recommendations from time to time. HHS must provide a minimum interval – of no less than one year – between the date on which a recommendation or guideline is issued and the plan year with respect to which the requirement is effective.

A plan is not required to provide coverage or waive cost-sharing for any item or service that has ceased to be a recommended preventive service.

Rules clarifying office visit reimbursements for preventive care services:

- If a recommended preventive service is billed separately from an office visit, the plan may impose cost-sharing for the office visit only
- If a recommended preventive service is ***not*** billed separately from an office visit:
  - And the primary purpose of the office visit is the provision of a preventive service, the plan may not impose cost-sharing for the office visit
  - And the primary purpose of the office visit is *not* the provision of a preventive service, the plan may impose cost-sharing for the office visit

A plan may impose cost-sharing for a treatment that is not a recommended service, even if the treatment results from a recommended preventive service.

Rules pertaining to additional preventive services:

- A plan may elect to cover additional preventive services
- A plan may impose cost-sharing on any additional preventive services covered

HHS may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

On February 20, 2013, the agencies issued ACA FAQ Part XII which address ongoing questions about the preventive care requirement, including these clarifications:

- Out-of-network preventive care must be provided at no cost if the service is not available in-network
- If a polyp is removed during a screening colonoscopy, the entire procedure must be covered without cost-sharing, as a preventive service
- The BRCA test itself, as well as genetic testing, must be covered at 100% if the attending provider determines the woman is at high risk for the BRCA mutation based on family history
- Preventive over-the-counter drugs, such as aspirin for those at risk for heart attacks, must be covered at 100% only if the over-the-counter drug is actually prescribed
- Required contraceptive coverage does not include male contraceptives
- Plans may not limit coverage to oral contraceptives, and must cover IUDs, implants, sterilization, device removal, etc. Plans may impose reasonable management techniques, such as limiting first dollar coverage to generics

unless use of the generic would be medically inappropriate for the individual. Over-the-counter contraceptives must be covered only if they are FDA-approved and prescribed by the woman's health care provider

- Annual HIV testing and triennial HPV DNA testing must be covered as part of well-woman care
- Routine immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) must be covered without cost-sharing beginning with the plan year that begins one year after the recommendation is adopted by the Centers for Disease Control and Prevention (CDC)
- When a screening or immunization recommendation applies only to those who are "high risk," the attending provider is the one who determines if the person is high risk
- Services covered in a well-woman visit
- Basic information on how to screen for domestic violence
- Affirmation that breast feeding needs to be supported, with discretion left to the payer on reimbursement levels and reasonable length

See FAQs About Affordable Care Act Implementation Part XII.

In May 2015 the DOL provided an FAQ on commonly confusing aspects of preventive service requirements, including BRCA testing, contraception coverage, and anesthesia charges in conjunctions in with colorectal cancer screening tests.

On July 14, 2015, federal agencies released the final rules implementing the accommodations for religious employers and closely held for-profit entities. The final regulations provide two accommodations for eligible organizations to provide notice of a religious objection to the coverage of contraceptive services. Employers that object to providing contraceptive services will need to determine if they meet the criteria of an eligible organization in order to use one of the two accommodations. The two accommodations include filing EBSA Form 700 or going through the "alternative process."

For self-insured plans subject to ERISA, once they provide proper notice to HHS, the Department of Labor (DOL) and HHS will send a notification to the TPA of the ERISA plan notifying the TPA of the eligible organization's objection. The government notice will list the contraceptive services that are objected to, and will provide the TPA with its obligations and designate the relevant TPA as plan administrators under ERISA for the contraceptive benefits the TPA would otherwise manage.

For fully insured plans (or a student health plan), HHS will send notification to each health insurance issuer of the plan. The notification will inform the issuer or carrier of the eligible organization's objection, and will list the contraceptive services that are objected to. Issuers will be responsible for compliance with statutes and regulations to provide coverage for contraceptive services without cost sharing to participants notwithstanding that the policyholder is objecting. Participants (employees and their covered spouses and dependents) will still have seamless access to contraceptive services at no cost, but the accommodations will shift the cost burden of the contraceptive services away from an employer that is an eligible organization.

The final rules also provided that plans and issuers must provide coverage for any recommended preventive service on the first day of its plan or policy year through the last day of its plan or policy year, even if the recommendation or guideline is changed or eliminated during the plan or policy year. The only exception to this rule is when a preventive service is downgraded to a "D" rating by an applicable federal task force, or a preventive service is the subject of a safety recall or other significant safety concern, as designated by a federal agency that has the authority to regulate the

item or service. If this happens, there is no requirement for a plan or issuer to cover the item or service through the last day of the plan or policy year.

The government list of preventive services can be found on the healthcare.gov website, and will be updated soon to include the date on which the recommendation or guideline is adopted. Any new recommendations or guidelines will be listed on this page when they become available. Plans and issuers should annually check the list of recommended preventive services, as they will be obligated to cover them in the first plan or policy year beginning on or after the date that is one year after the new recommendation or guideline goes into effect.

In October 2015, federal agencies released FAQ XXIX, which included information on preventive care.

- Lactation Counseling. The FAQ clarified that plans and issuers are required to provide a list of lactation counseling providers within the network. The plan's Summary of Benefits and Coverage (SBC) should include an Internet address or other contact information so a beneficiary may be able to obtain a list of network providers. Further, plans subject to ERISA must ensure that provider network information accompany the Summary Plan Description (SPD). Similar obligations exist for issuers of qualified health plans and the ACA's Marketplace plans and SHOP plans.

  If a plan does not have in-network lactation counseling providers, the plan may not impose cost sharing for lactation counseling services obtained out of network. If a state does not license lactation counselors and plans require providers to be licensed by the state, and the service could not be provided in the scope of another type of provider license (such as a registered nurse), the plan will have to provide coverage for the services without cost sharing. Plans may not limit lactation counseling services without cost sharing to an inpatient basis. Coverage for lactation support services must extend for the duration of breastfeeding. Plans may not require individuals to obtain equipment within a specified time period, such as within six months of delivery, in order for it to be covered without cost sharing.

- Obesity Screening and Interventions. The FAQ clarified that non-grandfathered group health plans and issuers must cover, without cost sharing, screening for obesity in adults. In addition, federal guidelines recommend that, for an adult patient with a body mass index of 30 or higher, intensive multicomponent behavior interventions should be provided. Plans and issuers may use reasonable medical management techniques to determine the scope of such services, but may not impose general exclusions on those services, which can encompass group and individual high intensity sessions, behavior management activities, and others.

- Colonoscopies. Plans may not impose cost sharing for the required specialist consultation prior to colonoscopy screenings, if a provider determines the pre-procedure consultation is medically appropriate. Furthermore, pathology exams on a polyp biopsy from a colonoscopy performed as a preventive service must be covered without cost sharing.

- Contraception Coverage Accommodations for Self-Funded Plans. Qualifying non-profit or closely held for-profit employers with an ERISA-covered self-insured plan have two methods for obtaining their religious accommodation in relation to the objection to provide coverage of contraceptive services. They may either complete EBSA Form 700 or provide a letter to the HHS. The DOL will use either method to notify the plan's third party administrator (TPA) so the TPA may provide coverage for contraception separately.

- BRCA Testing. The DOL has previously provided FAQs regarding BRCA testing (relating to breast cancer susceptibility) requirements. The DOL now clarifies that women found to be at increased risk for breast cancer, using a screening tool designed to identify family history that may be associated with an increased risk of having a potentially harmful gene mutation, must receive coverage, without cost sharing, to test for BRCA mutations.

- Wellness Programs. The FAQ clarified that wellness programs with non-financial or in-kind incentives, such as gift cards, thermoses and sports gear, for wellness program participants that satisfy a standard relating to a health factor are subject to federal wellness program regulations.

  In a 2016 FAQ on preventive services, the DOL confirmed that if a colonoscopy is scheduled and performed as a screening procedure, the plan cannot impose cost sharing for the bowel preparation medications. In regard to contraception, the FAQ confirms that, although plans and issuers must ensure access to a full range of FDA-approved contraception methods, plans may utilize reasonable medical management techniques within a specified method of contraception, and may develop and use a standard exception form and instructions for participants. The Medicare Part D Coverage Determination Request Form may serve as a model for plans and issuers when developing a standard exception form.

Limit on Lifetime Benefits

Plan years beginning on or after September 23, 2010

Prohibits lifetime limits on the dollar value of "essential health benefits" (EHBs) for any participant or beneficiary of:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans
- Plans with grandfathered status

Good faith efforts to comply with a reasonable interpretation of "essential health benefits" are allowed if the interpretation is applied consistently. Until additional guidance is issued, self-funded, large, and grandfathered plans that use a benchmark plan (from any state) when determining EHBs will be considered in compliance.

Individuals who have reached a lifetime limit prior to the effective date must be informed that the lifetime limit no longer applies. If the individual is no longer enrolled in the plan, they generally must be treated as a special enrollee and allowed to enroll in any plan offered by the employer beginning not later than the first policy year beginning on or after September 23, 2010.

The following language can be used to satisfy the lifetime limit notice requirement:

“The lifetime limit on the dollar value of benefits under name of group plan or insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator/ issuer] at [insert contact information].”

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Carriers and group health plans are prohibited from imposing lifetime and annual limits on coverage. Because health reimbursement arrangements (HRAs) cannot meet this requirement and are a group health plan, HRAs must be

integrated with a group health plan in order to meet the requirements of the ACA. HRAs are still prohibited from being used to purchase individual plan premiums.

Annual Benefit Limits

Restricted annual benefit limits on coverage for "essential health benefits" (EHBs) for plan years beginning prior to January 1, 2014, may be permitted to insure minimal impact on premiums, as determined by HHS for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans
- Group plans with grandfathered status

Until additional guidance is issued, self-funded, large, and grandfathered plans that use a benchmark plan (from any state) when determining EHBs will be considered in compliance.

Annual limits solely on "essential" health benefits per individual may not be less than:

- $750,000 for plans beginning on or after September 23, 2010, but before September 23, 2011
- $1,250,000 for plans beginning on or after September 23, 2011, but before September 23, 2012
- $2,000,000 for plans beginning on or after September 23, 2012, but before January 1, 2014

Annual limits for EHBs would be prohibited entirely for plan years beginning on or after January 1, 2014.

Annual limits are still allowed for:

- Health FSAs (up to $2,500)
- MSAs
- HSAs
- HRAs if integrated with a medical plan with no lifetime or annual benefit limits
- Retiree HRAs

A DOL FAQ issued January 24, 2013, states that an employer-provided HRA will not be considered integrated if it:

- Provides coverage through individual policies or individual market coverage, or
- Credits amounts to an individual when the individual is not enrolled in the other, major medical coverage

Existing HRAs that cannot meet the 2014 requirements generally will be allowed to reimburse expenses incurred after 2014, in accordance with the terms of the plan. Retiree only HRAs generally are not subject to the ACA and are not affected by this rule.

FAQs About Affordable Care Act Implementation Part XI

Note: A specific condition may still be excluded in its entirety.

Plan years beginning on or after September 23, 2010

(Not applicable to *individual* grandfathered policies.)

In August 2011, The U.S. Center for Consumer Information and Insurance Oversight (CCIIO) issued guidance which *exempts* HRAs that are subject to the restricted annual limits as a class from having to apply individually for an annual limit waiver.

An HRA in effect prior to September 23, 2010, is exempt from applying for an annual limit waiver for plan years beginning on or after September 23, 2010, but before January 1, 2014. These HRAs still must comply with the record retention and Annual Notice requirements to participants and subscribers set forth in the supplemental guidance issued on June 17, 2011.

See CCIIO guidance on exemption for HRAs subject to PHS Act Section 2711

Note: On February 13, 2012, the Department of Health and Human Services (HHS) stated a health insurance issuer that has received a waiver of the annual dollar limit requirements pursuant to Section 2711 of the Public Health Service Act for a group health insurance product can sell that product to a self-insured grandfathered group health plan that has

itself been granted a waiver and wishes to switch from being a self-insured plan to a fully insured plan, as long as the following criteria are satisfied:

- In all cases, the plan sponsor must have been offering group health coverage to its employees before September 23, 2010, for which it obtained from HHS a waiver of the annual limits requirement.
- The issuer from whom the group health plan is now obtaining the insured policy must have obtained a waiver from HHS for the newly purchased policy.
- The annual limits of the new policy may not be lower than the annual limits of the previous policy, unless comparable coverage is not available.
- The plan sponsor may obtain a replacement policy with a lower annual limit only if other comparable coverage is not available. If a plan purchases a lower annual limit policy due to lack of comparable coverage, this change would cause a loss of status under 45 CFR 147.140(g)(1)(vi)(C), relating to status as a grandfathered health plan.
- The health insurance issuer must obtain from the plan sponsor an attestation that the criteria outlined above are satisfied and the attestation must be accompanied by documentation outlining the terms of the prior coverage. Issuers shall retain this information in accordance with the data retention requirements of the September 3, 2010, and November 5, 2010, annual limits guidance documents.
- To the extent not superseded here, all prior HHS guidance regarding annual limits waivers continues to apply to the plan and policies described here.

Beginning with the 2014 plan year, IRS Notice 2013-54 states that standalone HRAs will not be permitted, due to their dollar limits. An HRA will be permitted if it is integrated with another group medical plan (sponsored by either the employee's employer or another employer). In addition:

- The HRA must only be offered to employees enrolled in a group medical plan
- The HRA must only be provided to employees who actually are covered by another group medical plan
- The employee must have an annual option to elect out of the HRA (since the HRA is considered minimum essential coverage that will preclude eligibility for a premium subsidy)

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition

exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Carriers and group health plans are prohibited from imposing lifetime and annual limits on coverage. Because health reimbursement arrangements (HRAs) cannot meet this requirement and are a group health plan, HRAs must be integrated with a group health plan in order to meet the requirements of the ACA. HRAs are still prohibited from being used to purchase individual plan premiums.

Waiver of Annual Limits for Mini-Med Plans

Plan years beginning on or after September 23, 2010

HHS is required to establish a program under which "Mini-Med" plans may be excused from complying with the new annual limit requirements if compliance would result in:

- A significant decrease in access to benefits ***or***
- A significant increase in premiums

The key components of the waiver program are:

- A plan or insurer may apply for a waiver from the annual limits requirements for coverage offered prior to September 23, 2010, for the plan or policy year beginning between September 23, 2010, and September 23, 2011.
- Waiver applications must be submitted to HHS (by mail or e-mail) at least 30 days before the beginning of the plan or policy year, and will be processed within 30 days of receipt. For a plan or policy year that begins before

  November 2, 2010, however, the application may be submitted 10 days before the beginning of the plan or policy year, and HHS will process the application no later than 5 days in advance of such plan or policy year.
- A waiver will last only one year, and a plan or insurer must reapply for any subsequent plan or policy year prior to January 1, 2014, when the waiver process will expire in accordance with future guidance to be issued by HHS.

Note: HHS said it will stop accepting applications after September 22, 2011. In addition, plan sponsors that already have received waivers – including those whose waivers have not yet expired – had until September 22, 2011, to seek an extension.

The waivers now will last through the end of 2013 if sponsors comply with certain requirements, including submitting information about their plans to the government each year and ensuring that enrollees understand the limits of the coverage. Previously, waivers lasted only one year. A change in plan year or policy year will not extend the waiver period.

The waiver application must include all of the following:

- The terms of the plan or policy form(s) for which a waiver is sought
- The number of individuals covered by the plan or policy form(s) submitted
- The annual limit(s) and rates applicable to the plan or policy form(s) submitted
- A brief description of why compliance with the restricted annual limits would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation

- An attestation, signed by the plan administrator or Chief Executive Officer of the insurance issuer, certifying:
  - that the plan was in force prior to September 23, 2010; and
  - that the application of the restricted annual limits would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies.

As a condition of receiving waivers, Mini-Med Plan sponsors are required to provide employees with written notification (in clear 14-point type) within 60 days that:

- The plan does not meet the annual limit requirements of the ACA
- That their coverage is extremely limited
- The plan's actual annual limits (and that those limits are below those allowed under the law)
- Is only allowed because their health insurer or company was granted a waiver
- The waiver from those annual requirements has been approved for only one year
- Consumers must be directed to www.HealthCare.gov where they can get information about other coverage options

Annual limit waiver instructions and model notice

Note: Limited Benefit Plans (those built on a hospital-indemnity platform) are not the same as Mini-Med Plans (which are built on a traditional group medical platform), and are exempt from HCR provisions.

Coverage of Emergency Services

Plan years beginning on or after September 23, 2010

(Not applicable to grandfathered plans.)

Mandates coverage of emergency department services for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans

Requires equivalent cost-sharing for network and non-network providers, and prohibits any limitations more restrictive than those imposed on emergency services provided by network providers.

If coverage is provided out-of-network, the patient may be responsible for balanced bill amounts. (If state law prohibits balance billing–or if a plan or insurer is contractually responsible for any amounts balanced billed by an out-of-network provider–the plan is ***not*** required to pay the minimum amount otherwise required.)

The regulations provide a detailed methodology for insurers to determine out-of-network reimbursement amounts for emergency services. See Appendix 6: Out-of-Network Emergency Services Payment Methodology.

Prohibits pre-authorization for emergency services, even if provided out-of-network.

Utilizes a "prudent layperson" definition of emergency medical condition.

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition

exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Plans and carriers may not impose administrative hurdles or requirements to limit access to emergency care, or charge additional copayments or coinsurance for out-of-network emergency care. Out-of-network emergency providers may balance bill, and plans or carriers are not required to pay a balance bill. Plans and carriers must pay a reasonable amount for out-of-network emergency care, which is:

- The median amount it pays for in-network-providers;
- The amount it usually pays out-of-network providers; or
- The Medicare rate.

Federal agencies indicated they might prohibit balance billing in the future.

Designating a Primary Care Physician (PCP)

Allows enrollees to designate any in-network allopathic or osteopathic doctor as their primary care physician (including a pediatrician) for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans

Plan years beginning on or after September 23, 2010

(Not applicable to grandfathered plans.)

See Appendix 7: Model Notice: Designating a Primary Care Physician

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Plans that require or provide for designation of a primary care provider must allow the participant (or beneficiary or enrollee) to designate any available in-network primary care provider. Women do not need authorization for care from an obstetrician or gynecologist, who must be treated as primary care providers for purposes of ordering and authorizing services.

Similarly, plans that require the designation of a participating primary care provider for a child must permit the designation of a physician who specializes in pediatrics if they are in-network.

Cost-Sharing Limits

Cost-sharing limits (apply to all non-grandfathered plans, regardless of size and insured status):

- Limits cost-sharing (deductible, coinsurance, copayments, etc.; however, premiums, balance billing for out-of-network services, and costs of non-covered services are excluded from cost-sharing limits) to health savings

Plan years beginning on or after January 1, 2014

(Not applicable to grandfathered

account (HSA) cost-sharing limits in 2014 (2010 co-insurance is $5,950 for single coverage, $11,900 for family coverage; 2013 limits are $6,250 for single and 12,500 for family; 2014 limits are $6,350 for single and $12,700 for family) then indexed annually to per capita premium increases (rounded to the next lowest multiple of $50) measured after 2014. For 2015, OOP limits are $6,600 single and $13,200 family (these are less than originally proposed), with a stand-alone pediatric dental limit of $350 for one child and $700 for 2 or more children.

- For plans beginning on or after January 1, 2016, annual cost-sharing limitations for self-only coverage apply to all individuals, regardless of whether the individual is covered by a self-only plan or is covered by another kind of plan. This requirement will apply to both high-deductible health plans (HDHPs) and non-high-deductible plans, and is in response to consumer complaints about high deductibles and out-of-pocket limits.
- The new annual cost-sharing limitation for self-only coverage applies to all non-grandfathered group health plans; including non-grandfathered self-insured and large group health plans.
  - For 2014, under FAQ Part XII a plan that uses different vendors may apply the OOP limit only to the major medical portion of the plan. If the plan has an OOP limit on separate (e.g. prescription drug) coverage, that OOP may not exceed $6,350 single and 12,700 family
  - A separate maximum out-of-pocket for standalone pediatric dental is proposed for 2015, which would be $300 for one child and $400 for more than one child
  - FAQ Part XVIII clarified that:
    - For 2015, a plan may have different OOP limits for each vendor or benefit type as long as the total OOP limit does not exceed the limit
    - The OOP limit only needs to apply to EHBs
    - The OOP limit only needs to apply to in-network services
    - Excluded services do not need to be applied to the OOP limit
    - The OOP limit must include deductible, coinsurance and copays
    - A self-funded plan may use any benchmark plan to determine its EHB coverage
  - ACA FAQ XIX clarifies that:
    - If the plan chooses to apply out-of-network expenses toward the out-of-pocket maximum it can do so in any reasonable manner (for instance, it could apply all or a part of an amount that is above the allowed amount)
    - If a large or self-funded plan chooses to define essential health benefits to only include generic drugs (unless a name brand is medically necessary), the plan does not need to apply the participant's cost for a name-brand drug that is not medically necessary toward the out-of-pocket maximum (note that the FAQ states that the summary plan description must clearly state which covered benefits are not applied to the out-of-pocket maximum)
    - If a large or self-funded plan chooses to use reference-based pricing as the full amount it will allow for a procedure, at least until further notice the plan may consider any provider that will not accept the reference-based price as the full allowed amount as out-of-network, as long as the pool of providers that accept reference-based pricing is adequate

plans)

- For any other plans, the limits for self-only will be indexed to double the individual increase.
- Cost-sharing limits do not apply to out-of-network services (other than emergency department care).
- An FAQ states that the agencies will permit the reference price to be treated as the in-network price, as long as the plan uses a reasonable method to provide adequate access to quality providers who are willing to accept the reference price. Adequate access is based on:
  - The Type of Service. Plans may treat providers that accept the reference price as the sole network providers only for those services for which consumers have enough time to make an informed choice of provider. For example, this design is not appropriate for emergency services.
  - Reasonable Access. Plans should ensure the availability of an adequate number of providers that accept the reference price. Considerations include network adequacy approaches developed by the states, geographic distance measures, and patient wait times.
  - Quality Standards. Plans should ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.
  - Exceptions Process. Plans should offer an easily accessible exceptions process when access to a provider that accepts the reference price is unavailable or would compromise the quality of services for a particular individual because, for example, of the patient's other medical issues.
  - Disclosure. Plans should provide, automatically and free of charge, information about the pricing structure, including the services to which it applies and the exceptions process. In addition, the plan should provide specified information, such as provider lists, upon request.

Access to Pediatric Care

Requires plans that require or provide for designation of a participating primary care provider (PCP) for a child to permit individuals to select any participating pediatrician. Applies to all markets (but not to grandfathered plans).	Effective for plan years beginning on or after September 23, 2010 (Not applicable to grandfathered plans.)

OB/GYN Non-Referral Provision

Where the plan provides obstetrical and gynecological coverage, and requires designation of a primary care physician, the plan must allow covered females to obtain obstetrical or gynecological care from an in-network provider without authorization or referral from the primary care physician.	Plan years beginning on or after September 23, 2010 (Not applicable to grandfathered plans.)

Children's Pre-Existing Conditions Exclusion

No pre-ex exclusion periods for individuals under age 19.

On June 28, 2010 HHS issued an interim regulation clarifying:

- Children with preexisting conditions could not be denied access to their parent's coverage, and
- Insurers would not be allowed to insure a child, but exclude coverage for the child's pre-existing condition.

Applies to all markets and grandfathered *group* health plans.

Effective for plan years beginning on or after September 23, 2010

(Not applicable to *individual* grandfathered policies.)

Pre-Existing Conditions Exclusion

Exclusions based on pre-existing conditions are prohibited in all markets and grandfathered *group* health plans, including self-insured plans.

Note: The prohibition regarding pre-existing conditions as it applies to individuals under age 19 is effective for plan years beginning on or after September 23, 2010.

Plan years beginning on or after January 1, 2014.

(Not applicable to *individual* grandfathered policies.)

Employee Final Rule for Coverage

An employer that requires a waiting period before an employee can enroll in health care may not impose a waiting period in excess of 90 days after the employee becomes eligible. Conditions for eligibility (full-time status, a bona fide job category, receipt of a license, etc.) are permissible, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

- A plan may provide that certain employees are eligible for coverage only after they complete a specified cumulative number of hours of service (not to exceed 1,200 hours) within a specified period
- A waiting period that is longer than 90 days is allowed for new variable hours employees while they complete their initial measurement period. A waiting period may be imposed after the measurement period is completed as long as both are completed by the first day of the month following completion of 13 months of employment.
- Earnings and residual requirements under multiemployer plans are permitted types of eligibility requirements and allowing employees to buy or bank hours does not violate the rule
- Reasonable rules for restarting the waiting period for rehires are allowed (but see the play or pay requirements if the employer is large)

The regulations make it clear that the 90 day limit is 90 calendar days – the first of the month following 90 days will not comply.

The waiting period limit is fully effective as of the start of the 2014 plan year. This means that starting on that date an employee may not be required to wait more than 90 days from his eligibility date to enroll, even if he was hired under the old plan terms. For 2014 employers may follow either the proposed or the final rules.

Applies to all markets, including all grandfathered coverage, and to all eligible employees.

The final rule was published February 24, 2014.

Effective for plan years beginning on or after January 1, 2014

A Final Rule released on June 25, 2014, limits permitted orientation periods (that precede the start of the eligibility waiting period) to one month.

Wellness Programs

Effective for plan years beginning on or after January 1, 2014

Permits employers to vary premiums by 30% (for programs not related to avoidance of tobacco) or 50% (for programs related to avoidance of tobacco) in connection with health promotion and disease prevention ("wellness") programs.

A final rule jointly published by the DOL, HHS, and IRS on May 29, 2013, largely follows the existing wellness program rules, with a few significant changes or clarifications to be effective with the start of the plan year beginning on or after January 1, 2014.

See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans – Final Rule.

Employers may not impose surcharges or provide rewards in connection with any health status unless it is done through a wellness program. Smoking and body mass index (BMI) are considered health status factors.

Requires the wellness program to be "reasonably designed to promote health or prevent disease" – that is, it must:

- Have a "reasonable chance" of improving health or preventing disease in participating individuals
- Not be overly burdensome
- Not be a subterfuge for discriminating based on a health status factor
- Not be "highly suspect" in the method chosen to promote health/prevent disease

Programs not subject to requirements ("participatory programs"):

- Programs where participation is not based on a health status factor
- Programs that do not link rewards to a standard related to a health status factor – so long as participation is made available to all "similarly situated individuals"
- Programs that do not provide rewards – so long as participation is made available to all "similarly situated individuals"

Specific program components listed as participatory programs ***not*** subject to requirements:

- Programs that reimburse some or all of fitness membership costs
- Diagnostic testing programs that provide rewards for participation and do not base any rewards on outcomes
- Programs that encourage preventive care through waivers of cost-sharing (e.g., well baby care)
- Programs that reimburse the costs of smoking cessation programs, regardless of whether the individual quits smoking
- Programs that provide rewards to individuals for attending a periodic health education seminar

The following requirements apply to programs that condition rewards or requirements on satisfying a standard related to a health status factor (a "health-contingent wellness program"):

- Rewards for such programs may not exceed 30% of the cost of employee-only coverage, determined based on the

total amount of employer and employee contributions (or, if dependents are eligible for the program, 30% of the cost of coverage in which an employee and any dependent are enrolled). Except that, the reward could be as much as 50% of the total cost if designed to prevent or curtail tobacco use. (The 50% surcharge for tobacco use aligns with the allowed 1.5:1 premium rating in the small group and individual markets.) Multiple rewards can be provided as long as they do not exceed the total or specific reward.

- Rewards apply to both activity-based programs and outcomes-based programs.
- Rewards may take the form of:
  - Premium discounts or rebates
  - The absence of a surcharge
  - A waiver of one or more cost-sharing mechanisms
  - The value of a benefit that would not otherwise be covered under the plan
- The program includes a health standard that includes attainment of certain biometric scores, not smoking, satisfying exercise targets, diet programs and requiring individuals with health conditions to do anything that those without health conditions are not required to satisfy.
- The Plan gives individuals eligible for the program the opportunity to qualify for the award at least once a year.
- The full reward must be available to all similarly situated individuals.
- Plans must provide a reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward for an individual for whom it is unreasonably difficult due to a medical condition or for whom it is medically inadvisable to attempt to satisfy the standard if the program is activity-based.
- Plans are permitted, “if reasonable under the circumstances,” to seek verification, such as a statement from an individual’s physician, that a health status factor makes it medically inadvisable or unreasonably difficult for the individual to satisfy or attempt to satisfy the program standard.
- Plans must provide a reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward to anyone who cannot meet the outcome standard for all outcomes-based requirements – without medical verification of the need for the alternative.
- Plans are required to disclose in all plan materials that describe the terms of the wellness program, the availability of any alternative standard, or the possibility of a waiver of the program standards. (Plan materials that disclose the availability of a wellness programs without describing its terms do not require such disclosure.) New sample notices have been provided.
- Alternative standards do not need to be designed in advance.
- The employer is required to make an educational program available, if that is the standard, or help the employee find a program, rather than expecting the employee to find the program, and would prohibit the employer from charging for the program.
- If a diet program is the alternate standard, the employer would need to pay the membership fee (but not the cost of food).
- If the employee’s personal physician disagrees with an alternate standard recommended by a medical professional

who is an employee or agent of the employer or issuer, a new alternate standard that accommodates the personal physician's concerns about medical appropriateness must be provided.

- Adverse determinations regarding an individual's entitlement to a reasonable alternative standard are eligible for external review under the plan's claims and appeals procedures.
- Prior unsuccessful attempts do not exempt the employer from providing the same or another alternative standard.

The updated rules apply to both grandfathered and non-grandfathered plans.

Note that these rules do not address employer obligations under GINA and the ADA.

On April 20, 2015, federal agencies released a Proposed Rule to amend regulations and provide guidance on implementing Title I of the Americans with Disabilities Act (ADA) as it relates to employer wellness programs. Title I of the ADA applies to employers with 15 or more employees, prohibits discrimination against people with disabilities, and requires equal opportunity in promotion and benefits, among other things.

In the Proposed Rule, "group health plan" refers to both insured and self-insured group health plans. All of the other proposed changes relate to "health programs," which include wellness programs regardless of whether they are offered as part of or outside of a group health plan or group health insurance coverage. The term "incentives" includes financial and in-kind incentives for participation such as awards of time off, prizes, or other items of value.

The ADA restricts employers from obtaining medical information from employees by generally prohibiting them from making disability-related inquiries or requiring medical examinations, with an exception for voluntary medical examinations for wellness programs. The Proposed Rule announced that federal agencies decided that allowing certain incentives related to a wellness program, while limiting them to prevent economic coercion that could make the program involuntary, is the best way to achieve the purposes of the wellness program provisions of both the ADA and HIPAA.

The Proposed Rule defines "voluntary" as meaning that a covered entity: (1) does not require employees to participate; (2) does not deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation; and (3) does not take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees within the meaning of Section 503 of the ADA. Furthermore, employers must provide a notice that clearly explains what medical information will be obtained, who will receive that medical information, how the medical information will be used, the restrictions on its disclosure, and the methods the covered entity will employ to prevent improper disclosure of the medical information.

The Proposed Rule would permit the disclosure of medical information obtained by wellness programs to employers in aggregate form only, except as needed to administer the health plan. The Proposed Rule also underscored the importance of the 30 percent limit (in relation to the total cost of employee-only coverage under the plan, including both the employee and employer contributions) on incentives for wellness program participation, with the exception for tobacco cessation program incentives of 50 percent so long as they do not involve disability-related inquiries or medical examinations. Employee health programs that do not have disability-related inquiries or medical examinations, such as an education program, would not be subject to the incentive requirements under the Proposed Rule.

The Proposed Rule would protect individually identifiable health information collected from or created about participants in a wellness program that is part of a group health plan, under the HIPAA Privacy, Security, and Breach Notification Rules. When an employer is a health plan sponsor performing plan administration it would need to certify that it will not use or disclose information for purposes not permitted by its group health plan documents and the HIPAA Privacy Rule.

Clinical Trials Coverage

Requires coverage of routine costs for and prohibits discrimination against clinical trial participants (routine costs cannot be carved out at a different coverage level).

Defines routine costs to include all items and services consistent with the coverage provided that is typically covered for a qualified individual who is not enrolled in a clinical trial. Specifically excludes:

- The investigational item/device/service itself
- Items and services provided solely to satisfy data collection and analysis needs, and not for the patient's direct clinical management
- Services clearly inconsistent with widely accepted and established standards of care for a diagnosis

Permits plans to require enrollees to participate in the trial through a participating provider, if such providers are participating in the trial and will accept the individual as a trial participant.

Applies the general requirements of this provision to enrollees participating in approved trials being conducted out of state, unless that plan does not otherwise cover out-of-network benefits.

Plan cannot deny coverage on out-of-network grounds, if the trial is conducted out of state, but it appears that routine patient costs can be paid at out-of-network levels.

Plans must cover routine items furnished in connection with participation in an approved clinical trial. If a plan typically covers an item or service, it cannot deny or restrict coverage of the item furnished in connection with participation in an approved clinical trial. Similarly, a plan must cover items and services to diagnose or treat complications or adverse effects from clinical trials, if it would routinely furnish them outside of a clinical trial.

Enrollees are qualified individuals if:

- They are eligible to participate in an approved trial according to the trial protocol for cancer or other life-threatening diseases ***and*** either:
- The referring health care professional is a participating provider and has concluded that the individual's participation would be appropriate, or
- The individual provides medical and scientific information establishing that his/her participation would be appropriate.

An approved clinical trial is defined as a phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, that is also one of the following:

- A federally funded trial sponsored by:
  - the National Institutes of Health (NIH)
  - the Centers for Disease Control (CDC)
  - the Agency for Healthcare Research & Quality (AHRQ)
  - the Centers for Medicare & Medicaid Services (CMS)

Effective for plan years beginning on or after January 1, 2014

(Not applicable to grandfathered plans.)

(Not applicable to individual and small group policies renewed between October 1, 2013, and October 1, 2014, on 2013 policy forms with state insurance department consent)

  - a cooperative group or center of any of the previous entities or the Departments of Defense (DOD), U.S. Department of Veterans Affairs (VA), or U.S. Department of Energy (DOE)
  - a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
- A study conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA)
- A drug trial that is exempt from having an investigational new drug application

Does not preempt state clinical trials laws that go beyond the requirements of this provision.

Applies this provision to health plans offered under the Federal Employees Health Benefits (FEHB) Program.

Applies to insured plans in all markets and self-funded plans (but not grandfathered plans).

Other Provisions Affecting Employer-Based Coverage

Non-Retaliation Provisions

An employer may not discriminate or retaliate against an individual because the individual:

- Notifies the government of the employer's violation of the health reform laws
- Qualifies for federal insurance subsidies or tax credits

Employees (including employees of insurers) who believe a violation has occurred must file a complaint with OSHA within 180 days following the alleged violation. A detailed procedure for investigations, determinations and appeals was published by OSHA on February 27, 2013, and can be found at Procedures for Handling Retaliation Complaints. OSHA has published a fact sheet regarding the filing of "whistleblower" complaints under the ACA.

Effective March 23, 2010

(Not applicable to grandfathered plans.)

Technical Assistance for Employer-Based Wellness Programs

Requires CDC to provide employers with technical assistance in evaluating worksite wellness programs, including:

- Training on the benefits of employer-based wellness programs
- Providing resources on wellness programs (websites, call centers, etc.)

Effective March 23, 2010

Break Time for Nursing Mothers

Requires employers to provide a reasonable break time for working mothers to express breast milk for one year after a child's birth, and to provide a private place – other than a bathroom – for such activities.

Exempts employers with fewer than 50 employees if this requirement would impose an undue hardship.

Employers are not required to compensate employees during such break times.

Effective March 23, 2010

Extended Dependent Coverage

Increases the age of a dependent (regardless of status regarding marriage, full-time student, place of residence, or financial dependency) for health plan coverage until age 26 (for the entire calendar month during which he or she attains age 26) for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans
- COBRA coverage

Applicable dependent children includes only the following children meeting the Code Section 152(f)(1) definition:

- Sons and daughters
- Stepchildren
- Adopted children
- Foster children

Does not require plans to make coverage available to a child of a child receiving dependent coverage.

State insurance laws that require coverage beyond age 26 are still applicable.

Employer contribution structure and benefit eligibility for other dependents must be extended to adult children now covered as a result of this provision.

- Benefit options cannot be age restricted unless such restrictions apply to all employees, spouses, and dependents.
- An adult child surcharge is not allowed.
- Tiered or per dependent contributions are permitted if applied uniformly.

For grandfathered *group* plans until 2014, the coverage until age 26 provisions would only have to be extended to those dependents that are *not* eligible to enroll in another source of employer-sponsored health insurance other than a group health plan of a parent.

If a child has coverage available through both parents, the child could be covered by both parents, even if both plans are grandfathered. (A grandfathered plan will generally only be able to exclude the child if the child has coverage available through his or his spouse's employment).

These provisions seem to indicate that spousal carve-outs that limit a dependent child's ability to be enrolled in the group health plan would ***not*** be allowed for plan years beginning on or after September 23, 2010.

Transition rules

A plan or issuer is required to provide written notice to a dependent (either directly or through their covered parent) that the dependent has at least a 30 day opportunity to enroll in any coverage option offered to similarly situated children under age 26, and coverage is to begin no later than the first day of the plan year beginning on or after September 23, 2010 (even if the request for coverage is made after that date) for dependents with the following situations:

Effective for plan years beginning on or after September 23, 2010

(Limited grandfathering applies as noted)

- A child was covered under the plan as a dependent but lost eligibility prior to age 26
- If, when a parent first became eligible for coverage, a child was under age 26 but older than the age at which the plan ceased covering children

If a child is eligible under these new rules, parents not currently enrolled must be given the opportunity:

- If not currently enrolled, to enroll.
- If currently enrolled, to switch to any benefit package option for which a child is eligible.

The following model language can be used to satisfy the increased dependent age notice requirement:

"Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010]. For more information contact the [insert plan administrator or issuer] at [insert contact information]."

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Group health plans and carriers must cover all children up to age 26, regardless of financial dependency or shared residence, student status of the child, employment status, or marital status. They must also be covered even though they do not live in a plan's service area. Plans are not required, however, to cover out-of-network services for adult children, and the rule does not extend to grandchildren or other relatives.

Self-Funded Non-Federal Government Plan Opt-Outs

Effective for plan years beginning on or after September 23, 2010

Prior to enactment of the Patient Protection and Affordable Care Act (ACA), sponsors of self-funded, nonfederal governmental plans were permitted to elect to exempt those plans from (opt-out of) seven specific Public Health Service Act (PHSA) provisions established under the Health Insurance Portability and Accountability Act (HIPAA):

1. Limitations on preexisting condition exclusion periods
2. Requirements for special enrollment periods
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008 (GINA)
4. Standards relating to benefits for newborns and mothers
5. Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008)
6. Required coverage for reconstructive surgery following mastectomies

7. Coverage of dependent students on a medically necessary leave of absence

Under the ACA, for plan years beginning on or after September 23, 2010, self-funded, non-federal governmental plans (including grandfathered plans) are required to comply with the first three requirements, but may continue to opt out of the last four requirements.

No opt-out election is available for health care reform's new mandates (e.g., coverage for children under age 26). And, just as before health care reform, no opt-out election is available for HIPAA's requirements to provide certificates of creditable coverage, to protect genetic information, or to comply with administrative simplification (i.e., HIPAA's privacy, security, and EDI rules).

A group health plan that is maintained under a collective bargaining agreement that was ratified before March 23, 2010, and that has been exempted from any of the first three requirements listed above, will not have to come into compliance with those provisions until the commencement of the first plan year following the expiration of the last plan year governed by the collective bargaining agreement.

Beginning in 2015, the opt-out must be filed electronically. HHS released a Bulletin and User Manual that describe the electronic filing process on July 21, 2014.

Model Election Document

Model Notice to Enrollees

Fact Sheet on self-funded non-governmental plans

Gun Rights Protection

Prohibits any requirements for disclosure or collection of information on gun ownership under the bill.

Prohibits insurers from using such information to increase premiums, deny coverage, or reduce or withhold rewards for wellness program participation.

Effective for plan years beginning on or after September 23, 2010

(Not applicable to grandfathered plans.)

Non-Discrimination Rules for Highly Compensated Individuals

Requires all group health plans to comply with current Internal Revenue Code § 105(h)(2) rules that prohibit discrimination in favor of highly compensated individuals in terms of eligibility and benefits (which currently apply to self-insured plans).

Note: Non-discrimination penalties vary for self-funded plans (highly-compensated individual is taxed on benefits received) and insured plans (employer is fined $100 per day per individual).

See Appendix 8: Section 105(h) Nondiscrimination Rules.

Effective for plan years beginning on or after September 23, 2010

However, effective date has been delayed until additional guidance is provided. There is no timeline for when the guidance will be released.

(Not applicable to grandfathered plans.)

Policy Rescissions

Prohibits rescissions of health plan coverage in all insurance markets, self-insured group health plans, and grandfathered plans except for:

- Cases of fraud
- Enrollees making an *intentional* misrepresentation of material fact as prohibited by the terms of the plan or coverage

Coverage may not be cancelled without prior notice to the enrollee.

Administrative recordkeeping exceptions:

- If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, is allowed.
- If a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) ***and*** the plan is not notified of a divorce ***and*** the full COBRA premium is not paid by the employee or ex-spouse for coverage, a plan's termination of coverage retroactive to the divorce is allowed.

Special rules for network plans. The issuer may:

- Limit eligible employers to those having eligible individuals who live, work, or reside in the service area of the network plan.
- Within the service area of the plan, deny coverage to employers and individuals if:
  - It lacks the capacity to deliver services adequately to any additional groups or individuals because of its obligations to its existing contract holders and enrollees, ***and***
  - It is applying the denial of coverage uniformly without regard to prior individual or group claims experience or any health status-related factor related to those individuals or dependents.
- Upon denying coverage in any service area, the issuer may not offer coverage in the group or individual markets within that service area for the next 180 days.

Requires guaranteed renewability in the individual market ***except*** for the following reasons:

- Non-payment of premiums or contributions or untimely payments
- Fraud or intentional misrepresentation of material fact by an individual or a plan sponsor
- Withdrawal of the product from the market
- Withdrawal of the issuer from the market
- For network plans, movement of the individual or employer outside the service area, but only if coverage is terminated uniformly without regard to health status of the individuals
- For bona fide association coverage, cessation of association membership, but only if coverage is terminated uniformly without regard to health status of the individuals

Effective for plan years beginning on or after September 23, 2010.

This provision does not eliminate the HIPAA group participation and contribution requirements.

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

Rescissions of coverage, or cancelling coverage retroactively or with a retroactive effect, have been prohibited since 2010, unless there is fraud or misrepresentation of material fact. The final rule did not provide a definition of "material fact."

The rescission rules do not apply when an employee fails to or delays informing its employer that he or she has divorced a covered spouse, or a COBRA-qualified beneficiary fails to pay for COBRA coverage.

Rescissions are subject to internal and external appeal. Coverage must remain effective until an internal appeal is completed, and enrollees must be given 30 days notice prior to rescission to allow them time to appeal.

The DOL has also stated that a group health plan may not terminate coverage with a retroactive effect when an individual paid the premium but resigns from his or her position of employment.

Coverage and Claims Appeals Process

Requires plans to have an *internal and external* claims and coverage appeals process for:

- Fully-insured individual health plans
- Fully-insured group plans
- Self-insured group health plans

Effective for plan years beginning on or after September 23, 2010

(Not applicable to grandfathered plans.)

Non-ERISA plans will now be subject to many ERISA regulations. On August 17, 2012, HHS clarified that adverse benefit determinations from these plans need not provide notice of the ERISA private right of action or contact information for Employee Benefits Security Administration (EBSA) or a state department. Instead they must provide contact information for member assistance from the carrier or third-party administrator, any assistance directly from the plan, and if the applicable state does not have a consumer assistance program from the HHS Health Insurance Assistance Team**.**

Internal appeals

- Requires group plans to have in effect an internal claims and appeals process that initially incorporates the existing DOL claims and appeals procedures, updated as necessary with any standards established by the DOL.
- Requires non-group plans to have in effect an internal claims and appeals process that initially incorporates claims and appeals procedures under existing law, updated in accordance with any standards set by HHS for this market.
- Provide notice to enrollees (in a culturally and linguistically appropriate manner) of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to help enrollees with the appeals processes.
- Allow enrollees to review their files, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the appeals outcome.

The interim final regulations set forth seven new requirements in addition to those in the existing DOL claims procedure regulation in order to implement an effective internal claims and appeals process.

1. An adverse benefit determination eligible for internal claims and appeals processes under these regulations includes a denial, reduction or termination of, or a failure to provide or make a payment for a benefit, including any of the following:
   - A determination of an individual's eligibility to participate in a plan or health insurance coverage
   - A determination that a benefit is not a covered benefit
   - The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits
   - A determination that a benefit is experimental, investigational, or not medically necessary or appropriate
2. The regulations provide that a plan must notify a claimant of a benefit determination (whether adverse or not) of a claim involving urgent care (as defined in exist DOL claims procedure regulations) as soon as possible, but not later than 24 hours after the receipt of the claim by the plan or health insurance coverage, unless the claimant fails to provide sufficient information to determine whether benefits are covered or payable. (This 24-hour provision does not apply to appeals.)

   Note: On June 24, 2011, this provision was revised. The amended rule permits plans to revert to the original DOL claims procedure rule (requiring a decision as soon as possible, but in no event later than 72 hours).
3. A plan must provide the claimant, free of charge, with any new or additional evidence considered by the plan in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond. Additionally, before the plan can issue an adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale.
4. The plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Thus, decisions regarding hiring, compensation, termination, promotion, or other similar matters must not be made based upon the likelihood that the individual will support a denial of benefits.
5. Plans and issuers are considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language based on thresholds of the number of people who are literate in the same non-English language. In the group market, for a plan that covers fewer than 100 participants, the threshold is 25%; for a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants or 10% of all plan participants.

   Note: On June 24, 2011, this provision was revised.
   - The requirement to provide "culturally and linguistically appropriate" notices has been eased. Plans now need only look to whether the claimant resides *in a county* in which 10% or more of the population is literate only in the same non-English language. The applicable counties are based on U.S. Census data; and the guidance includes a table, which will be updated periodically, listing 255 counties and four languages.

- Each notice to a claimant in such a county must include a sentence in the applicable language explaining the availability of language services. Language services must include, upon request, translated written notices and verbal assistance in the applicable language (i.e., a telephone hotline).
- This language requirement appears to apply to all plan notices, not just those regarding appeals and denials.

6. A plan must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved. This includes:
   - The date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes.

     Note: On June 24, 2011, this provision was revised. The requirement that plans automatically provide diagnosis and treatment codes as part of any notice of adverse benefit determination or final internal adverse benefit determination has been eliminated. Instead, a plan must include a notification of the opportunity to request diagnosis and treatment codes (and their meanings) in all notices, and then provide this information upon request.
   - The plan or issuer must ensure that the reasons for an adverse benefit determination or final internal adverse benefit determination include the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
   - The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
   - The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.
7. If a plan fails to *strictly* adhere to all the requirements of the internal claims and appeals process, the claimant "is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was *de minimis*." Upon such a failure, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

   Note: On June 24, 2011, this provision was revised. The amended regulations provide an exception to the strict compliance standard for minor errors that are:
   - De minimus
   - Non-prejudicial
   - Attributable to good cause or matters beyond the plan's control
   - Part of an ongoing good-faith exchange of information
   - Not reflective of a pattern of non-compliance

   The claimant, in this situation, is entitled upon written request to an explanation of the claim reviewer's basis for asserting that the reviewer meets this exception.

With respect to items 2, 5, 6, and 7 above, a grace period from enforcement action by the DOL, IRS, and HHS was provided until January 1, 2012, for plans that are working in good faith to comply with the provisions.

External review

Requires plans in all markets to either:

- Comply with state external review requirements that include, at a minimum, the consumer protections in the National Association of Insurance Commissioners' (NAIC's) External Review Model Act on July 23, 2010; or
- For states without an external review process that meets these requirements and **for self-funded plans**, implement an external review process that meets minimum federal standards established by HHS through guidance.

Note: The June 24, 2011 revised guidance (via Technical Release 2011-02) clarified that the scope of claims eligible for federal external review is limited to those involving medical judgment (as determined by the external reviewer) or rescission of coverage.

Additionally, the DOL and IRS are modifying their enforcement policy with respect to independent review organizations (IROs). In order to be eligible for a safe harbor from enforcement, self-insured plans must have contracted with only two IROs (rather than three) by January 1, 2012, and with at least three IROs by July 1, 2012, and must rotate them.

Permits HHS to deem an external review process of a group plan or insurer in operation as of the date of enactment as compliant with these requirements. All state law external appeals standards are deemed to comply through January 1, 2012.

The interim regulations provide a basis for determining when plans must comply with a state external review process and when they must comply with the federal external review process.

For health insurance coverage, if a state external review process includes, at a minimum, the 16 "strict standards" consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer **must** comply with the applicable state external review process and not with the federal external review process.

In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the state external review process or the federal external review process.

Note: The June 24, 2011, amended regulations clarified that fully-insured plans must comply with each state's external review requirements, while self-insured plans must comply with the external review standards set by the Secretary of Health and Human Services.

Note: On or after January 1, 2012, through January 1, 2014, states may comply with a temporary set of 13 "similar standards." (In Technical Release 2013-01 the transition period was extended to January 1, 2016.) Subject to the transition rule and temporary standards, insurers in a state not in compliance with the strict standards are to follow the federal external review process administered by HHS or contract with accredited IROs to conduct external review for the insurer. (Note that grandfathered group health plans and health insurance coverage as well as certain excepted benefits, such as limited-scope dental and vision, are not subject to the external review requirements.)

HHS has issued preliminary determinations regarding compliance by the states:

- Twenty-three states are identified as complying with the "strict standards."

- Ten states are identified as complying with the temporary "similar standards."
- Seventeen states (including Ala., Alaska, Fla., Ga., La., Mass., Miss., Mont., Neb., N.D., Ohio, Pa., Texas, W.Va., and Wis.), the District of Columbia, and five territories are identified as not complying with either set of standards (thus requiring insurers to comply with the HHS-administered federal process or contract with IROs to perform required external reviews).

These determinations will be considered final unless a state requests reconsideration, in which case a final determination will be made by October 1, 2011. In addition, if a state makes any changes in its external review processes, it may request a new determination.

These interim final regulations do not preclude a state external review process from applying to and being binding on a self-insured group health plan under some circumstances.

Note: Group health care plans must comply with the decision of the external reviewer by providing benefits or payments regardless of whether the plan intends to seek review from the courts and until a court rules against the claimant.

The external review changes apply to claims for which external review has not been initiated before September 20, 2011. The Technical Release states that these changes are a temporary *suspension* of the original rule, meaning that the original rule could become applicable again if the suspension is lifted.

For detailed interim guidance (including rules for non-grandfathered, self-funded plans) see Appendix 9: Interim Guidance on External Review Procedures

Additional guidance and revised model notices related to the amended (June 24, 2011) interim final rules:

- Technical Release 2011-02
- Technical Release 2013-01
- Revised Model Notice of Adverse Benefit Determination
- Revised Model Notice of Final Internal Adverse Benefit Determination
- Revised Model Notice of Final External Review Decision

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

The final rule finalized additional requirements for internal appeals for individual plans. The final rule clarified that non-grandfathered fully insured group health plans and individual insurers must comply with the state's external review processes if the state process offers the same consumer protections offered by the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act. Self-insured plans and insurers in states without this requirement must use a process that meets HHS standards, which were narrowed in regard to adverse benefit determinations. Originally all final adverse benefit determinations were permitted to be reviewed. The final rule determined that only final review of adverse benefit decisions involving medical judgment and rescission may be reviewed. Examples of medical judgment claims were provided. Coding decisions may involve medical judgment and are appealable.

The final rule also provided the federal review process rules which were previously found in guidance. A group health plans has five days to complete a review of an appeal to determine if it is eligible for an external review, and then assign the appeal to an accredited independent review organization. That organization, or IRO, notifies the claimant, who has 10 days to provide additional information.

Decisions must be issued, in writing, within 45 days, unless the situation involves serious jeopardy to life or health, in which case decisions must be made within 72 hours. Group health plans must contract with three accredited IROs and assign them claims through unbiased means.

The regulations discourage filing fees for claimants, but in states that are required to charge a filing fee, it must not exceed $25, and must be waived if it would cause hardship.

Penalties for Non-Compliance with Benefit Mandates

Effective for plan years beginning on or after September 23, 2010

Penalties for non-compliance with any mandated benefit provision is an excise tax on the employer of $100 per day per affected participant per provision violated.

- Penalties for unintentional violations are capped at *the lesser of*:
  - $500,000
  - 10% of employer's annual health care cost
- Most provisions in THE ACA are also subject to potential penalties under ERISA or PHSA.
- Certain provisions (auto-enrollment; notification regarding exchanges) are subject to Fair Labor Standards Act (FLSA) penalties.
- Non-compliance must be reported on IRS Form 8928.
- Tax reporting requirements are subject to IRS penalties.
- The IRS has issued an FAQ that states that employer reimbursement of individual premiums on a tax-favored basis will trigger this excise tax. All three agencies have issued an additional FAQ that states that reimbursement of premiums for individual coverage on either a pre-tax or an after-tax basis is an impermissible employer payment plan. This prohibition applies whether the payment or reimbursement is through a Section 125 plan, a 105 plan or as compensation.

Small Employer Wellness Program Grants

Effective October 1, 2010

Employers eligible for wellness program grants are those:

- Who employ less than 100 employees
- Whose employees work 25 hours or more per week
- Who do not have a wellness program in place as of March 23, 2010
- That develop comprehensive worksite wellness programs

Rather than individual grants, the program will provide significant wellness support to up to 100 employers selected from among seven regions (Pierce County, Wash.; Kern County, Calif.; Shelby County, Tenn.; Somerset County, Maine; Harris County, Texas; Buchanan County, Mo.; and Marion County, Ind.). Applications were due by April 30, 2012.

Appropriates $200 million in funding for fiscal years 2011 through 2015.

See the National Healthy Worksite Program website for more information about the program.

Simple Cafeteria Plans for Small Business

Applies to taxable years beginning on or after January 1, 2011

Allows small employers to adopt new "simple cafeteria plans." By meeting minimum eligibility, participation and contribution requirements, these plans will be treated as:

- Meeting the non-discrimination requirements that would otherwise apply to the cafeteria plan
- Meeting the non-discrimination requirements for specified qualified benefits offered under a cafeteria plan, including:
  - Group term life insurance
  - Benefits under a self-insured medical expense reimbursement (Sec. 105) plan
  - Benefits under a dependent care assistance program

An "eligible employer" is one that has an average of 100 or fewer employees on business days during either of the two preceding years.

- If an employer was not in existence throughout the preceding year, the number of employees is based on the average number of employees the employer is reasonably expected to employ on business days in the current year.
- An "eligible employer" who establishes a simple cafeteria plan retains its status as an "eligible employer" in subsequent years unless an average of 200 or more employees were employed on business days during any year preceding any such subsequent year.
- An employer is defined to include all predecessors of the employer.
- An employer is determined to be an eligible small employer by applying the controlled group rules of the Work Opportunity Credit under IRC § 52(a) and (b).
- The definition of employee includes leased employees within the meaning of the deferred compensation rules under IRC § 414(n) and (o).

A "simple cafeteria plan" is one that is established and maintained by an "eligible employer" and meets contribution, eligibility, and participation requirements as follows.

Contribution requirements

- Regardless of whether an employee makes any salary reduction contributions, the employer is required to make contributions to qualified benefits under the plan on behalf of each qualified employee (i.e., an employee who is not a highly compensated individual as defined in IRC§ 414(q)) or a key employee as defined in IRC § 416(i).

- The employer must contribute a uniform percentage (not less than 2%) of an employee's compensation for the plan year (without regard to any employee salary reduction), *or* an amount equal to the *lesser of*
  - 6% of an employee's compensation for the plan year
  - Twice the amount of an employee's salary reduction contributions of each qualified employee (but the rate of an employer's contributions for highly compensated employees or key employees must not be greater than that for other employees)
- Regardless of which of the two contribution methods noted above is used, the same method must be used for calculating the minimum contribution for all non-highly compensated employees.
- Subject to the preceding limitation on the rate of employer contributions, employers are permitted to make additional contributions to provide qualified benefits greater than the minimum contributions required.
- The minimum contribution must be available for application to any qualified benefit (other than a taxable benefit) offered under the plan.

Eligibility and participation requirements

Generally, eligibility is met if:

- All employees with at least 1,000 hours of service for the preceding plan year are eligible to participate *and*
- All eligible employees may, subject to terms and conditions applicable to all participants, elect any benefit under the plan.

An employer may exclude employees who:

- Regardless of the satisfaction of the 1,000 hour requirement:
  - Have not attained age 21 before the close of a plan year
  - Have less than one year of service as of any day during the plan year
  - Are covered under an agreement that the DOL finds to be a collective bargaining agreement if there is evidence that cafeteria plan benefits were the subject of good faith bargaining between employee representatives and an employer
  - Are non-resident aliens working outside the U.S. and whose income did not come from a U.S. source
- Have fewer than 1,000 hours of service for the preceding plan year

A plan may also provide for an age younger than 21 or a service period shorter than 1,000 hours, but only if such shorter service or younger age applies to all employees.

Exchange-Participating QHPs Offered Through Cafeteria Plans

A cafeteria plan **cannot** offer a qualified health plan (QHP) offered through an exchange, a Consumer-Operated and Oriented Plan (CO-OP), or a community health insurance option, with the following exceptions:

- Exchange-eligible small employers for coverage purchased through a SHOP

Effective for tax years beginning on or after January 1, 2014

- Exchange-eligible large employers, if the state allows large employers (after January 1, 2017) to participate in the exchange

State Benefit Mandates

Effective January 1, 2014

Continues to apply state benefit mandates to coverage outside of exchanges.

States can mandate additional benefits inside exchanges but they must make payments to cover the additional costs for such benefits for those that are eligible for a subsidy. These state payments must be made directly to individual enrollees or to the health plans in which the individuals are enrolled.

For the multi-state plans the Office of Personnel Management (OPM) is required to offer through state exchanges, states are allowed to mandate additional benefits but must cover the costs for all enrollees from that state (including those who are not eligible for a subsidy). As with single-state plans, payments may be made directly to individual enrollees or to the health plans in which the individuals are enrolled.

Under the Final Rule on Essential Health Benefits, any state mandate that had been adopted by December 31, 2011, (even if not effective by that date) is considered an Essential Health Benefit, so the state is not responsible for those costs.

Expatriate Plans

Expatriate plans that are fully insured will be deemed to be in compliance with THE ACA until the start of the 2016 plan year. (Note that this exemption does not apply to self-funded plans.) An expatriate plan is a plan that limits enrollment to employees who live outside their home country for at least six months of the plan year, and their covered dependents. For more information see the Frequently Asked Questions - The Affordable Care Act Implementation Part XIII.

An expatriate plan is considered minimum essential coverage.

The Consolidated and Further Continuing Appropriations Act, 2015, signed December 16, 2014, modifies existing relief – set forth in FAQs issued in March 2013 and January 2014 – for expatriate health plans (whether fully insured or self-funded) issued or renewed on or after July 1, 2015. To be an expatriate health plan, substantially all of the primary enrollees (i.e., not including dependents) must be "qualified expatriates" fitting into one of the following categories:

Workers in the U.S.: Individuals whose skills and expertise caused the employer to temporarily transfer or assign them to the U.S., who are reasonably determined to require access to health insurance in multiple countries, and to whom the employer periodically offers "other multinational benefits" (such as tax equalization).

Workers Outside the U.S.: Individuals working outside the U.S. for at least 180 days in a consecutive 12-month period that overlaps with the plan year.

Charitable Workers: Members of groups formed for traveling or relocating internationally to do certain nonprofit work (and not formed primarily for the sale of health insurance), if determined by HHS to require access to health insurance in multiple countries.

Coverage Standards. To qualify for the relief, expatriate health plans must provide coverage that meets certain standards. For example, they must provide "minimum value;" cover inpatient hospital services, physician services, and emergency services in countries where qualifying expatriates work (and, for workers transferred to the U.S., in both the U.S. and the transferring country); satisfy the HIPAA portability provisions (such as special enrollment rights) in effect before health care reform; and, if they provide dependent child coverage, offer coverage until age 26. Other standards

ensure that coverage is administered by insurers or administrators with international operations and experience.

Scope of Relief. Most health care reform requirements will not apply to expatriate health plans under this relief. However, coverage under an expatriate health plan will count as minimum essential coverage—for both the individual mandate and employer shared responsibility—and reporting under Code §§ 6055 and 6056 is required. (Reversing the otherwise applicable reporting rule, electronic delivery of individual statements is allowed unless the individual explicitly refuses to consent to electronic distribution.) The Act exempts expatriate plans from health care reform's fees (such as the PCOR fee, reinsurance contributions, and the annual fee on health insurance providers), but it states that the tax on high-cost health coverage (often referred to as the "Cadillac tax") will apply to employer-sponsored coverage of a qualified expatriate assigned to work in the U.S.

The IRS released a notice providing further guidance on expatriate health coverage. The guidance generally provided for:

- Temporary relief allowing taxpayers to apply the requirements of Expatriate Health Coverage Clarification Act (EHCCA) using a reasonable and good faith interpretation of the EHCCA while issuers/employers/plan sponsors modify their current arrangements to comply with EHCCA.
- Clarification that the EHCCA exemption from ACA provisions does not apply to requirements of sections 6055 and 6056 (play or pay reporting). However, statements to individuals reporting an offer of minimum essential coverage may be furnished electronically (unless the recipient refuses consent).
- PCORI fee calculations may exclude lives covered under specified health insurance policy that is issued or renewed on or after July 1, 2015, or under an applicable self-insured health plan for plan years starting on or after July 1, 2015, if the facts and circumstances demonstrate that the policy or plan

  (1) was designed and issued specifically to cover primarily employees

    (a) who are working and residing outside the United States, or

    (b) who are not citizens or residents of the United States but who are assigned to work in the United States for a specific and temporary purpose or who work in the United States for no more than six months of the policy year or plan year; or

  (2) was designed to cover individuals who are members of a group of similarly situated individuals for purposes of § 3(d)(3)(C) of the EHCCA under the rule described in Special rule for groups of similarly situated individuals

Multiemployer Plans

THE ACA has very few special rules for multiemployer or union plans. In general, the employer is responsible for providing compliant, affordable, minimum value coverage, even if another entity actually provides the coverage. Until further notice, an employer contributing to a multiemployer plan will be considered to have met its employer shared responsibility/play or pay obligation if:

- The employer is required to make a contribution to the multiemployer plan for some or all of its employees pursuant to a collective bargaining agreement
- Coverage is offered under the multiemployer plan to any employee (and dependent) who meets the plan's eligibility requirements

- The coverage is affordable and provides minimum value
- The multiemployer plan complies with the 90 day waiting period limit

A multiemployer plan may meet the affordability requirement through any of the three safe harbors. It also may meet affordability if the employee's required contribution toward self-only health coverage does not exceed 9.5% (9.56% in 2015, 9.66% in 2016) of the wages reported by the employer to the multiemployer plan, which may be determined based on actual wages or an hourly wage rate under the collective bargaining agreement.

Health insurance coverage maintained pursuant to a collective bargaining agreement (CBA) that was ratified prior to March 23, 2010, is deemed to be grandfathered until the date on which the last of the CBAs in effect on March 23, 2010, terminates. Then, the otherwise applicable grandfather rules apply. Note that this special rule only applies to *insured* plans maintained pursuant to a CBA (not self-funded collectively bargained plans). For more information, see Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule.

Multiemployer plans are subject to the 2014 TRF fee. HHS has issued regulations that exempt self-administered, self-funded plans from the TRF for 2015 and 2016.

An offer of coverage from or through a multiemployer plan to which an employer contributes is considered an offer of coverage from that employer.

Employer Reporting and Notice Requirements

Employee Notice Regarding Plan Grandfather Status

The plan must notify participants in writing (in conjunction with the distribution of Benefits Summaries) of:

- The plan benefits it believes to be grandfathered
- Contact information for beneficiary questions and complaints
- The plan administrator's contact information

See Model Notice: Plan Grandfather Status

Effective March 23, 2010

Employer W-2 Reporting

Requires all employers (including government entities) to include the aggregate cost (whether paid by the employer or the employee) of employer-sponsored health benefits on the employees' annual Form W-2. The specific value attributable to each benefit is *not* required.

If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage.

The coverage costs that must be reported (whether under an insured or self-insured plan) include:

- Medical plans
- Prescription drug plans
- Dental and Vision plans (unless they are each stand-alone plans)
- Executive physicals
- On-site clinics if a COBRA premium is charged
- Medicare supplemental policies
- Employee assistance programs if a COBRA premium is charged
- Specific disease or illness policies, and hospital or other indemnity insurance policies where the full premium is paid by the employee on a pre-tax basis
- Employer-paid flex credits

Not required to be reported:

- Long-term care, accident, or disability income benefits
- Specific disease or illness policies, and hospital or other indemnity insurance policies where the full premium is paid by the employee on an after-tax basis

Benefits payable during taxable years beginning on or after January 1, 2011

(Delayed until benefits payable during taxable years: beginning on or after January 1, 2012, for employers that issue 250 or more W-2s; until further notice for employers that issue fewer than 250 W-2s)

- All contributions to HSAs of the employee or employee's spouse
- All contributions to Archer medical savings accounts (MSAs) of the employee or the employee's spouse
- Salary reduction contributions to FSAs as defined in Internal Revenue Code § 125
- Coverage through a multiemployer plan

Plan value is determined by using the same calculation as is currently used in determining the employer-provided portion of the applicable premiums for the taxable year for the employee determined under the rules for COBRA continuation coverage, including the special rule for self-insured plans.

Information must be available no later than February 1, 2011 (delayed until January 31, 2013 - see note on right). In the event a terminating employee requests a W-2 prior to January 31, 2013, the value of coverage need not be included. The delay for employers that issued fewer than 250 W-2s in the prior year, for multiemployer plans, and for HRAs was reaffirmed by the IRS on April 26, 2013. See Form W-2 Reporting of Employer-Sponsored Health Coverage. Notice 2012-9 provides (on page 6) that at least six months' notice will be provided before the start of a calendar year for which reporting will be required from entities under the delay, so one can conclude that employers that issued fewer than 250 W-2s in 2012 and employers in a multiemployer plan will not be required to report on their 2013 W-2s (issued in January 2014).

Note: Because of some of the unresolved issues regarding HRAs, the IRS has temporarily indicated that W-2 reporting of HRAs is optional. The exemption is open-ended and does not set a date for when reporting will begin. The IRS has indicated this is transition relief and does not set a date for when it will end.

Employers are not required to issue W-2s to retirees who receive health care coverage but no longer receive wages or salary.

Employers do not have to include or report payments to Taft-Hartley plans.

Reporting of Income and Purchases on Form 1099

This section was repealed on April 14, 2011. See Appendix 16: Superseded Proposed Rules, Notices and Bulletins, for details.

Uniform Health Plan Summary of Benefits and Coverage (SBC)

Requires that all group health plans (including **self-insured** plans), group health insurers, individual health insurers, and plans with grandfathered status provide a summary of benefits and a coverage explanation (in paper or electronic form) to:

- All applicants at the time of application
- All enrollees prior to the time of enrollment or re-enrollment
- All policyholders or certificate holder at the time of issuance of the policy or delivery of the certificate

Directs HHS to develop the summary of benefits standards (in consultation with the NAIC and a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurers, health professionals, patient advocates, and other qualified individuals) on or before March 23, 2011. Provides for periodic reviews and updates of such standards.

Health Plans and employers must begin notifying enrollees on or before March 23, 2012

Note: Effective date of Final Rules is April 14, 2012. Application date is generally September 23, 2012 (or the first day of the first plan year after this date, or the first day of the first open enrollment period after this date).

On February 14, 2012, the DOL, HHS, and Treasury issued final regulations that would ensure consumers have access to two forms to help them understand and evaluate their health insurance choices. These requirements were again updated in a subsequent Final rule in June 2015:

- An easy to understand summary of benefits and coverage
- A uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copay"

Health plans and issuers must also provide notice at least 60 days before any significant modification is made in the plan or coverage during the plan or policy year that affects the Summary of Benefits and Coverage (SBC).

Note: This information must be provided with all application materials. If renewal or reissuance is automatic, the SBC must be provided *30 days prior to reissuance or renewal of their coverage*.

Standards required:

- Must be in a uniform format no longer than four pages (double-sided) and using print no smaller than 12-point font.
- Must be presented in a culturally and linguistically appropriate manner and using terminology that average enrollees can understand.

Contents must include:

- Uniform definitions of standard insurance and medical terms.
  - Insurance related terms to be defined include at least: premium, deductible, coinsurance, copayment, out-of-pocket limit, preferred and non-preferred provider, out-of-network copayments, UCR fees, excluded services, and grievance and appeals
  - Medical terms to be defined include at least: hospitalization, hospital outpatient care, emergency room care, physician services, Rx drug coverage, DME, home health care, skilled nursing care, rehabilitation services, hospice services, and emergency medical transportation
- A description of coverage, including cost-sharing for each of the categories of essential benefits (and other benefits identified by HHS)
- Exceptions, reductions and limitations on coverage
- Cost-sharing provisions (deductibles, coinsurance, and copays)
- Renewability and continuation of coverage provisions
- A “coverage facts label” that includes examples to illustrate common benefits scenarios, including pregnancy or chronic medical conditions and related cost-sharing (with scenarios based on recognized clinical practice guidelines)
- Beginning in the 2014 plan year, a statement of whether the plan provides minimum essential and minimum value coverage
- A statement that the outline is a summary of the policy and that the coverage document itself should be consulted for contractual provisions

- A contact number for consumers and an Internet web address where a copy of the actual coverage policy or certificate of coverage can be reviewed and obtained
- For plans and issuers that have a provider network, an Internet address for obtaining a listing of network providers
- For plans and issuers that the a prescription drug formulary, an Internet address for obtaining information on prescription drug coverage
- An Internet address to access the uniform glossary, a contact number to request a paper copy of the glossary, and a disclosure that paper copies are available
- New in 2015, qualified health plan issuers must disclose whether abortion services are covered or excluded, and whether coverage is limited to excepted abortion services, for plans sold through an individual market Exchange. Until the template and associated documents are finalized and applicable, individual market issuers may adopt reasonable wording and placement of the disclosure on the SBC.
- New in 2015, a statement as to whether the plan offers minimum essential and minimum value coverage (until the template, for use beginning in 2017, is released, this information can be provided in a separate letter)

Preempts related state standards that provide less information to consumers than is required under this provision. States may require additional disclosures.

Employers and health plans that willfully fail to provide the information required can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.

A key feature of the SBC is a new, standardized plan comparison tool called coverage examples, which will illustrate sample medical situations and describe how much coverage the plan would provide in an event such as having a baby (normal delivery) or managing Type II diabetes (routine maintenance, well-controlled).

In September 2015, the HHS announced that, due to difficulties for some issuers that have several hundreds of documents that must be posted to comply with the requirement for both individual and group coverage, it will not take enforcement action against issuers that make available individual coverage policy or group certificate of coverage documents no later than November 1, 2015. HHS expects all group and individual health insurance issuers to provide an Internet address for the group certificate of coverage or individual policy documents by the date on which the SBC is otherwise required.

This does not require early posting of SBCs relating to individual policies for coverage beginning on or after January 1, 2016.

An issuer may post a sample group certificate of coverage for each applicable product for plan sponsors that are shopping for coverage, but once the certificate of coverage is executed, it must be available.

Additional guidance:

- 2015 Final rule
- 2012 Final rule
- Guidance for Compliance
- Summary of Benefits and Coverage (SBC) Template Corrected) | MS Word Format

- Sample Completed SBC | MS Word format
- Instructions for Completing the SBC - Group Health Plan Coverage
- Instructions for Completing the SBC - Individual Health Insurance Coverage
- Why This Matters Language for "Yes" Answers
- Why This Matters Language for "No" Answers
- HHS Information For Simulating Coverage Examples
- Uniform Glossary of Coverage and Medical Terms

On April 24, 2013, the template and completed sample SBC to be used for the 2014 plan year were released. The only material change is that the SBC must state whether the plan provides minimum essential and minimum value coverage. The 2014/Year 2 version of the form also will be used for 2015. In 2015 federal agencies announced the template and associated documents would be finalized by January 2016, and will apply to coverage that will renew or being on the first day of the plan year (or policy year) that begins on or after January 1, 2017.

Corrected sample SBC

Completed sample SBC

If more than 10% of the residents of a county in which the SBC is being distributed are literate only in Chinese, Navajo, Spanish, or Tagalog, the SBC and glossary must be provided in that language. Translations are available on the Centers for Medicare & Medicaid Services website. (Scroll down to the Summary of Benefits section.) A listing of counties that meet the 10% threshold is available from CMS.

Note: Clarifications made by regulators in the FAQs regarding SBC statements include making clear that separate statements do *not* have to be provided for each coverage tier. Also, regulators said they do not intend to impose penalties during the first year the requirement is in effect, so long as employers are working in "good faith" to comply.

For plan years ending on or before December 31, 2014, plans may (but are not required to) use a calculator provided by HHS to complete the coverage examples.

- Checklist for Coverage Calculator
- Coverage Example Calculator Instructions
- Coverage Examples Calculator

In February 2016, the Department of Labor (DOL) issued proposed revisions to the template and related materials, which were finalized shortly thereafter. Employers should utilize the new blank template and a sample completed template along with instructions for completion. All information about current and future SBCs can be found on the DOL's website. The new templates to into effect for plans or policies beginning on or after April 1, 2017.

The template is shorter than the original four-page (double sided) communication. It includes a new "important question" that asks "Are there services covered before you meet your deductible?" and requires family plans to disclose whether or not the plan has embedded deductibles or out-of-pocket limits. This is reported in the "why this matters" column in relation to the question "what is the overall deductible?" and plans must list "If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met" or alternatively,

"If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay."

Tiered networks must be disclosed and the question "Will you pay less if you use a network provider" is now included. The proposed SBC also includes language that warns participants that they could receive out-of-network providers while they are in an in-network facility. The SBC also indicates a consumer could receive a "balance bill" from an out-of-network provider.

The "explanatory coverage page" was dropped from the template.

The coverage examples provide clarification to the "having a baby" example and the "managing type 2 diabetes" example, in addition to providing a third example of "dealing with a simple fracture."

The coverage example must be calculated assuming that a participant does not earn wellness credits or participate in an employer's wellness program. If the employer has a wellness program that could reduce the employee's costs, they must include the following language: "These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert]."

The column for "Limitations, Exceptions, & Other Important Information" must contain core limitations, which include:

- When a service category or a substantial portion of a service category is excluded from coverage (i.e., column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);
- When cost sharing for covered in-network services does not count toward the out-of-pocket limit;
- Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- When prior authorization is required for services.

The template and instructions indicate that qualified health plans (those certified and sold on the Marketplace) that cover excepted abortions (such as those in cases of rape or incest, or when a mother's life is at stake) and plans that cover non-excepted abortion services must list "abortion" in the covered services box. Plans that exclude abortion must list it in the "excluded services" box, and plans that cover only excepted abortions must list in the "excluded services" box as "abortion (except in cases of rape, incest, or when the life of the mother is endangered)." Health plans that are not qualified health plans are not required to disclose abortion coverage, but they may do so if they wish.

Material Modification of Plan Provision

If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days *prior to* the date on which such modification will become effective if the change occurs other than at renewal. If the change occurs at renewal, the updated SBC must simply be provided with the enrollment materials, regardless when they are provided. This disclosure may serve as a Summary of Material Modifications (SMM).

Preempts related state standards that provide less information to consumers than is required under this provision.

Employers and health plans that willfully fail to provide the information required can be fined up to $1,000 for each such failure. Each failure to provide information to an enrollee constitutes a separate offense.

Health Plans and employers must begin notifying enrollees on or before March 23, 2012

Note: Effective date of Final Rules is April 14, 2012. Application date is generally the first plan year on or after September 23, 2012

Employee Notice Requirement Regarding Exchanges

Requires employers subject to the Fair Labor Standards Act (FLSA) (those with $500,000 or more in sales or engaged in interstate commerce, and governmental entities and not-for-profits regardless of size) to inform all current employees and new hires once of their coverage options through a written notice that includes the following information:

- Notice of the existence of the insurance exchange(s)
- Description of exchange services
- Contact information for the exchange for requesting assistance
- Statement that the employee may be eligible for a premium tax credit through the exchange if the employer plan is less than 60% actuarial value and the employee purchases a qualified plan through the exchange
- Statement that if the employee purchases a qualified health plan (QHP) through an exchange, the employee may be eligible for of a cost-sharing reduction
- Statement that if the employee purchases a qualified plan through the exchange, the employee may lose any employer contribution toward health benefits and such contributions may be excludable from income for federal income tax purposes

Delayed effective date was announced in FAQs released January 24, 2013: FAQs About Affordable Care Act Implementation Part XI

Model notices (one for employers that offer coverage and one for those that don't) were issued under Technical Release 2013-2 on May 8, 2013:

- Model notice for employers without plans
- Model notice for employers with plans (note that page 2 must be completed but that page 3 is optional)

On June 21, 2013, the DOL issued Spanish versions of the model notices:

- Spanish version of the model for employers without plans
- Spanish version of the notice for employers that sponsor plans

All current employees must receive the notice by October 1, 2013 (regardless how many hours they work and whether they are eligible for coverage). Newly hired employees must receive the notice within 14 days after their start date. The notice may be mailed. It may be provided electronically if the employee regularly uses a computer as part of his job and the other standard requirements for electronic disclosures are met.

In FAQs released during September 2013, the DOL stated that:

- A third party could provide the notice to all or part of an employer's employees on its behalf. See Frequently Asked Questions – The Affordable Care Act Implementation, Part XVI
- No penalties would apply if an employer fails to provide the notice. See Frequently Asked Question – Notice of Coverage Options

Original effective date was March 1, 2013.

Effective date was delayed to October 1, 2013

Employer Reporting Obligation Regarding Providing Minimum Essential Coverage

Requires insurers (and employers who self-insure) providing minimum essential coverage to report the following information to the Treasury Department reflecting the months during the calendar year for which the individual had "minimum essential coverage" (to avoid the individual mandate penalty for those months):

- Name, address, and taxpayer identification number of each enrolled member
- Dates of coverage for such individual(s) during the calendar year (changed to number of months with coverage for at least one day in proposed regulation)
- Whether coverage is a qualified health plan offered through an exchange; if yes, the amount, if any, of advance payment for premium credits and cost-sharing subsidies. (The requirement to provide premium credit and cost-sharing subsidy amounts was eliminated in the proposed regulation.)

Treasury may prescribe additional reporting requirements.

In the case of health insurance through an employer-sponsored group health plan, the insurer is also required to report the following information to Treasury:

- Name, address, and employer identification number of the employer maintaining the plan
- Portion of the premium, if any, required to be paid by the employer
- If coverage is a qualified health plan in the small group market and offered through the exchange, such information as Treasury may require for administering the small employer tax credit

Requires insurers (and employers that provide minimum essential coverage) to provide written statements with similar information to each covered individual. Required information includes:

- Information required by the above bullets with respect to each individual listed in return
- Name, address, and contact information of the insurer (or others that provide acceptable coverage)

Statements are to be given to individuals on or before January 31 for the previous calendar year.

In the case of coverage provided by any governmental unit or agency, the officer or employee who enters into an agreement to provide such coverage shall make the returns and statements.

Reporting was delayed to 2016 (based on 2015 coverage) through IRS Notice 2013-43.

Final regulations on the reporting requirement under Code Section 6055 were issued March 10, 2014.

Final regulations for reporting by the exchanges were issued May 2, 2014.

As part of an effort to simplify reporting, certain requirements in the statute were eliminated or modified. Under the regulation, reporting will be required by:

- Insurers, but only on plans sold through the SHOP exchange, and outside the individual exchange
- Sponsors of self-funded plans (employer, trustees or committee of a multiemployer plan, a designated agency on behalf of government plans)
- Exchanges for individual plans in an exchange

Originally effective January 1, 2014

Employer reporting requirements will first apply in 2015, with the first report due to participants by February 1, 2016, and to the IRS by February 29, 2016 (March 31 if filing electronically).

Reporting deadlines for 2016 were extended, with the first report due to participants by March 31, 2016, and to the IRS by May 31, 2016 (June 30 if filing electronically).

- Government entity responsible for Medicaid, Medicare, CHIP, Tricare, etc.
- Each employer in a MEWA

Section 6055 reporting is only required on individuals who actually elect coverage. The insurer or plan sponsor will need to report:

- The insurer's or plan sponsor's name, address, and employer identification number
- The name, address, and Social Security number of the named insured (called "responsible individual" in the regulation)
- The name and Social Security number (or date of birth if a Social Security number is not available) of each covered spouse and dependent
- The number of months each covered person was covered for at least one day
- The name, address, and EIN of any employer sponsoring the plan
- Whether coverage is through a SHOP exchange, and if so, the SHOP's unique identifier

Participant reporting will be on Form 1095-B unless the participant is in a self-funded plan sponsored by a large (50+ FT or FTE) employer, in which case reporting will be on Form 1095-C. A substitute form may be used. Only one form is required per household. The form may be provided electronically if elaborate prior consent is obtained. IRS reporting will be on Form 1094-B. Employers who file more than 250 returns (including W-2s) must file electronically with the IRS.

The IRS issued drafts of Form 1095-B and Form 1095-C on July 24, 2014 and updated those drafts October 1, 2014. Draft instructions for forms 1095-B and for 1094-C and 1095-C were issued August 28, 2014. Reporting will be by calendar month, to provide information on whether minimum essential coverage was in place for the employee, spouse and dependents during the month. If an employee had no employer-provided medical coverage from the employer during the year, a Form 1095 will not be issued.

The IRS published final versions of the forms and instructions for reporting under Section 6055 and 6056 in February 2015. The forms are labeled as the 2014 forms, but reporting is voluntary for most employers until 2015. The 2015 forms are anticipated to be substantially similar to the 2014 forms. An employer will not have any reporting requirement under Sections 6055 or 6056 if it has fewer than 50 full-time and full-time equivalent employees in its controlled group and it sponsors a fully insured medical plan. All other employers will have at least some reporting. This includes employers with 50 to 99 employees for 2015 – even though the employer-shared responsibility requirement has been delayed until 2016 for most employers in this group, reporting is still needed to help the IRS determine whether individual employees owe penalties or are eligible for premium subsidies. Parts I and II of Form 1095-C will be used to comply with the Section 6056 reporting requirement that applies to large employers.

On May 20, 2015, the IRS updated all of its FAQs relating to reporting under ACA sections 6055 and 6056. These FAQs provided more information on reporting COBRA coverage and offers, qualifying offers, when employees must be provided with forms, how governmental units should report, reporting on terminated employees, and third-party reporting. The IRS has an FAQs on "Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)," "Questions and Answers about Employer Information Reporting on Form 1094-C and Form 1095-C," and one on "Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)." These FAQs were updated in early 2016 to reflect IRS notices that were released in 2015.

In 2016 it is anticipated that for Form 1095-C, there will be two new indicator codes for Line 14. These codes would

indicate if an offer of coverage to an employee's spouse is a conditional offer.

Continuation sheets have been added to Part III of Form 1095-C and Part IV of Form 1095-B.

Final 2015 instructions for both the 1094-B and 1095-B and the 1094-C and 1095-C were released in September 2015, as were the final forms for 1094-B, 1095-B, 1094-C, and 1095-C.

The 2015 instructions include a variety of changes from the 2014 instructions. For the 1094-C and 1095-C forms, the changes include information on extensions and waivers, how to correct returns, offers of COBRA coverage and reporting on employee premiums. Clarification was provided on reporting coverage from a health reimbursement arrangement (HRA).

For the 1094-B and 1095-B forms there were fewer updates, with information regarding penalties for not reporting and how to file for an extension. Clarification was provided on reporting coverage from an HRA.

In June 2015, President Obama signed the Trade Preferences Extension Act of 2015, which increased the penalties for failing to file a number of required tax forms, including the 1094 and 1095 forms.

- The penalty for failing to file required information returns with the IRS increased from $100 to $250.
- The cap on the total amount of penalties for failures to file will increase from $1,500,000 to $3,000,000.
- If a failure relates to both an information return and a payee statement (sent to the employee) the penalties are doubled.
- If the failure is due to intentional disregard, the new $250 penalty is doubled to $500 for each failure; and no cap applies.

The IRS issued Notice 2015-68 stating that it intends to propose regulations relating to reporting on MEC that would:

- Provide that health insurance issuers must report coverage in catastrophic health insurance plans, as described in section 1302(e) of the Affordable Care Act, provided through an Affordable Insurance Exchange (Exchange, also known as a Health Insurance Marketplace),
- Allow electronic delivery of statements reporting coverage under expatriate health plans unless the recipient explicitly refuses consent or requests a paper statement,
- Allow filers reporting on insured group health plans to use a truncated taxpayer identification number (TTIN) to identify the employer on the statement furnished to a taxpayer, and
- Specify when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage.

On December 28, 2015, the IRS issued Notice 2016-4, delaying the ACA's employer shared responsibility reporting deadlines.

The transition relief provided by Notice 2016-4 **extended the due date for furnishing Form 1095-B and 1095-C to individuals to March 31, 2016. The due date for filing all forms (1094-C, 1095-C, 1094-B, and 1095-B) to the IRS is moved from February 29, 2016, to May 31, 2016, if filing by paper. If filing electronically, the date is moved to June 30, 2016.**

Employer Reporting Requirements Regarding Furnishing of Qualifying and Affordable Coverage

Requires large employers (those subject to the employer responsibility requirements) and "offering employers" (those offering affordable, minimum essential coverage) to report the following information to the U.S. Treasury Department to allow the IRS to determine if surcharges apply:

- Name, address, and employer identification number of the employer maintaining the plan
- Certification as to whether the employer offers minimum essential coverage to its employees (and their dependents)
- Length of any waiting period
- The months during the calendar year coverage was made available to employees
- Monthly premium for the lowest cost option for each enrollment category within the plan
- Employer's share of the total allowed costs of benefits provided under the plan
- For offering employers, the option for which employer pays the largest portion of the cost of the plan
- For offering employers, the portion of the cost paid by employer in each enrollment category under that option
- Number of full-time employees for each month during the calendar year
- Name, address, and taxpayer identification number for each full-time employee during the calendar year
- The months each full-time employee (and any dependents) were covered under any health benefits plan
- Any other information Treasury may require

Requires employers to provide each full-time employee with a written statement on or before January 31 for the previous calendar year with the following information:

- Information required by the above bullets with respect to the individual
- Name, address, and contact information of the employer submitting the above information

The penalty for noncompliance is $50 for each missed statement to an employee, up to a maximum of $100,000.

Provides for coordination of these requirements with the return and statement requirements in Internal Revenue Code § 6055 and the new W-2 requirements.

The employer may enter into an agreement with a health insurance carrier to coordinate information required to be reported under IRC §§ 6055 and 6056.

On March 10, 2014, the IRS published the final regulation on 6056 reporting. As part of an effort to simplify reporting, certain requirements in the statute were eliminated or modified. Under the proposed regulation, each large employer will need to report:

- The employer's name, address, and EIN
- The name and telephone number of a contact person

Effective January 1, 2014

First report will be due in 2015 (IRS Notice 2012-33)

Employer reporting requirements will first apply in 2015, with the first report due to participants by January 31, 2016, and to the IRS by February 28, 2016 (March 31 if filing electronically).

Reporting deadlines for 2016 were extended, with the first report due to participants by March 31, 2016, and to the IRS by May 31, 2016 (June 30 if filing electronically).

- The calendar year for which the information is being reported (even non-calendar year plans must report on a calendar year basis)
- A certification, by calendar month, as to whether minimum essential coverage was offered to employees (and dependents)
- The number of full-time employees for each month
- For each full-time employee
  - The months during the year that minimum value coverage was offered
  - The employer's share of the cost of self-only coverage for the least expensive minimum value plan offered to the employee, by calendar month
  - The employee's name, address, and Social Security number and the number of months, if any, that the employee was actually covered

In addition, if is likely that employers will be required to use a series of codes to indicate:

- Whether the offered coverage meets minimum value (60%)
- Whether the employee's spouse and/or children are eligible for coverage
- If a full-time employee was not offered coverage, whether the employee was excluded due to a permissible waiting period, because the employee was not full-time for the month, because the person was not employed for the month, or for another reason
- If coverage was offered to an employee who is not full-time
- The total number of employees, by calendar month
- If the employer was not conducting business in any months
- If a member of a controlled or affiliated service group, the name and EIN of all other employers in the group
- The name, address, and EIN of anyone filing on behalf of the employer
- If a contributing employer to a multiemployer plan, whether the employee is eligible for that plan because of the employer's contributions, and the name, address, and EIN of the administrator of the multiemployer plan.

In certain limited situations abbreviated reporting will be allowed.

Although members of a controlled group with a self-funded plan are aggregated to determine whether the controlled group is large (more than 50 full-time or full-time equivalent employees), each employer will report separately on its employees. Governmental units may file directly or designate in writing a related government entity to file on its behalf.

Reporting will be on Form 1095-C. A substitute form may be used. Only one form is required per household. The form may be provided electronically if elaborate prior consent is obtained. IRS reporting will be on Form 1094-C. Employers who file more than 250 returns (including W-2s) must file electronically with the IRS.

The IRS issued draft copies of Form 1095-C and of Form 1094-C on July 24, 2014 and updated those drafts on October 1, 2014. Draft instructions for forms 1094-C and 1095-C were released August 28, 2014. A complex series of codes will

be used to report to report whether coverage was offered to the employee, and the extent of the coverage offered. This reporting must be made on a calendar year basis, even if the employer has a non-calendar year plan.

The employer also will report the employee's share of the lowest cost monthly premium for self-only minimum value coverage for which the employee is eligible and will enter codes that address whether the employee was eligible for coverage during the month, including whether the employee was employed, classified as full-time, in a waiting period or covered. If the employee was covered during the month, the employer will report whether coverage was affordable and which affordability safe harbor was used.

In addition, employers with self-funded plans will complete Part III of Form 1095-C. Part III information will be used to determine whether the employee's family met its requirement to have minimum essential coverage.

The large employer will file form 1094-C, along with copies of each 1095-C. The 1094-C will include:

The total number of Forms 1095-C submitted with the transmittal form

- Whether the employer is part of an ALE Aggregated Group (i.e., a controlled or affiliated service group)
- Whether the employer is exempt from some or all reporting or penalties because of its size or offer of coverage to a very high percentage of individuals
- On a month by month basis (with some ability to report for the full year if nothing changes):
  - Whether minimum essential coverage was offered
  - The total number of full-time employees of that employer
  - The total employee count of that employer
  - Whether the employer qualifies for transition relief either because it had 50 to 99 employees or because it had more than 100 employees, but is a non-calendar year plan

Employers that are part of a controlled or affiliated service group also must enter the name and EIN of all other employers that were part of the group during the calendar year. Each employer in a controlled or affiliated service group must file a separate report, although one member of the controlled group may complete the form on behalf of other members. In certain circumstances, government plans may report on a single form through a "designated government entity."

The IRS published final versions of the forms and instructions for reporting under Section 6055 and 6056 in February 2015. The forms are labeled as the 2014 forms, but reporting is voluntary for most employers until 2015. The 2015 forms are anticipated to be substantially similar to the 2014 forms. An employer will not have any reporting requirement under Sections 6055 or 6056 if it has fewer than 50 full-time and full-time equivalent employees in its controlled group and it sponsors a fully insured medical plan. All other employers will have at least some reporting. This includes employers with 50 to 99 employees for 2015 – even though the employer-shared responsibility requirement has been delayed until 2016 for most employers in this group, reporting is still needed to help the IRS determine whether individual employees owe penalties or are eligible for premium subsidies. Parts I and II of Form 1095-C will be used to comply with the Section 6056 reporting requirement that applies to large employers.

On May 20, 2015, the IRS updated all of its FAQs relating to reporting under ACA sections 6055 and 6056. These FAQs provided more information on reporting COBRA coverage and offers, qualifying offers, when employees must be provided with forms, how governmental units should report, reporting on terminated employees, and third-party reporting. The IRS has an FAQs on "Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)," "Questions and Answers about Employer Information Reporting on Form 1094-C and Form

1095-C," and one on "Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)." These FAQs were updated in early 2016 to reflect IRS notices that were released in 2015.

In June 2015, President Obama signed the Trade Preferences Extension Act of 2015, which increased the penalties for failing to file a number of required tax forms, including the 1094 and 1095 forms.

- The penalty for failing to file required information returns with the IRS increased from $100 to $250.
- The cap on the total amount of penalties for failures to file will increase from $1,500,000 to $3,000,000.
- If a failure relates to both an information return and a payee statement (sent to the employee) the penalties are doubled.
- If the failure is due to intentional disregard, the new $250 penalty is doubled to $500 for each failure; and no cap applies.

Final 2015 instructions for both the 1094-B and 1095-B and the 1094-C and 1095-C were released in September 2015, as were the final forms for 1094-B, 1095-B, 1094-C, and 1095-C.

The 2015 instructions include a variety of changes from the 2014 instructions. For the 1094-C and 1095-C forms, the changes include information on extensions and waivers, how to correct returns, offers of COBRA coverage and reporting on employee premiums. Clarification was provided on reporting coverage from a health reimbursement arrangement (HRA).

For the 1094-B and 1095-B forms there were fewer updates, with information regarding penalties for not reporting and how to file for an extension. Clarification was provided on reporting coverage from an HRA.

On December 28, 2015, the IRS issued Notice 2016-4, delaying the ACA's employer shared responsibility reporting deadlines.

The transition relief provided by Notice 2016-4 **extended the due date for furnishing Form 1095-B and 1095-C to individuals to March 31, 2016. The due date for filing all forms (1094-C, 1095-C, 1094-B, and 1095-B) to the IRS is moved from February 29, 2016, to May 31, 2016, if filing by paper. If filing electronically, the date is moved to June 30, 2016.**

On December 16, 2015, the Internal Revenue Service (IRS) and other federal agencies released IRS Notice 2015-87, which provided significant guidance on how HRAs, flex credits, and opt-out waivers will impact affordability.

HRA contributions by an employer that may be used to pay premiums for an eligible employer sponsored plan are counted toward the employee's required contribution, subsequently reducing the amount required for their contribution. Practically speaking, an employer can design an HRA to reduce the employee premium and meet affordability requirements. Similarly, an employer's flex contributions to a cafeteria plan can reduce the amount of the employee portion of the premium so long as the employee may not opt to receive the amount as a taxable benefit, the flex credit may be used to pay for the MEC, and the employee may use the amount only to pay for medical care. If the flex contribution can be used to pay for non-health care benefits (such as dependent care), it could not be used to reduce the amount of the employee premium for affordability purposes. Furthermore, if an employee is provided with a flex contribution that may be used for health expenses, but may be used for non-health benefits, and is designed so an employee who elects the employer health plan must forego any of the flex plan's non-health benefits, those flex benefits may not be used to reduce the employee's premium for affordability purposes.

However, for plan years beginning before January 1, 2017, and for benefits adopted prior to December 16, 2015, an employer flex contribution that is not a health flex contribution because it may be used for non-health benefits but that may be used by the employee toward the amount the employee is otherwise required to pay for the health coverage, will be treated as reducing the amount of an employee's required contribution. Furthermore, only for coverage for plan years beginning before January 1, 2017, an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution (other than a flex contribution made under a non-relief-eligible flex contribution arrangement) for purposes of information reporting on Line 15 of Form 1095-C.

However, because treating a non-health flex contribution as reducing an employee's required contribution may affect the employee's eligibility for the premium tax credit, the IRS encourages employers not to reduce the amount of the employee's required contribution by the amount of a non-health flex contribution for purposes of information reporting. After reports have been submitted, if the employer is contacted by the IRS concerning a potential penalty relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief described in the Notice, to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the non-health flex contribution or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the non-health flex contribution. An employer's non-health flex contribution will not be used to reduce the employee's premium for purposes of determining their eligibility for a tax credit.

The IRS announced that it intends to propose regulations that will treat an unconditional opt-out arrangement (an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan and not on an employee satisfying any other meaningful requirement) in the same manner as a salary reduction for purposes of determining an employee's required contribution relating to affordability.

The IRS has determined that opt-out arrangements increase an employee's contribution for health coverage beyond the amount of the salary reduction. It provides the following example: If an employer offers employees group health coverage through a Section 125 cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage, and offers an additional $100 per month in taxable wages to each employee who declines the coverage, the offer of $100 in additional compensation has the economic effect of increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

However, the regulations will apply only for periods after the issuance of final regulations. Until then, federal agencies also anticipate that mandatory inclusion in the employee's required contribution of amounts offered or provided under an unconditional opt-out arrangement that is adopted after December 16, 2015 (a "non-relief-eligible opt-out arrangement"), will apply for periods after December 16, 2015. This means that employers who are subject to affordability provisions should be very cautious and consult counsel if they plan on offering a new opt-out waiver after December 16, 2015. In particular, employers who have a new opt-out program beginning on or after January 1, 2016, should consult with their legal counsel if they are subject to affordability provisions. Employers who have had opt-out arrangements in place prior to December 16, 2015, will not be required to increase the amount of an employee's contribution for reporting purposes on the 1095-C but individual taxpayers may rely on opt-out payments as increasing their cost for purposes of tax credit eligibility. Employees who must meet a condition to receive the opt-out payment (such as demonstrating they have MEC from another source such as their spouse) may treat the opt-out payment as increasing their required contribution for purposes of premium tax credit eligibility.

McNamara-O'Hara Service Contract Act (SCA) and the Davis-Bacon and Related Acts (DBRA)

The IRS noted that very complicated issues are presented by the SCA and the DBRA, which require federal contractors to pay prevailing wages and fringe benefits or cash out fringe benefits for workers. As a result, until these issues are resolved, for purposes of play or pay and related reporting, employers may consider cash payments in lieu of fringe benefits as increasing the affordability of coverage, although employees are not required to consider the payments as making coverage more affordable for purposes of premium tax credit eligibility. Employers in this situation should work with employees to provide necessary information relating to affordability.

Return Filing Requirements for Employers Not Offering Coverage

Large employers that do not offer coverage must file a return stating:

- Name, date, and employer ID
- Certification that they do not offer coverage
- The number of full-time employees for each month of the calendar year
- Any other information required by the Secretary of the Treasury.

It appears this requirement will be met through the Form 6056 filing described above.

Effective January 1, 2014

Employer reporting requirements will first apply in 2015. The first report will be due in 2016.

Updated COBRA and CHIPRA Notices

The model COBRA General Notice and Election Notice and the CHIPRA Notice Regarding Premium Assistance have been updated to advise participants that exchange coverage is available, possibly with a premium tax credit/subsidy. The model general notice and model election notice and the model CHIPRA notice are available on the DOL website.

COBRA-eligible individuals have special enrollment periods in the exchange when:

- they initially are eligible for COBRA due to a loss of other minimum essential coverage
- COBRA coverage is exhausted

COBRA beneficiaries may choose exchange coverage during open enrollment.

There is also a special enrollment period in the FFM (and in state exchanges if elected by the state) for all current COBRA beneficiaries from May 2 through July 1, 2014.

Effective May 2, 2014

Health Plan Identification Number

Large health plans must obtain a national health plan identifier number ("HPID") by November 5, 2014. Small health plans have until November 5, 2015 to obtain an HPID. For this requirement, a large health plan is one with more than $5 million annual receipts Interpreted to mean $5 million premiums for insured plans and claims paid for self-funded plans for the prior plan year.

Although this requirement applies to all health plans, as a practical matter the insurer will obtain the identification number for fully insured plans. All self-funded plans will need to obtain the number, even if they use a third party to pay claims.

Originally effective November 5, 2014; effective date has been delayed indefinitely

HHS has provided an instructions guide and FAQs.

On October 31, 2014, the compliance date was delayed indefinitely. In May 2015 federal agencies sought public comment on the requirements of HPID use, which is often an indicator they are preparing to formulate further regulations.

Individual Mandate

Coverage Requirements

Non-exempt U.S. citizens and legal residents are required to purchase and maintain "minimum essential coverage" which includes the following:

- Individual market plans offered within a state, whether through or outside the exchange
- Eligible employer-sponsored plans, including the following:
  - Governmental plans, including qualified SHOP plans
  - Other group health plans offered in the small or large group market within a state
  - Retiree coverage
  - Self-funded plans
  - Plans offered by a third party (e.g. multiemployer, collective bargaining unit, PEO, temporary staffing agency) on behalf of an employer
  - Coverage provided by an insured plan regulated by a foreign government or a self-funded plan sitused outside the U.S. on foreign nationals residing in the U.S. if it provides coverage for care in the U.S.
  - Coverage provided by an insured plan regulated by a foreign government or a self-funded plan sitused outside the U.S. providing coverage to U.S. citizens living abroad
  - HRAs with a balance
  - Non-compliant policies renewed between 2013 and 2016
- Grandfathered individual or group coverage
- Government sponsored programs, including:
  - Medicare (including Medicare Advantage plans); Medicare Part B only is not considered minimum essential coverage
  - Medicaid unless the program does not provide full coverage for medical expenses
  - CHIP
  - Department of Defense health benefit programs (TRICARE, Veterans' Administration programs that provide full coverage for medical expenses, Health Care for Peace Corps Volunteers)
  - Medicare Advantage plans
  - Refugee medical assistance
- Conversion coverage
- Other coverage (state health benefit risk pool, etc.) deemed acceptable by HHS in coordination with Treasury

Effective January 1, 2014

Except that individuals with access to employer-sponsored coverage need not comply until the start of the employer's 2014 plan year (IRS Notice 2013-42)

Also an exception through an HHS Q&A for those who enroll in the marketplace/exchange by March 31, 2014 even though coverage may not be effective until May 1, 2014

Minimum essential coverage does not include certain HIPAA excepted benefits. “Skinny plans” do not fall under the definition of “excepted benefits.”

Resident aliens generally must purchase coverage or pay penalties. Resident aliens include those with green cards those meet the substantial presence test. Generally, a person meets this test once they have been in the U.S. for six months. However, even if in the U.S. for six months, these individuals are exempt:

- An individual temporarily present in the United States as a foreign government-related individual
- A teacher or trainee temporarily present in the United States with a J or Q visa who substantially complies with the requirements of the visa
- A student temporarily present in the United States with an F, J, M, or Q visa who substantially complies with the requirements of the visa
- A professional athlete temporarily present to compete in a charitable sports event

For more information see:

- Questions and Answers on the Individual Shared Responsibility Provision
- Final regulations on the individual mandate, released August 27, 2013
- IRS Fact Sheet on the individual shared responsibility for health coverage
- IRS Notice 2013-42, issued June 26, 2013
- CMS Q&A, issued October 31, 2013
- Final rule - minimum essential coverage

Non-Compliance Penalty

The annual penalty for not having insurance would be equal to the *greater of* the following amounts:

- Flat dollar amount:
  - $95 in 2014
  - $325 in 2015
  - $695 in 2016
  - Flat dollar penalties are indexed to cost of living (based on CPI-U) rounded to the next lower $50, after 2016.
  - The total family flat dollar amount is capped at 300% of the applicable per person adult amount.
  - For any dependent under age 18, the per person amount for calculating flat dollar amount is one half the adult individual amount.
- An amount equal to a percentage of taxable gross household income that is in excess of the applicable tax filing threshold (generally, for 2010, the filing threshold is $9,350 for singles and $18,700 for married, filing jointly; for 2014, $10,150 for singles and $20,300 for married, filing jointly):

Effective January 1, 2014

Except that individuals with access to employer-sponsored coverage need not comply until the start of the employer’s 2014 plan year (IRS Notice 2013-42)

  - 1.0% in 2014
  - 2.0% in 2015
  - 2.5% in 2016 and thereafter
- In any event, the penalty is capped at the national average Bronze premium in the exchange for the family size involved. For 2014, the cap is $2448 per individual and $12,240 for families of five or more. For 2015, the cap is $2484 per individual and $12,420 for families of five or more.

Note: In 2016, the 2.5% penalty will apply to gross household incomes above $27,800 (the point at which it exceeds the flat $695 penalty).

The penalty applies to each family member who is without coverage, to a maximum of 300% of the individual penalty. (The penalty for children is 50% of the adult fee.)

If the individual is a dependent of another taxpayer, the taxpayer claiming the dependency exemption is liable for any penalty payment with respect to the individual.

Married taxpayers who file a joint return are jointly liable for any penalty imposed on either taxpayer.

The penalty is calculated on a monthly basis; i.e., the penalty is prorated for partial coverage during the year. If the person is covered for one day during the month, they are considered covered for the entire month.

See Appendix 10: Refusal to Purchase Health Coverage Sample Annual Penalty Table

Exemptions to Individual Mandate

Effective January 1, 2014

Individuals are exempt from the individual mandate in the following cases:

- Affordable coverage is not available (insurance cost exceeds 8% (8.05% for 2015 and 8.13% for 2016) of modified adjusted gross household income)
  - In the case of those enrolled in an employer plan, insurance cost is the portion of the premium paid by the individual (including through salary reduction) for single coverage; HRA contribution to an HRA that is integrated with a group medical plan sponsored by the employer and for which the employer contribution is publicized before the employee must decide to enroll in the health plan that may be used to pay premiums reduce the cost of coverage; employer flex contributions reduce cost if flex contributions may not be taken as a taxable benefit, (2) may be used to pay for minimum essential coverage, and (3) may only be used to pay for medical care
  - If the employee and spouse are both employed, the cost for each person's coverage is combined
  - Household income for this purpose is increased by any salary reduction contribution through a cafeteria plan
  - In the case of those only eligible for individual market coverage, insurance cost is the premium for the lowest cost Bronze plan available through the exchange and reduced by any premium subsidy that is allowable under the ACA
  - The 8% of household income threshold is indexed after 2014 by the amount by which premium growth exceeds income growth
  - If a smoker surcharge is assessed, the smoker premium will be used for the affordability test. Other wellness incentives will be disregarded.

- The individual's income is below the tax filing threshold. (In 2014 the threshold for taxpayers under age 65 is $10,150 for singles and $20,300 for couples)
- A hardship situation exists (as determined by HHS – see below. This automatically includes individuals who would be eligible for Medicaid had the state expanded Medicaid eligibility).
- Dependents (the penalty is assessed against the taxpayer claiming the dependency exemption)
- Individuals with a coverage gap of less than three months.
  - The coverage gap is determined without regard to the calendar year in which the gap occurs.
  - If the coverage gap is three months or greater, then no exemption is provided for any months (including the initial period without coverage).
  - If there is more than one period with a coverage gap during a calendar year, this exemption only applies to the months in the first period without coverage.
  - A person is credited for a month of coverage if covered for at least one day during the month.
  - For 2014 the 3-month period may be extended if:
    - the person enrolls in the marketplace by March 31, 2014 (with coverage beginning by May 1, 2014)
    - the person enrolls in any coverage that is effective by May 1, 2014
    - they have access to employer coverage that is offered on a non-calendar year basis
- Individuals living outside the U.S. (if they qualify for the foreign earned income exclusion) are deemed to have minimum essential coverage
- Residents of U.S. territories (for at least 183 days during the year) are deemed to have minimum essential coverage
- Members of recognized Native American Tribes; other Native Americans can apply for a hardship exemption
- Religious exemption (certain faiths). Those exempt due to religious reasons must be members of a recognized religious sect exempt from self-employment taxes and who adhere to tenets of the sect. (e.g., Amish)
- Members of a Health Care Sharing Ministry (HCSM) that has been continuously in existence since December 31, 1999
- Incarcerated individuals, other than incarceration pending the disposition of charges
- Individuals not lawfully present (illegal aliens)
- For 2014, individuals who enroll in the health marketplace between February 16 and March 31, 2014, as described in a CMS FAQ even though they will exceed the allowable three month coverage gap
- For 2014 - 2016, a person whose individual policy was cancelled and who cannot find reasonably priced marketplace coverage
- Any other hardship described in IRS Notice 2014-76 or as allowed by HHS under its November 21, 2014 guidance.

Proposed rules for Eligibility for the Individual Mandate Exemption describing how to claim an exemption were published February 1, 2013, and fine-tuned in an HHS final rule published July 1, 2013.

The exchange will issue an exemption certificate to individuals who can demonstrate they are eligible for the hardship or the religious conscience exemption. The exemption for falling below the tax filing threshold, lack of affordable coverage, going without coverage for less than three months, or not being lawfully in the U.S. may only be claimed at tax filing time. The exemption for being part of an HCSM, a Native American tribe, or being incarcerated may be obtained through the exchange or at tax time. The exchange will copy the IRS on any exemption.

Hardship exemptions are available to individuals in states that declined to expand Medicaid, up to 133% of the Federal Poverty Level.

For purposes of the federally facilitated exchanges (FFEs), a hardship exemption will be available if:

- The person experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan
- The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing, or other necessities
- The person experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan

This includes homelessness, eviction that is imminent or occurred within the last six months, utility shut-offs, domestic violence, flood, fire or other significant damage to the person's property, bankruptcy, significant unreimbursed medical expenses within the past 24 months, and delays in implementing a QMCSO.

See these Proposed Rules and CMS Guidance for details.

The hardship application forms are on the healthcare.gov website.

Form 8965 is now available. Individuals claiming a hardship exemption based on unaffordability may use this calculator to determine the cost of the least expensive bronze plan available to them.

Verification and Enforcement

Effective January 1, 2014

Not later than June 30 of any year, the IRS, in consultation with HHS, is required to send a notification to each individual who files an income tax return and who is not enrolled in minimum essential coverage. Notification will include information on services available through the state exchange.

A penalty is assessed through the tax code and counted as an additional amount of federal tax owed.

Criminal and civil penalties are waived for any failure to pay the tax penalty. In addition, Treasury shall not file notice of lien or levy with respect to any property of a taxpayer.

Forms 1040, 1040-A and 1040-EZ have added a "yes/no" box for the employee to check if they, and all dependents, had full-year minimum essential (basic medical) coverage. Individuals will not be required to attach proof of coverage in 2014. Individuals who did not have the needed coverage for the entire year must use Form 8965 to claim an exemption or determine their penalty (which is determined on a month-by-month basis). The IRS has issued a Notice stating that for 2014 it will waive penalties for underpayment of estimated taxes and late payment of taxes if the taxpayer owes additional taxes after the reconciliation process.

Individual Subsidies

Premium Assistance Tax Credits – Eligibility (for Lower Income Individuals Purchasing Coverage via an Exchange)

Effective for tax years beginning on or after January 1, 2014

Individuals with household modified adjusted gross incomes (AGI) of at least 100% and not exceeding 400% of the Federal Poverty Level (FPL) may purchase subsidized coverage in the Individual health insurance exchanges (not the SHOP exchanges) if:

- They (including any eligible dependents of the employee) are not enrolled in employer or government group coverage (Note: the Individual Shared Responsibility final rules clarify that a self-insured employer group health plan can be considered minimum essential coverage) and
- They do not have access to employer-based coverage that
  - pays at least 60% of covered medical costs *and*
  - is priced to the individual at 9.5% (9.56% in 2015, 9.66% in 2016) or less of the individual's household income (indexed to 9.56% for 2015 and to 9.66% for 2016)

The individual must:

- Be a U.S. citizen or national, or an alien *lawfully* present in the U.S., likely to be present for the entire period of enrollment for which the tax credit is sought
- Not be incarcerated at the time of enrollment (other than incarcerated pending disposition of charges)
- Not be eligible to be claimed as another taxpayer's dependent
- File a tax return (Note: All individuals who receive premium tax credits must file an income tax return, even if the individual would generally be exempt from filing due to low gross income.)
- Seek to enroll in a qualified plan in the individual market offered through an exchange

Married couples must file joint tax return in order to be eligible for premium subsidies although the IRS has granted a limited exception for those who are married but do not file jointly because of domestic abuse.

An individual who has the opportunity to enroll in minimum essential coverage through an affordable employer-sponsored group health plan that meets the minimum value requirements for coverage generally will *not* be eligible for the premium tax credit, *regardless of whether the individual actually enrolls in such employer-sponsored group health coverage. Except:* an individual must actually enroll in COBRA coverage in order to be considered eligible for minimum essential coverage under an employer group health plan.

Employer-sponsored coverage will be treated as affordable if an individual *actually enrolls in such coverage, even if the coverage does not meet affordability and minimum value requirements.*

When determining the affordability of coverage for a spouse or dependent under an employer group health plan, the test for premium tax credit eligibility is based on the cost of *self-only* coverage. Therefore, a spouse or child who is eligible for coverage through the employee's employer will not be eligible for the premium tax credit, even if the employer makes no, or a minimal, contribution toward family coverage. This was clarified in final regulations published February 1, 2013:

However, *for purposes of the individual mandate*, affordability will be based on the cost of *family* coverage.

Affordability safe harbors:

- The exchange determines whether an individual is eligible for the premium tax credit at the time of enrollment in coverage purchased through the exchange.
- An employer-sponsored group health plan is evaluated at the time of enrollment, and a plan that is then determined to be unaffordable is treated as unaffordable for the whole plan year.

No income tax deduction is allowed for the portion of premiums received as a premium subsidy.

Premium assistance tax credits are **not** included in a recipient's income for purposes of determining eligibility for any federal program or under any state or local program financed with federal funds.

The IRS would be responsible for determining eligibility for the tax credit (also called the premium subsidy).

Federal Poverty Levels

	2013		2014		2015		2016	
	100% FPL	400% FPL	100% FPL	400% FPL	100% FPL	400% FPL	100% FPL	400% FPL
Individual	$11,490	$45,690	$11,670	$46,680	$11,770	$47,080	$11,880	$47,520
Family of four	$23,550	$94,200	$23,850	$95,400	$24,250	$97,000	$24,300	$97,200

Note: These amounts differ based on family size. Different figures apply in Alaska and Hawaii. Current and prior FPL figures can be found on the HHS website at http://aspe.hhs.gov/poverty/index.cfm. The premium tax credit reduces as income approaches 400% of FPL.

Individuals *ineligible* to receive subsidies:

- Illegal immigrants
- Individuals incarcerated at the time of enrollment (other than incarceration pending disposition of charges)
- Generally, those *eligible* for minimum "essential" coverage under:
  - Employer-sponsored plans
  - Grandfathered plans
  - Medicare
  - Medicaid
  - CHIP
  - TRICARE
  - VA
  - Other coverage deemed acceptable by HHS

- Non-aged citizens and legal permanent residents at or below 100% of FPL (effectively this is 133% of FPL in states that have adopted expanded Medicaid)

In Notice 2013-41 the IRS clarified that:

- An individual terminated from Medicaid or CHIP is not eligible for the subsidy during any lock-out period or period for which coverage would have been provided if the premium had been paid
- An individual is eligible for the subsidy during any CHIP waiting period
- An individual will not be considered eligible for government coverage (and therefore remains subsidy-eligible) while waiting for a determination of Medicare or Medicaid eligibility based on disability, illness or blindness
- An individual will not be considered eligible for government coverage (and therefore remains subsidy-eligible) until he actual enrolls in Medicare Part A, a state high risk pool, a student health plan or TRICARE

A qualified plan is a certified plan that:

- Is recognized by each exchange through which it is offered
- Provides an essential benefits package
- Is offered by an issuer that offers at least one Silver plan and one Gold plan in each exchange

CMS is allowing limited retroactivity for subsidy eligibility to individuals who were not able to enroll in exchange coverage because of the exchange's technical problems.

Eligible individuals can use the premium credit (*which is tied to Silver Plan coverage and only in the individual market*) for any level of coverage inside exchange, *except* catastrophic plans.

See Appendix 11: Income Levels for Various FPSs and Numbers of People

Note: The IRS published final regulations addressing various aspects of the premium tax credit enacted as part of health care reform on May 23, 2012. The final regulations address a number of technical issues affecting eligibility for and calculation of the tax credit. Here are some highlights of significance for employer-sponsored plans:

- Guidance on determining tax credit eligibility
  - As a general rule, if an eligible employer-sponsored plan meets the two conditions (affordability and minimum value) merely being eligible for the plan will make an employee ineligible for the tax credit.
  - The regulations clarify that an eligible employee who declines enrollment in such a plan remains ineligible for the tax credit for each month in the coverage period related to the enrollment period (e.g., for the full plan year in the case of an annual enrollment period).
  - As a corollary to the general rule, if an employee actually enrolls in an eligible employer-sponsored plan, the tax credit is not available—even if the plan does not meet the two conditions.
  - If employees are automatically enrolled in an eligible employer-sponsored plan, they have a grace period to unwind the enrollment to maintain their eligibility for the tax credit.
  - An employee is not considered eligible for minimum essential coverage (i.e., may qualify for the tax credit) during any required waiting period before coverage becomes effective under an eligible employer-sponsored plan. An employer would not have to pay the shared responsibility tax penalty for failing to offer coverage for

the first three months after an employee's hire date (or during the entire measurement period for a variable hours employee).

- Guidance on determining affordability
  - Under the law, the determination of whether a plan is affordable is based on the cost of self-only coverage.
  - Reiterating the statute, the regulations state that employer-sponsored coverage is considered unaffordable if the employee's cost for self-only coverage exceeds 9.5% (9.56% in 2015, 9.66% in 2016) Indexed) of the employee's household income for the taxable year. (In Notice 2012-17, the IRS stated its intention to issue proposed regulations or other guidance that would allow employers to use an employee's Form W-2 earnings (instead of household income) in assessing affordability).
  - Employer contributions to a health savings account (HSA) do not affect the affordability calculation since HSAs cannot be used by employees to pay premiums for employer-sponsored health coverage.
  - The preamble indicates that health reimbursement arrangement (HRA) contributions that may be used exclusively to reimburse medical expenses would not affect the affordability of employer-sponsored coverage.
  - The regulations do not address how HRA contributions that can be used to offset the employee's cost of coverage may affect affordability.

See the full text of the Final Regulations on the Health Insurance Premium Tax Credit

On July 15, 2013, final regulations were issued that include rules addressing verification of an individual's eligibility for employer-sponsored health plan coverage and the procedures for an employer to dispute whether an individual is eligible for coverage under the health insurance exchanges. For more information, see:

- Final Rules for Eligibility and Enrollment
- Final Rules for Eligibility Appeals

An individual seeking eligibility for advance payment of the premium tax credit must provide the exchange certain information regarding his access to qualifying coverage in an employer-sponsored plan, including:

- The employer's contact information and employer identification number
- Whether the individual is employed on a full-time basis
- Whether the individual's employer provides minimum essential coverage and, if so, the required employee contribution for the lowest-cost plan offered by the employer

The exchanges can rely on methods that include HHS-approved electronic data sources (including any state-based data sources, for example, relating to a state CHIP). If an exchange cannot obtain information regarding enrollment in, and eligibility for, employer-sponsored coverage, beginning in 2015 it must undertake a random sampling process that includes:

- Informing an individual that it will contact any employer identified on the employee's application
- Making reasonable efforts to contact the employer to verify whether the individual is enrolled in an employer-sponsored plan or is eligible for qualifying plan coverage

In September 2015, CMS issued an FAQ on the implementation of a more robust employer notice program. Beginning in 2016 the Federally Facilitated Marketplaces will notify certain employers whose employees enrolled in Marketplace coverage with the advance premium tax credit.

The regulations also include an appeals process under which employers can dispute a determination that either the employer:

- Does not provide minimum essential coverage under its plan
- Provides minimum essential coverage, but that coverage is not affordable with respect to the employee identified in the notice from the exchange addressing the employer's potential tax liability

Under the appeals procedures, employers must be allowed to:

- Request an appeal within 90 days from the date the notice to the employer informing it of an employee's eligibility for advance payment of the premium tax credit or cost-sharing reductions is sent
- Submit relevant evidence to support an appeal request, for example, information addressing whether:
  - an employee is actually employed by the employer;
  - coverage is offered by the employer; or
  - the employee has taken this coverage.

The application form is available on the healthcare.gov website.

On July 1, 2014, HHS issued a Proposed Rule that provides that if an individual who is receiving a subsidy has authorized the exchange to get updated tax information from the IRS before 2015 exchange open enrollment begins the person will receive a notice providing the open enrollment dates, reminding them they need to notify the exchange within 30 days after eligibility or income information changes, explaining the subsidy reconciliation process and stating that their subsidy level will remain the same for 2015 unless the person notifies the exchange their situation has changed. Variations of this notice will be sent to those who have not authorized release of tax information or whose income was close to the subsidy maximum during the prior year. State exchanges may, but are not required to, follow this procedure.

Premium Assistance Tax Credits – Credit Amount

Effective for tax years beginning on or after January 1, 2014

“Annual credit" is the sum of "monthly credits" for each month a credit-eligible individual begins the month enrolled in qualifying exchange-based coverage.

"Monthly credit" is *lesser* of:

- Total monthly premium for an exchange-based plan covering the employee, spouse, or dependent who is enrolled through an exchange
- The amount by which the "Adjusted Monthly Premium" available to the employee through the exchange ***exceeds*** 1/12th of the employee's household income for the year multiplied by the employee’s "applicable percentage"

"Adjusted monthly premium" is the *age-adjusted* premium the employee would pay for the second least expensive *Silver Plan* (“benchmark plan”) for himself or any family member enrolled in the exchange plan, less the premium cost for benefits judged non-essential benefits.

Note: The regulations describe procedures for determining the applicable benchmark plan and for calculating the premium tax credit when family members enroll in different exchange plans. See the full text of the regulations as amended in the final rule on Benefit and Payment Parameters.

CMS has provided a calculator that individuals may use to find the premium for the second least expensive silver plan in their area.

"Applicable percentage" is based on the following table (a sliding scale applies in a linear manner, rounded to the nearest one-hundredth of one per cent between the minimum and maximum percentage):

	2014		2015		2016	
Household income as a percent of FPL	**Minimum**	**Maximum**	**Minimum**	**Maximum**	**Minimum**	**Maximum**
Less than 133%	2.0%	2.0%	2.01%	2.01%	2.03%	2.03%
At least 133% but less than 150%	3.0%	4.0%	3.02%	4.02%	3.05%	4.07%
At least 150% but less than 200%	4.0%	6.3%	4.02%	6.34%	4.07%	6.41%
At least 200% but less than 250%	6.3%	8.05%	6.34%	8.10%	6.41%	8.18%
At least 250% but less than 300%	8.05%	9.5%	8.10%	9.56%	8.18%	9.66%
At least 300% but not more than 400%	9.5%	9.5%	9.56%	9.56%	9.66%	9.66%

The applicable percentage multiplied by the person's household income determines his required share of premiums for the benchmark plan.

Household income includes the income of all taxpayers in the household (e.g., employed adult children).

If any individual for whom the taxpayer can claim a personal exemption is an *undocumented alien*, the taxpayer's household income is reduced proportionately.

If a state is participating in a wellness discount pilot project, the premium, for purposes of determining the tax credit, is determined without regard to any of the discounts for this pilot program.

In the case of individuals enrolling in both a qualified health plan and a stand-alone plan providing for pediatric dental coverage (as part of the "essential health benefits" package), amounts allocable to pediatric dental coverage will be included in the premium for calculating the premium tax credit, under regulations prescribed by HHS.

Indexing of percentage of income caps:

- Starting in 2015, the percentages of income caps are adjusted to reflect the excess rate of premium growth over the rate of income growth for the preceding year. The net effect is that the income caps are expected to increase if premiums grow faster than the rate of income growth.
- Starting in 2019, a "fail-safe mechanism" is applied if the aggregate amount of premium tax credits and cost-sharing reductions exceeds 0.504% of gross domestic product (GDP) for the preceding year. This mechanism, if

applied, further adjusts income caps to reflect the excess rate of premium growth over growth in the consumer price index (CPI) for the preceding year.

See Appendix 12: Premium Tax Credit Table

See Appendix 13: Illustrative Silver Plan Premiums and Maximum Out-of-Pocket Payments

Special rules apply to self-employed individuals who are eligible for a premium subsidy. They are described in Rev. Proc. 2014-41. Rules for splitting the credit in cases of divorce and similar situations are described in an IRS rule.

Premium Assistance Tax Credits – Advance Payment

Effective for tax years beginning on or after January 1, 2014

The premium tax credit (or a portion thereof) may be paid directly and in advance to the insurer by Treasury to cover a portion of monthly insurance premiums.

Should this advance payment exceed the premium tax credit allowed, the applicable taxpayer may be assessed the excess as additional tax for the year, subject to a maximum.

Reconciling the credit and advance credit payments:

- The premium credit is computed using the household income and family size for the taxable year, but premium assistance amounts for different coverage months may be based on different benchmark plans depending on the taxpayer's family size. This means, for example, that the amount of the credit that should be provided to a taxpayer may change in the middle of a tax year in the event of a marriage, divorce or other change in income tax filing status.
- Thus, the regulations provide rules for reconciling the credits actually provided for a tax year with the amount of the credit that should have been available to the taxpayer. The repayment amount is capped based on the taxpayer's household income. The repayment amount cap is $300 if filing single and $600 if filing other than single if household income is less than 200% of FPL, $750 single / $1,500 other than single if income is 200% to 300% of FPL, and $1250 single / $2,500 other than single if income is 300% to 400% of FPL.

See Health Insurance Premium Tax Credit - Final Rule, and

Health Insurance Premium Tax Credit Eligibility for Dependents – Final Rule, released February 1, 2013

Reconciliation of the subsidy received and the subsidy the taxpayer is entitled to will occur as part of filing the individual's federal income tax return. Individuals will file form 8962 to calculate the premium tax credit they are entitled to and to reconcile that amount with any tax credits received during the year. The IRS issued a draft of Form 8962, which will be used for this process, on July 24, 2014. The Marketplace will provide a Form 1095-A which will include information needed to complete the Form 8962. HHS has provided an FAQ and the IRS has provided Publication 5187 to assist with these requirements. Insurers must reflect payment on the member's bill and notify the exchange and HHS of such reduction.

The exchanges must provide *extensive* information to the IRS and each enrolled individual. Proposed regulations were issued July 2, 2013, that would require the exchange to report to the IRS by January 31 each year on form 1095-A:

- Name, address, and tax ID number (TIN) of enrollee, and spouse, of each person determined eligible for the subsidy
- Name, address, and TIN of each adult enrolled in the exchange not receiving a subsidy
- Name and dates of coverage for each person enrolled under the plan

- Monthly premium for the benchmark plan used to determine the subsidy
- The amount of the subsidy
- Identifying information about the plan

A copy of the annual report must be provided to the taxpayer.

By the fifteenth of each month the exchange must report to HHS:

- Whether enrollees are the taxpayer's dependents
- If available, the name, address and TIN of the employer
- Whether the employer offered minimum essential coverage, whether the coverage was minimum value, and the cost of single coverage
- Name and TIN of exempt individuals

See the Proposed final regulation for reporting of premium tax credit

Grace Period for Non-Payment

Grants subsidy-eligible individuals failing to pay any remaining premiums a three-month mandatory grace period prior to any termination of a policy by an insurer. If the premium is not paid, the insurer is not responsible for claims incurred during the second and third months of the grace period.

Insurer shall also notify HHS of any nonpayment.

Effective for tax years beginning on or after January 1, 2014

Plan Design Cost-Sharing Reductions for Exchange Plans

Individuals with household modified adjusted gross incomes (AGI) in excess of 100% but not exceeding 400% of the Federal Poverty Level (FPL) may be eligible for cost-sharing reductions for *coverage purchased through health insurance exchanges* ***if***:

- The individual is:
  - A U.S. citizen or national of the U.S., likely to be present for the entire period of enrollment for which the tax credit is sought
  - An alien lawfully present in the U.S. likely to be present for the entire period of enrollment for which the tax credit is sought
  - Not incarcerated at the time of enrollment (other than incarcerated pending disposition of charges)
  - Not eligible to be claimed as another taxpayer's dependent
- The individual is enrolled in a Silver plan in the individual market

A special rule applies to those aliens lawfully present in the U.S. with household incomes that do not exceed 100% FPL but who are not Medicaid eligible. These individuals are treated as eligible for exchange-based subsidies with household income of 100% of FPL for the applicable family size.

Effective for tax years beginning on or after January 1, 2014

Federal Poverty Levels

	2012		2013		2014		2015		2016	
	100% FPL	400% FPL	100% FPL	400% FPL	100% FPL	400% FPL	100% FPL	400% FPL	100% FPL	400% FPL
Individual	$11,170	$44,680	$11,490	$45,960	$11,670	$46,680	$11,770	$47,080	$11,880	$47,520
Family of four	$23,050	$92,200	$23,550	$94,200	$23,850	$95,400	$24,250	$97,000	$24,300	$97,200

Cost-sharing reductions are limited to coverage months for which the individual is allowed a premium tax credit. *Eligibility* for cost-sharing reductions is based on the tax year for which advanced eligibility determinations are made by HHS, rather than the tax year for which premium credits are allowed.

Cost-sharing subsides reduce out-of-pocket (OOP) limits ($5,950 for individuals; $11,900 for families in 2010; $6,250 for individuals and $12,500 for families in 2013; $6,350 for individuals and $12,700 for families in 2014):

- Less than 100% but not exceeding 200% of FPL: OOP limits reduced by two-thirds
- Greater than 200% but not exceeding 300% FPL: OOP limits reduced by one-half
- Greater than 300% but not exceeding 400% FPL: OOP limits reduced by one-third

For 2015 and later years, the OOP limits will be adjusted based on a percentage of average per capita health insurance premium increases. The limit for family coverage will be twice that of self-only coverage.

HHS will adjust OOP limits, if necessary, to ensure reduced OOP limits do not result in actuarial values (AV) that exceed the following AV limits:

Household income as a percent of FPL	Plan cost-sharing subsidy results in coverage of % of plan's benefits
100% - 150%	94%
> 150% - 200%	87%
> 200% - 250%	73%
> 250% - 400%	70%

"Household income" means gross income of the employee plus gross income of other family members for whom the employee takes the tax exemption, and who were required to file a tax return for the year.

Under the final rule for Benefit and Payment Parameters, if a household includes multiple taxpayers, the cost-sharing available based upon the highest income will determine the cost sharing percentage. Also, the cost-sharing reduction must be available at the point of service.

No cost-sharing is available for Native Americans with household income 300% or less of FPL enrolled in individual market coverage through an exchange.

Benefits offered, including any state-mandated benefits, in addition to the required "essential health benefits," are excluded from any cost-sharing reductions.

In the case of individuals enrolled in both a qualified health plan and a stand-alone dental plan, cost-sharing reductions do not apply to the portion of premiums that, under regulations prescribed by HHS, are properly allocable to pediatric dental benefits.

The cost of reductions will be paid to issuers by the federal government.

Cost-sharing reductions are **not** included in a recipient's income for purposes of determining eligibility for any federal program or under any state or local program financed with federal funds.

If a QHP or exchange incorrectly determines a cost-sharing subsidy or misapplies an advance tax credit and the error has caused the individual to overpay, the QHP or exchange must reimburse the person (through a credit against future amounts owed). If the error results in the person underpaying, the QHP or exchange must absorb the error.

Plan Design Cost-Sharing Payment

HHS shall notify insurers if an enrollee in a qualified health plan is eligible for cost-sharing reductions. Insurers shall then notify HHS of any cost-sharing reductions and HHS will make periodic and timely payments to plans.

HHS may establish a capitated payment system to take into account the cost-sharing subsidies with appropriate risk adjustments.

Effective for tax years beginning on or after January 1, 2014

Tax Credits Tied to Exchange

Premium tax credits and cost-sharing subsidies are tied exclusively to coverage purchased through the public exchange.

The IRS has issued a regulation that provides that individuals are eligible for tax credits and subsidies regardless of whether they purchase coverage though a state-run or federally-facilitated exchange. This interpretation has been challenged and courts have issued conflicting decisions, in Pruitt v. Burwell, *King v. Burwell* and *Halbig v. Burwell*. All of the decisions are on hold while they are appealed. While the cases were pending the IRS issued a statement confirming that during litigation, premium tax credits remain available through both the state and federally run exchanges.

In June 2015 the Supreme Court held that the IRS may issue regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under the ACA.

Effective for tax years beginning on or after January 1, 2014

Advance Determination and Payments

HHS shall establish a program for determining eligibility and amount for premium tax credits and cost-sharing subsidies, to be made during the individual's annual open enrollment period.

Application for Health Coverage & Help Paying Costs (Short Form)

Application for Health Coverage & Help Paying Costs

In most cases, advance determination is based on the latest tax return (2012 for 2014). Taxpayer advance payments are later reconciled on the applicable year's tax return.

In case of excess advance payments, the taxpayer's tax liability increases by the amount of any excess payment made by the federal government.

Effective for tax years beginning on or after January 1, 2014

Revenue Provisions That Affect Employers

Definition of Qualified Medical Expenses

Changes the definition of medical expense for purposes of employer-provided health coverage (including reimbursements under employer-sponsored health plans, HRAs, health FSAs, HSAs, and Archer MSAs) to the definition for purposes of the itemized deduction for medical expenses.

An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Effective January 1, 2011, regardless of whether or not a claim incurred prior was filed during the grace period which ended on or after January 1.

Effective January 1, 2011

OTC Drug Exclusion from Account-Based Plans

Account-based plans (health FSAs, HRAs, HSAs, Archer MSAs, and other Section 105 plans) cannot provide non-taxable reimbursements of over-the-counter (OTC) medications unless the over-the-counter medications are prescribed by a doctor.

In addition, after January 1, 2015, prescribed over-the-counter medicines and drugs purchased with health FSA or HRA debit cards may not be used unless the purchase is accompanied by a receipt noting the name, date, amount, and either the prescription number or a copy of the prescription.

Prescribed medicines and drugs, insulin (whether prescribed or not), and qualified medical devices, supplies, or equipment still qualify for non-taxable reimbursements from those accounts.

Note: The IRS has ruled that after January 15, 2011, FSA and HRA debit cards *may* continue to be used to purchase OTC medicines or drugs at drug stores, pharmacies, non-health care merchants that have pharmacies, mail order, web-based vendors, “90 percent pharmacies,” and non-prescription drug vendors having health care related “merchant codes” *if prior to purchase*:

- The prescription is presented
- A prescription number is assigned
- The prescription drug vendor retains:
  - a record of the prescription number (except in the case of a non-prescription drug vendor having a health care-related “merchant code”)
  - the name of the purchaser or the name of the person to whom the prescription applies
  - the purchase date
  - the dollar amount of the purchase

Applies to expenses incurred on or after January 1, 2011

Tax on Group Health Plans to Fund Comparative Effectiveness Research (PCORI)

Comparative Effectiveness Research (CER) is conducted, synthesized, and reported by the Patient-Centered Outcomes Research (PCOR) Institute. The Institute's activities are funded by the PCOR Trust Fund, which collects a tax of:

- For plan or policy years ending prior to October 1, 2013: $1 multiplied by the average number of lives covered under each health insurance policy or self-insured health plan
- In fiscal year 2014: $2 multiplied by the average number of lives covered
- In fiscal years 2015 to 2019: $2 adjusted for increases in projected per capita health care spending. For years ending October 1. 2014 through September 30, 2015 the indexed fee is $2.08

Note: Since fees are based on covered lives, an incentive exists for insurers and self-funded plans to bundle benefits into a single plan.

A final regulation was published December 6, 2012: Fees for the Patient-Centered Outcomes Research Trust Fund

- Affected policies and plans
  - The fees paid by insurers generally apply to any accident or health insurance policy issued on U.S. residents (determined by address in employer's records).
  - The fees paid by self-insured plan sponsors generally apply to plans established or maintained by an employer or employee organization (or by certain other entities, including voluntary employees' beneficiary associations (VEBAs)) that provide health or accident coverage, so long as any portion of that coverage is not provided through an insurance policy.
  - No exclusion is provided for retiree-only plans.
  - The fee applies to government plans.
- Excluded policies and plans
  - Policies and plans are not subject to the fees if they cover only excepted benefits (e.g., a standalone dental or vision plan).
  - Also exempt are EAPs, disease-management programs, and wellness programs if they do not provide significant benefits in the nature of medical care or treatment.
- Payment process and timing
  - The Insurer is responsible for paying the fee on fully insured policies and the plan sponsor is responsible for the fee on self-funded plans.
  - PCOR fees are to be reported and paid once a year by the plan sponsor, even though they are reported on IRS Form 720 (Quarterly Federal Excise Tax Return).
  - Reports and payments for policy and plan years that end in a calendar year are generally due by July 31 of the following year.
  - Comment: While the amount of the PCOR fee is, by itself, unlikely to drive plan design, it is one more factor to be taken into account. It may be most significant with respect to health FSAs (if the employer contributes) and

First policy years ending on or after October 1, 2012

No longer applies to policy years ending after September 30, 2019.

HRAs, since failing to adequately integrate one of these account-based plans with a sponsor's self-insured major medical coverage (or to restrict the plan to excepted benefits) will result in an increased total fee. (An HRA integrated with insured coverage will result in the plan sponsor paying the fee on the HRA – note that the HRA fee will not count dependents – and the insurer paying the fee on the medical policy on both the employee and covered dependents.)

- Definition of self-insured plan sponsor
  - Controlled group rules do not apply to PCOR fees. Consequently, if a plan is maintained by more than one employer, each employer that maintains the plan will generally be responsible for filing and paying its portion of the fees.
  - This result may be avoided if – before reporting and payment is due – an employer is designated in the plan document as sponsor, or designated as plan sponsor for purposes of the PCOR fee rules.
  - In a collectively bargained setting, both the multiemployer plan and the employer may owe the fee, because of this definition.
- Multiple self-insured arrangements
  - If the same plan sponsor maintains more than one arrangement that provides self-insured accident or health coverage -- e.g., if the sponsor maintains an HRA or health FSA in addition to major medical coverage -- the arrangements can be treated as a single self-insured health plan if the arrangements have the same plan year.
- Combined fully insured and self-funded arrangements
  - The plan sponsor must file on behalf of all self-funded plans.
  - Individuals covered *solely* by a fully insured option are excluded from this reporting by the employer (they will be reported by the insurer).
- Average number of lives covered

  For self-insured plans, any one of three methods may be used to determine the average number of lives covered:
  - An "actual count method" that takes into account the lives covered on each day during the plan year
  - A "snapshot method" based on the lives covered on one day during each quarter of the plan year (the snapshot method permits the number of lives covered by family coverage to be estimated by multiplying the number of participants by 2.35). The employer may measure more frequently than quarterly, however the employer must measure as of the same day each period, plus or minus three days (e.g., if the measurement is as of January 1, the April measurement must be between April 1 and April 7).
  - A "Form 5500 method" based on the number of participants as of the beginning and end of the plan year as reported on Form 5500 (under the Form 5500 method, the total number of lives is determined by simply adding the participant counts at the beginning and end of the year). The Form 5500 method may not be used for a year if the employer has not filed Form 5500 by the filing due date (i.e., by July 31).

Insurers cannot use the Form 5500 method, but they can use the actual count and snapshot methods as well as two other methods based on information reported to the NAIC or state regulators.

For health FSA and HRA coverage that is not disregarded under the rule for multiple self-insured arrangements (or because it offers only excepted benefits), each participant can be treated as a single life, regardless of how many other individuals (e.g., spouse, dependents, and other beneficiaries) are actually covered.

Must count retirees and COBRA participants.

FSA Contribution Limits and Carryover

Applies to taxable years beginning on or after January 1, 2013

Health FSAs that are part of a cafeteria plan must limit employees' salary reduction contributions for medical expenses to $2,500 annually.

- The $2,500 limit is subject to a cost of living adjustment for taxable years beginning January 1, 2014.
- Increases not a multiple of $50 must be rounded to the next lowest multiple of $50.
- The limit for 2015 is $2,550.

Note: In Notice 2012-40 issued on May 30, 2012, the IRS provided regulatory relief for health FSA participants and also said it is reconsidering its longtime use-it-or-lose-it rule for FSAs.

- **Plan year basis.** The $2,500 limit applies on a plan year basis and is effective for cafeteria plan years beginning after December 31, 2012. In the case of a short plan year, the limit must be prorated. The limit is indexed for cost-of-living adjustments for plan years beginning after December 31, 2013. Participants in non-calendar-year plans can still make the maximum contributions to their FSAs during the first year that a mandated FSA contribution cutback goes into effect under the health care reform law.
- **Only salary reductions count.** Non-elective employer contributions to a health FSA generally do not count toward the limit. However, if employees may elect to receive the employer contributions in cash or as a taxable benefit, then the contributions will be treated as salary reductions and will count toward the limit if contributed to the health FSA.
- **Per-employee limit.** The limit applies on a per-employee basis, regardless of how many other individuals' medical expenses are reimbursable under the employee's health FSA (e.g., a spouse or other family members). If spouses are each eligible to make health FSA salary reductions, then each spouse can make health FSA salary reductions up to the limit, even if they have the same employer and participate in the same health FSA.
- **Multiple health FSAs.** If an employee participates in multiple health FSAs maintained by members of a controlled group or affiliated service group, then salary reductions to the health FSAs are aggregated and a single $2,500 limit applies. In contrast, if the employers are not related, then the employee may make salary reductions of up to $2,500 under each health FSA.
- **Other benefits.** The $2,500 limit does not apply to contributions for other cafeteria plan benefits (such as salary reductions for the employee's share of health coverage premiums, DCAPs, or HSAs), or to amounts made available by an employer under an HRA.
- **Grace periods.** If a grace period is provided (in which unused balances from the prior plan year can be used to pay expenses that are incurred during the first 2.5 months of the next plan year), unused salary reductions that are carried over for use during the grace period will count toward the limit only in the plan year for which they were made; they do not count toward the limit for the subsequent plan year.

- **Correction of excess contributions.** A cafeteria plan that fails to comply with the limit will lose its tax-advantaged status. However, relief is provided for certain situations where employees are erroneously allowed to exceed the limit, if the excess contributions result from a reasonable mistake by the employer and are refunded to affected employees and reported as wages by a specified date.
- **Plan amendments.** Cafeteria plan documents must be amended to reflect the $2,500 limit. Cafeteria plan sponsors have until December 31, 2014 to amend their plans to conform to the new requirements, so long as the amendment is effective retroactively and the plan operates in compliance for plan years beginning after December 31, 2012.

In Notice 2013-71 the IRS has allowed individuals to carry over up to $500 of unused health FSA contributions to the following year. A plan may have carryover or a grace period, but not both. A plan generally must be amended by the last day of the plan year from which carryovers will first be allowed, but plans that allow carryover of 2013 contributions are not required to amend until the last day of the 2014 plan year. In a Chief Counsel Memorandum the IRS has stated that while any access to dollars in a general purpose health care FSA will make the employee ineligible to contribute to the HSA for the entire year (even once carryover amounts have been spent), an employee may contribute to an HSA despite access to health care FSA carryover if any of these are met:

- The plan is designed so that unused amounts in a general purpose health care FSA are automatically carried over to a limited purpose FSA for all employees enrolled in HDHPs linked to an HSA
- The employee enrolls in a limited purpose FSA and elects to have unused monies from the prior year's general purpose FSA carried over to a limited purpose health care FSA
- The plan allows participants to decline carryover and the employee declines the carryover option by the end of the year for which carryover is available
- Carryover amounts are not considered employer contributions when determining if the health FSA qualifies as an excepted benefit

Increased Medicare Health Insurance Tax on High-Income Individuals

Effective for taxable years beginning on or after January 1, 2013

An additional 0.9% Medicare Hospital Insurance (HI) tax is imposed on every taxpayer (other than a corporation, estate, or trust) with respect to earnings and wages received during the year:

- Above $200,000 for individuals
- Above $250,000 for joint filers
- Above $125,000 for married taxpayers filing separately

These earnings and wages thresholds are *not* indexed for inflation.

There is no change to the employer HI tax, which remains at 1.45%.

For purposes of the employer's withholding obligation, only wages that the employee receives in excess of $200,000 are taken into account.

- The employer must disregard the amount of wages received by the employee's spouse.
- The additional withholding begins in the pay period in which the employee reaches $200,000 for the year.

- All wages normally subject to Medicare withholding are subject to the additional tax (such as non-qualified deferred compensation (NQDC) and imputed income).

If the employer does not withhold the tax, the employee must pay the tax, but an employer is not relieved of penalties or additions to tax applicable to its failure to deduct and withhold any amount subject to employer withholding.

For a self-employed individual, the threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the FICA tax for that individual. Self-employed individuals are not permitted to deduct any portion of the additional tax.

If a taxpayer has both wages and self-employment income, those amounts are combined.

The additional amount withheld for AMT will be reported with other Medicare withholding in Box 6 of the W-2.

The AMT withheld will be reported on a new line 5d on Form 941, 941-PR or 941-SS. "Regular" Medicare tax should be reported on line 5c.

The IRS published Final Regulations on November 29, 2013 and a comprehensive, updated FAQ for the Additional Medicare Tax on December 2, 2013.

Repeal of Employer Business Deduction for Qualified Retiree Drug Programs

Eliminates the tax exclusion for subsidy payments made when employers offer retiree prescription drug coverage that is as good as or better than Medicare Part D.

Applies to taxable years beginning on or after January 1, 2013

The employer deduction for prescription drug claims will be reduced by the retiree drug subsidy (RDS) amount payable to the employer. The subsidy in 2010 was equal to 28% of actual plan costs in excess of $310 and not exceeding $6,300.

FAS109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability. Under ASC 740, the expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income from continuing operations for the period that includes the enactment date.

Therefore, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law may not be effective until later years.

Tax on High-Cost Insurance Plans – Tax, Type of Plans, and Thresholds

The tax on high-cost insurance plans is commonly referred to as the "Cadillac tax." In February 2015 the IRS began to "initiate and inform" the public on the process of developing regulations on the excise tax on high cost employer sponsored health coverage. In December 2015, omnibus legislation was signed by President Obama that included a two year delay on the Cadillac tax, which will now go into effect on January 1, 2020.

Effective for taxable years beginning on or after January 1, 2018.

Effective date was delayed to January 1, 2020

Imposes excise tax of 40% on health insurers and self-insured plans on the aggregate value of:

- Employer-sponsored health coverage
- Self-employed individuals' coverage under a group health plan if a deduction is permitted for any or all of the coverage
- Government plans that are included are those primarily for civilian employees

The tax applies for an employee whose coverage has an aggregate value that exceeds:

- $10,200 for self only coverage
- $27,500 for other than self only coverage
- These amounts may be adjusted for excess cost growth between 2010 and 2018.

"Employee" includes former employees, surviving spouses, or other primary insured individuals.

Employer aggregation rules apply.

Employees and early retirees in multi-employer (union) plans will only be subject to the family thresholds.

Higher thresholds for apply for individuals who are:

- Receiving retiree coverage, age 55 and older, not eligible for Medicare; *or*
- Covered under employer-sponsored plans that have a majority of those covered engaged in certain high-risk professions (including retirees from a high-risk profession if the employees met the definition for a period of not less than 20 years during the employee's employment)

The increased limits are:

- $11,850 for self only coverage
- $30,950 for other than self only coverage

High risk professions mean:

- Law enforcement officers (as defined in 42 U.S.C. § 3796b)
- Employees in fire protection activities (as defined in 29 U.S.C. § 203(y))
- Individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders)
- Individuals whose primary work is longshore work (as defined in 8 U.S.C. § 1288(b), determined without regard to paragraph (2) thereof)
- Individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries
- Individuals employed to repair or install electrical or telecommunication lines

Thresholds are adjusted by a one-time adjustment in 2018 of:

- the percentage by which the per employee cost of a Blue Cross Blue Shield (BCBS) standard plan under the Federal Employees Health Benefits (FEHB) Program for plan year 2018 (determined using the benefit package for coverage in 2010) exceeds the cost for plan year 2010
- minus 55%
- plus 100%

Adding an age and gender adjustment percentage: Thresholds calculated with a health adjustment percentage are increased by the excess (if any) of:

- the premium cost of BCBS standard benefit plan under the FEHB Program for the type of coverage provided an individual in a taxable period, if priced for the age and gender characteristics of all employees of the individual's employer
- over that premium cost for the provision of coverage under this option in the taxable period if priced for the age and gender characteristics of the national workforce

All threshold amounts (including all adjustments) are indexed annually for inflation by:

- CPI-U plus 1% in 2019, rounded to the next nearest multiple of $50
- CPI-U for tax years beginning in 2020 and later, rounded to the nearest multiple of $50

On July 30, 2015, the agency released Notice 2015-52, the second of two informative notices, which addressed the IRS' thoughts on: (1) the definitions of applicable coverage; (2) the determination of the cost of applicable coverage; and (3) the application of the dollar limit on the cost of applicable coverage to determine any excess benefit subject to the excise tax. The IRS is seeking public comment on all of these issues, as well as:

- In order to compare the employer's premium cost with the national premium cost, the IRS is considering using the Current Population Survey, Employed Persons and Employment-Population Rations by Age and Sex, Seasonally Adjusted, published annually by the Department of Labor. The agencies request comment on whether this is an appropriate source of data.
- Seven different tables to facilitate and simplify calculations of age and gender adjustment
- Various issues surrounding the exclusion of amounts attributable to the excise tax

Tax on High-Cost Insurance Plans – Aggregate Value

Effective for taxable years beginning on or after January 1, 2018

Aggregate values of health plans will likely include:

- Employer or employee contributions to health flexible spending accounts;
- Employer or pre-tax employee contributions to Archer medical savings accounts;
- Employer or pre-tax employee contributions to health savings accounts;
- Plans maintained for civilian employees by the federal, state, or local governments;
- On-site medical clinics (except for clinics that provide only de minimis medical care, such as an on-site nurse who provides only emergency services);
- Retiree coverage;
- Multiemployer plan coverage;
- Executive physical programs;
- Health reimbursement arrangements; and

- Specified disease or fixed indemnity coverage if the cost of coverage is excluded or deducted from taxes.

Exceptions (not included in the aggregate value of benefits):

- Stand-alone dental and vision
- Fixed indemnity (specific disease, hospitalization, accidental injury) if purchased after-tax
- Disability
- Long-term care
- Liability insurance (including general liability, or auto liability)
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Other similar coverage under which benefits for medical care are secondary or incidental

Determination of plan cost used as aggregate value of employer-sponsored coverage:

- The cost of employer-sponsored coverage is determined using rules used to calculate premium for purposes of COBRA continuation coverage (except that the new high value plan tax is not considered in the calculation)
- Common COBRA rates for single and family are not allowed
- An employer that covers active employees and retirees, has the option to combine pre-65 and post-65 retiree groups when calculating the value of coverage
- Employer contributions to an HSA or an Archer MSA
- Salary reduction contributions to a health FSA
- The tax only applies to the cost of coverage in which an employee is actually enrolled, not the cost of what is offered
- Any amounts that are reimbursed under an HRA or as excess amounts under Health FSAs

The IRS is considering valuing HRAs based on either the amount made newly available to an employee under an HRA each year, or the on the total amount spent through HRAs each year by employees divide by the number of covered employees.

Tax on High-Cost Insurance Plans – Payment and Penalties

The excise tax is levied on each component (health, HSA, dental, etc.) based on its share of the total aggregate value.

Insurers pay taxes on insured plans, employers pay taxes on plans under which the employer makes HSA or MSA contributions, and the person administering the plan pays taxes on self-insured plans.

The tax is non-deductible from federal income tax.

Failure to properly calculate the excess benefit is subject to a penalty equal to any additional amount due plus interest.

Effective for taxable years beginning on or after January 1, 2018

The penalty is waived if:

- The employer or plan sponsor neither knew, nor by exercising reasonable due diligence could have known, that such failure existed
- The failure was due to reasonable cause and not willful neglect
- The failure is corrected within 30 days of reasonably learning the failure existed

Other Revenue Provisions

Limits on Section 833 Deduction for BCBS Plans

Limits the special deduction for Blue Cross Blue Shield (BCBS) organizations of 25% of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations' adjusted surplus.

The special deduction will be available only to those otherwise qualifying BCBS plans that expend at least 85% of their total premium on reimbursement for clinical services provided to enrollees.

BCBS plans must compute a medical loss ratio (MLR) for IRC § 833 status by dividing the total of "clinical services" by the total of premium revenue.

BCBS note: clinical services do *not* include activities that improve health care quality.

Final regulations outlining how the MLR is calculated were published January 7, 2014.

Applies to tax years beginning on or after January 1, 2010

Expansion of Adoption Tax Credit

Increases the amount of child adoption tax credit and adoption assistance income exclusion for employer-paid or employer-reimbursed adoption expenses through a qualified adoption assistance program to $13,170.

Provides for inflation indexing for tax years beginning on or after January 1, 2011.

Makes the credit refundable.

Extended the adoption credit through 2011.

The increased amount includes the credit and exclusion amounts for special needs children.

For tax year 2012, the credit has reverted to being non-refundable, with a dollar limit of $12,650 per child, subject to a MAGI phase-out.

Applies to taxable years beginning on or after January 1, 2010

Deductibility of Medical Expenses Extended to Age 27

Any employee's child who has not attained age 27 as of the end of the taxable year will be considered a dependent of a taxpayer for purposes of the general exclusion (IRC Sec. 105(b)) for reimbursements for medical care expenses.

Note: The deductibility applies to federal taxes. Some states have differing rules for deductibility which may result in the expanded dependent coverage being treated as taxable income for children above a lower state age limit regarding deductibility.

Children no longer need to be considered a dependent for the general exclusion to apply.

This applies to:

- Health plan premiums paid via Section 125 plans
- Health FSAs

Applies to coverage / reimbursements made on or after March 23, 2010

- HRAs (but **not** HSAs)
- Section 125 plans
- Premiums paid for such children
- Reimbursement of medical care expenses for such children

Mid-year status change rules apply to such children's eligibility.

Plan may allow employees to make contributions for such expenses immediately, so long as the plan was amended by December 31, 2010.

Indian Health Benefits

Native Americans may exclude from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from any Native American tribe or tribal organization.

The exclusion does not apply to the amount of the qualified benefit for which the beneficiary may claim a deduction under another provision of the Internal Revenue Code.

Coverage under the Indian Health Service is not considered minimum essential coverage, and therefore individuals with HIS coverage are subsidy-eligible.

Native Americans are not subject to the individual mandate.

Effective for health benefits and coverage provided after March 23, 2010

Excise Tax on Indoor Tanning Services

Creates a 10% excise tax on the full amount of the charge for indoor tanning services, whether or not an individual's insurance policy covers the service.

The tax is to be collected by the salon owner from the person receiving the service at the time the service is rendered and remitted to the IRS on a quarterly basis.

If the person receiving the service does not pay the tax, the salon owner remains liable for the tax.

Applies to services performed on or after July 1, 2010

HSA / Archer MSA Tax for Non-Qualified Distributions

The additional tax on distributions from an Archer medical savings account (MSA) or a health savings account (HSA) not used for qualified medical expenses is increased to 20% of the amount of the distributions.

Applies to distributions made on or after January 1, 2011

Medicare Premium Changes

Increases Medicare Part D premiums for those with modified adjusted gross incomes greater than $85,000 per individual and $170,000 per family.

The increases are based on a sliding scale (with individual thresholds at $85,000, $107,000, $160,000, and $214,000) and resulting increases ranging from 10.5% to 54.5%.

Effective January 1, 2011

Thresholds are to be adjusted annually by the Consumer Price Index for all urban consumers (CPI-U), and rounded to the nearest $1,000.

Freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019.

Tax on Brand-Name Prescription Drug Manufacturers or Importers

Annual non-deductible fee imposed on each manufacturer or importer (including foreign corporations) of certain branded prescription drugs (including certain biological products and excluding orphan drugs) for sale to specified government programs or pursuant to coverage under these programs:

- Medicare Parts B and D
- Medicaid
- Veterans Administration
- Department of Defense
- TRICARE

A "prescription drug" means any drug which is subject to the Federal Food, Drug and Cosmetic Act

- A "branded prescription drug" is a prescription drug the application for which was submitted under the Federal Food, Drug and Cosmetic Act (21 U.S.C. §355(b)), or any biological product the license for which was submitted under the Public Health Service Act (42 U.S.C. § 262(a)).
- "Branded prescription drug sales" are sales of branded prescription drugs to any specified government program or sales made pursuant to any such program.
- "Branded prescription drug sales" do not include sales of any drug or biological product for which the "orphan drug" credit was allowed for any taxable year under IRC § 45C, so long as the drug or biological product has not been subsequently approved by the FDA for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

Fee amounts are based on the ratio of each manufacturer's preceding year's branded drug sales to the preceding year's aggregate branded prescription drug sales by all manufacturers, multiplied by the annual amount due from all manufacturers as follows:

- 2011: $2.5 billion
- 2012: $2.8 billion
- 2013: $2.8 billion
- 2014: $3 billion
- 2015: $3 billion
- 2016: $3 billion
- 2017: $4 billion

Effective for calendar years beginning on or after January 1, 2011 (with respect to sales in the prior year)

- 2018: $4.1 billion
- 2019 and after: $2.8 billion

In calculating each manufacturer's annual share of the tax, the branded prescription drug sales taken into account are:

- 0% of sales of $5 million or less
- 10% sales of more than $5 million but not more than $125 million
- 40% of sales of more than $125 million but not more than $225 million
- 75% of sales of more than $225 million but not more than $400 million
- 100% of sales of more than $400 million

Fee amounts are calculated based on sales as reported to the IRS by HHS, the Veterans Administration (VA), and the Department of Defense (DoD) (reporting date to be set by IRS) or gathered by the IRS from any other source.

- HHS reports on:
  - Medicare Part B (per unit average sales or per unit Part B payment rate for separately paid branded prescription drug without a reported average sales price and number of units paid for under Part B). CMS must establish a process for determining units and allocated prices for branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.
  - Medicare Part D (per unit ingredient cost reported to HHS by prescription drug plans and Medicare Advantage prescription drug plans, minus price concessions, and number of units paid for under Part D)
  - Medicaid (per unit ingredient cost paid to pharmacies for branded prescription drugs dispensed to Medicaid beneficiaries, minus any per unit rebate paid by manufacturers, and number of units paid for under Medicaid)
- The VA reports, for each manufacturer and each branded prescription drug, the total amount paid for each branded prescription drug procured by the VA.
- The DoD reports, for each manufacturer and each branded prescription drug, the sum of:
  - The amount paid by the DoD for each prescription drug for its beneficiaries
  - For each branded prescription drug dispensed under the TRICARE retail pharmacy program, the per unit ingredient cost minus the per unit rebate paid by the manufacturer times number of units dispensed

Fees collected under the provision are credited to the Medicare Part B trust fund.

- All persons treated as a single entity for purposes of the tax are jointly and severally liable for the tax.
- Fees are nondeductible.
- The due date is set by the IRS, but will be no later than September 30 of each year.

Increased Unearned Income Tax on High-Income Individuals

With respect to those individuals with income over the threshold amounts noted below, this provision adds a 3.8% additional Medicare tax on *the lesser* of:

- Net investment income (income from interest, dividends, non-qualified annuities, royalties, rents, taxable net capital gains attributable to the disposition of properties, and similar passive activities)
- The excess of the taxpayer's modified AGI greater than:
  - $200,000 for individuals
  - $250,000 for joint filers or a surviving spouse
  - $125,000 for married taxpayers filing separately

The tax does *not* apply to distributions from qualified retirement plans, including IRAs, 410(a) money purchase plans, 403(b) plans, and 457(b) plans.

While this tax is also applicable to income from estates and trusts, the active income from trade for self-employed and S-corporations would not be subject to the tax. For these entities, the tax would only apply to passive income and income related to commodity trading.

There is also a special provision for the application of the tax to S-corporations who sell their business.

Proceeds from the sale of a principal residence are still subject to a partial exclusion from tax under current law. (Gains from the sale of a house up to $250,000 for single taxpayers and $500,000 for married couples filing jointly are excluded from taxation if the taxpayer has both owned and lived in the house for at least two years out of the past five years. This exclusion can be used every two years.)

This *new* tax would apply to capital gains from the sale of a primary residence includable in taxable income (capital gains above the exclusion amount) only if the taxpayers modified adjusted gross income (including any capital gains) exceeded the above thresholds.

The IRS published final and proposed rules on December 2, 2013.

Effective for taxable years beginning on or after January 1, 2013

Medical Expense Deduction Limitation

Increases the threshold for claiming an itemized deduction for unreimbursed medical expenses for regular tax purposes to 10% of a taxpayer's adjusted gross income (AGI).

For taxpayers (or their spouses) who are age 65 and older before the close of the tax year, the threshold for regular tax purposes remains at 7.5% of AGI prior to January 1, 2017.

The alternative minimum tax (AMT) treatment of the itemized deduction for medical expenses is not changed, and still applies to age 65 or older taxpayers (or their spouses).

Effective for taxable years beginning on or after January 1, 2013

Limitation on Deductibility of Compensation for Employees and Service Providers of Health Insurers

Limits deductibility of taxable year remuneration for officers, directors, employees, and service providers of health insurers to $500,000.

"Covered health insurance provider" is defined as:

- For tax years beginning after December 31, 2009, "health insurance issuers" (as defined in IRC § 9832(b)(2)) that provide "health insurance coverage" as defined in IRC § 9832(b)(1) ("…benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer").
- For tax years beginning after December 31, 2012, "health insurance issuers" (as defined in IRC § 9832(b)(2)) for which not less than 25% of gross premiums received is from providing "minimum essential coverage" as defined in IRC § 5000A(f).

All compensation from entities within a "controlled group" is subject to the limitation that compensation paid to the individual from any member of the controlled group of the covered health insurance provider as determined by applying rules applicable to qualified retirement plans is considered.

The deduction limits apply to both current and deferred compensation. The limit that applies to deferred compensation earned in a year is equal to the $500,000 limit for that year, reduced by the amount of current compensation paid *and* the portion of deferred deduction remuneration taken into account in a preceding tax year.

Applies to current compensation paid in taxable years beginning on or after January 1, 2013

Applies to deferred compensation paid in taxable years on or after January 1, 2013 for services performed on or after January 1, 2010

Tax on Medical Device Manufacturers or Importers

Imposes a non-deductible tax on the sale of any taxable medical device sold by the manufacturer, producer or importer of the device (according to market share) in the amount of 2.3% of the price for which the medical device is sold. In December 2015, omnibus legislation was signed by President Obama that included a two-year delay on the excise tax, which will now go into effect for sales made after January 1, 2018.

Defines a "taxable medical device" as any device as defined in the Federal Food, Drug and Cosmetic Act (21 U.S.C. § 321(h)) intended for humans, but does *not* include:

- Eyeglasses
- Contact lenses
- Hearing aids
- Any other medical device determined by Treasury to be of a type which is generally purchased by the general public at retail for individual use
- Products intended for use on animals

Applies to sales made on or after January 1, 2013

Effective date was delayed to January 1, 2018

Current manufacturers excise tax exemptions (noted below) for further manufacture and for export apply to this new tax as well.

- Use as supplies for vessels or aircraft
- Sales to state or local governments, non-profit educational organizations, or qualified blood collector organizations

Health Insurance Provider Tax

Imposes an aggregate annual tax apportioned among health insurers of "United States health risks" whose annual net premiums written exceed $25 million based on relative market share.

Insurers required to pay the tax are those providing health insurance during the calendar year in which the tax is due.

The annual tax burden shared by health insurers is:

- $8 billion in 2014
- $11.3 billion in 2015
- $11.3 billion in 2016
- $13.9 billion in 2017 (moratorium)
- $14.3 billion in 2018
- After 2018 the applicable tax is indexed to the rate of premium growth of the prior year's premium, defined as "the applicable amount for the preceding calendar year increased by the rate of premium growth for such preceding calendar year."

In December 2015, omnibus legislation was signed by President Obama that included a moratorium on the fee for 2017.

"United States health risks" mean the health risk of any individual who is:

- a U.S. citizen
- a resident of the U.S. (IRC § 7701(b)(1)(A)), or
- located in the U.S. for the period in which a health risk is involved

"Health risks" mean comprehensive hospital and medical, dental, vision, FEHB, Medicare, Medicaid, and other health insurance. It does not include:

- Disability income or accident insurance
- Hospital indemnity or other fixed indemnity insurance
- Specified disease or illness insurance
- Long term care insurance
- Medicare supplement insurance
- Non-commercial insurance

Applicable to calendar years beginning on or after January 1, 2014, except calendar year 2017.

(Based on net premiums written on or after January 1, 2013, and third-party agreement fees received on or after January 1, 2013)

- Stop-loss (at least for now)
- EAPs and wellness programs unless they provide significant medical coverage
- On-site clinics

"Health insurer" means:

- Health insurers
- HMOs
- Providers of Medicare Advantage, Medicare Part D, or Medicaid coverage
- Non-fully insured multiple employer welfare arrangements (MEWAs), with limited exceptions for those exempt from M-1 reporting under 29 CFR 2520.101-2

Market share is calculated based on net premiums written as reported to the IRS by insurers (IRS will use NAIC and MLR reporting to validate, and the 8963 will be open for public inspection):

- Premiums of $25 million or less are not taken into account
- Premiums of $25 million to $50 million are considered at 50%
- Premiums greater than $50 million are considered at 100%.

"Net premiums written" is "…intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions. … Net written premiums do not include amounts arising under arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance)."

Tax exempt insurers (after any application of the market size reductions above) consider only 50% of premium arising from tax-exempt business in calculating market share. The tax exempt insurers identified in the statute are:

- IRC § 501(c)(3) (charitable organization)
- IRC § 501(c)(4) (social welfare organization)
- IRC § 501(c)(26) (high risk pools)
- IRC § 501(c)(29) (health insurance Consumer Operated and Oriented Plans (CO-OPs) created by THE ACA)

Applies to all health insurers subject to federal income tax, as well as nonprofit insurers exempt from federal income taxes (except as specified). Exemptions include:

- Any governmental entity, agency or instrumentality, and Indian tribal governments and subdivisions
- Self-insured employers, including VEBAs sponsored by a single employer
- Nonprofit corporations that:
  - receive more than 80% of gross revenues from government programs that target low income, elderly or disabled programs (including Medicare, Medicaid, SCHIP, and dual-eligible plans)
  - meet the private inurement and limitation on lobbying provisions

- Voluntary Employee Benefit Associations established by non-employers (i.e., unions)
  - This exemption does **not** apply to MEWAs
- 501(c)9 non-profit insurers by an entity (other than employers or employees) for the provision of health care benefits

Controlled group rules apply. If members change, membership as of December 31 of the data year is determinative. Generally, the common parent, or another designated entity, will file on behalf of the whole group, although all members of the group are jointly and severally liable for the tax.

Information submitted to the IRS by insurers for the tax is not subject to IRC § 6103 confidentiality requirements.

The tax is nondeductible. On November 27, 2013 the IRS issued a Revenue Ruling that states that carriers that collect HIP fees from policyholders, whether as a separate charge or part of the premium, must include those amounts in their gross income.

Net premiums must be reported by April 15, using Form 8963. The IRS will then determine each entity's share and provide a preliminary calculation by June 15. Carriers will have until July 15 to submit corrections and the IRS will provide a final billing on August 31. The fee will be due September 30.

The penalty for failure to report to the IRS (unless reasonable cause is shown) is $10,000 plus the lesser of $1,000 per day or the amount of the tax. Understatement of the insurer's net premium written to the IRS is also subject to a penalty of the excess of the amount of tax the IRS says is due over the amount of tax paid.

Final regulations and a Notice describing the fee reporting process were published on November 29, 2013.

Certain Corporate Estimated Taxes Increased

Effective March 23, 2010

The estimated tax payment required to be made by in July, August, or September 2014 by a corporation with assets of $1 billion or more (determined as of the end of the preceding tax year) is increased by an additional 17.75 percentage points from the amount otherwise due.

In each year, the next required installment of estimated tax is reduced accordingly to reflect the increase.

The effect of the provision is to shift revenues from one fiscal year to another to satisfy budget limits.

Miscellaneous Provisions

Grandfathered Health Plans

A grandfathered health plan is any plan in which at least one individual was enrolled on March 23, 2010, and the policy or plan must have continuously covered someone since that date.

Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so ***if*** the only plan changes made were to:

- Add or delete new (or newly enrolled) employees
- Add or delete any new (or newly enrolled) dependent
- Transfer employees to another plan, as long as there's a bona fide employment-based reason for the transfer, other than cost (see anti-abuse rule below)
- Have scheduled plan changes as a result of an existing insured (not self-funded) collective bargaining agreement
- Extend dependent coverage to adult children up to age 26 earlier than required by the ACA
- Change a third-party administrator or insurer
- Increase or decrease premiums of the grandfathered plan
- Make plan changes to comply with state or federal law
- Make changes to voluntarily comply with provisions of the ACA
- Make changes to increase benefits
- Increase fixed dollar *deductibles* or fixed dollar *out-of-pocket* (OOP) *maximums* that do not exceed medical inflation plus 15% (as measured from March 23, 2010)
- Retain the existing fixed-percentage of salary in salary-based OOP limit plans, even if an increase in one or more salaries results in the OOP limit exceeding the targets noted above
- Increase *any* fixed dollar *copayments* that do not exceed the greater of:
  - Medical inflation plus 15% (as measured from March 23, 2010)
  - $5 (adjusted for medical inflation)
- Decrease the percentage of the premium paid by the employer for *any* tier of coverage (including tiers resulting from modifying the tier structure) of 5% or less of the contribution level on March 23, 2010
  - Exception: If the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers *and* those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards above.

Grandfathered status is available for certain plan provisions in effect on March 23, 2010

Put another way, any of the following changes will cause a benefit package to lose grandfathered status:

- Elimination of all or substantially all benefits for a particular condition
- Any increase in percentage cost-sharing or co-insurance requirements
- An increase in fixed-amount cost-sharing requirements by more than the specified medical inflation rate plus 15%
- An increase in copayment requirements greater than $5 or the specified medical inflation rate plus 15%
- A decrease in employer contribution rate by more than 5 percentage points
- The addition of a new policy, certificate, or contract of insurance effective before November 15, 2010
- Certain changes in annual limits

Note: With regard to age-banded plans, some insurers are interpreting the regulations such that employers who maintain (within the 5% allowed by the ACA) the same contribution percentage per tier and age band, are deemed to retain grandfather status. Further, an employee whose contribution changes *solely* because of moving into a new age band does not cause loss of grandfather status simply because the employee's contribution changed to that of everyone else in their new age band.

If an employer offers multiple health plan options, each option is treated separately in terms of its grandfather status.

See Appendix 14: Calculating Increases in Fixed Amount Cost-Sharing For Purposes of Retaining Grandfather Status

Grandfathered plans remain subject to:

- Mental Health Parity provisions
- Newborns' and Mothers' Health Protection Act provisions
- Women's Health and Cancer Rights Act
- Michelle's Law

Items requiring future regulatory guidance:

- Changes to plan structure (switching from an HRA to major medical coverage; switching from insured to self-funded)
- Changes to a provider network, and if so, the magnitude of change
- Changes to a prescription drug formulary, and if so, the magnitude of the change
- Effect of surcharges (smokers, etc.) in new wellness programs
- Effect of adding an HRA as a means of "functionally" keeping OOP costs the same (current law seems to imply such a change would cause a loss of grandfathered status)

The plan must maintain records of the level of benefits provided on March 23, 2010, and any subsequent plan changes it deems to be within the bounds of the grandfather status requirements.

Anti-abuse rule: The principal purpose of a merger or acquisition must not be to cover new individuals under a grandfathered plan.

Transition rules

For plans that made changes to plans prior to March 23, 2010 (even if they take effect after March 23, 2010), grandfather status is retained if such changes were adopted pursuant to a legally binding contract, insurance filing, or written plan amendment.

For plans that made routine changes to plans between March 23, 2010, and June 17, 2010, a good-faith compliance standard will be applied and any changes that only modestly exceed any grandfather requirements will be allowed for the current plan year. **Note**: The “good faith” standard has been extended until July 1, 2011.

Plans that made significant changes prior to June 17, 2010, that would cause them to lose grandfathered status are allowed a grace period lasting until the start of the next plan year beginning after September 23, 2010, to bring their coverage terms in compliance with the ACA.

The collective bargaining "safe harbor" rule (an automatic exemption for the duration of the term of the collective bargaining agreement (CBA) in effect on March 23, 2010):

- Applies only to *insured* plans
- Essentially permits such insured plans to change insurers during the term of the CBA without losing grandfathered status
- Permits the plan to be voluntarily amended to comply with selected new requirements without accelerating overall compliance date
- On expiration of final CBA, allows the plan to retain grandfathered status until lost under rules in effect at that time
- Does **not** delay the effective date of requirements otherwise applicable to grandfathered plans

The DOL has issued a series of Frequently Asked Questions (FAQs) following ACA enactment (under “Affordable Care Act Implementation”).

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

The final rule also noted that various transitional rules are now void, such as the allowance of grandfathered health plans to exclude children under age 26 who were eligible for other group health plan coverage, and rules that provided a special enrollment period for children under age 26 who had been excluded from coverage.

The final rule reaffirmed that grandfathered status applies separately with respect to each benefit package. For example a group health plan with a preferred provider organization (PPO) plan, a point of service (POS) arrangement, and a health maintenance organization (HMO) option would each carry grandfathered status (or not) separately. Requirements for grandfathered status notification remain the same -- plans must include a statement that the plan or health insurance coverage believes it is a grandfathered health plan in any summary of benefits provided under the plan. The model disclosure notice remains the same.

Grandfathered plans have been governed by anti-abuse rules, to prevent plans from maintaining grandfathered status when employees transferred into the plan are from a transferee plan that would have caused the transferor plan to lose

grandfathered status if its terms were adopted. There is an exception for bona fide reasons for employee transfers, such as a plan being eliminated by the carrier.

The final rule noted that a plan that eliminated substantially all benefits needed to diagnose a condition would cause a plan to lose its grandfathered status, but purposefully declined to provide a bright line rule to interpret the requirement. Excessive increases to a single or limited number of copayments would cause a plan to lose grandfathered status, even if the remaining copayments remained the same.

Plans that add additional tiers (such as individual plus one, individual plus two) will not lose grandfathered status if the contribution rate for the new tiers is not below the previous non-self-only tier by more than five percent. Employers with grandfathered health plans that offer wellness programs should take great caution if the wellness program imposes penalties for failing to meet standards, this could put the plan's grandfathered status at risk. Finally, grandfathered health plans may move brand-name versions of drugs that become generic to a higher cost-sharing tier.

Economic Substance Doctrine

A transaction would have economic substance only if:

- The taxpayer's economic position (other than its federal tax position) changed in a meaningful way *and*
- The taxpayer had a substantial purpose (other than a federal tax purpose) for engaging in the transaction

The economic substance doctrine is used to prevent taxpayers from engaging in transactions that lack economic reality and subvert the legislative intent of a section of the Tax Code simply to reap a tax benefit.

A 20% penalty is imposed for an underpayment attributable to any disallowance of claimed tax benefits by reason of a transaction lacking economic substance, and a 40% penalty is imposed for an underpayment attributable to a "non-disclosed non-economic substance transaction."

Applies to transactions entered into after March 23, 2010

Multiple Employer Welfare Arrangement (MEWA) Provisions

Making certain false statements or representations in the marketing of multiple employer welfare arrangements (MEWAs) regarding financial conditions or solvency, benefits, or state or federal regulatory status is a crime punishable by fines and up to 10 years in prison.

DOL may adopt regulations to set standards, or issue an order, to establish that state fraud and abuse (and all other applicable) laws will apply to persons providing insurance through a MEWA.

On March 1, 2013, the DOL issued Final Rules on MEWA Reporting and Final Rules on MEWA Enforcement.

Requires MEWAs to register with the DOL prior to operating in a state and enrolling participants. The final regulations establish new registration and reporting requirements for plan MEWAs, non-plan MEWAs and entities claiming exception (ECEs). The revised Form M-1 must be filed electronically, and will require more extensive financial information and more information about a broader group of individuals associated with the MEWA. In addition to the annual filing, a special Form M-1 filing will be required 30 days prior to operating in any state and within 30 days after certain triggering events such as operating in any new state not previously identified, a merger with another MEWA, the number of employees receiving coverage under the MEWA increasing 50% or more, or a material change. Similar requirements apply to ECEs. The final regulations also require ERISA-covered plans subject to the Form M-1 reporting rules to include

Effective March 23, 2010

proof of Form M-1 filings as part of the Form 5500. The filing deadline for the 2012 Form M-1 (which would normally be due March 1, 2013) has been delayed to May 1, 2013, with an extension available to July 1, 2013.

The DOL may issue administrative cease and desist and seizure orders for MEWA plans that are fraudulent or in hazardous financial condition. The final rules set out the procedures the DOL will follow to issue cease and desist and summary seizure orders. The regulations provide that a cease and desist order may apply to MEWAs and to persons having custody or control of assets of the MEWA, authority over management of a MEWA, or any role in the transaction of a MEWA's business.

The DOL has also released a Fact Sheet on MEWA Enforcement

Student Health Insurance Plans

Effective March 23, 2010

Within the limits of federal, state, and local laws, institutions of higher learning may continue to offer student health insurance plans. (the ACA does prohibit these policies.)

On February 8, 2011, HHS issued its proposed regulations regarding student health plans. Among the highlights:

- Defines student health plans as individual insurance, not association coverage
- Includes the provision of coverage in limited circumstances to certain non-actively enrolled students
- Confirms that coverage could not be conditioned on any health-related factor
- Confirms that self-funded student health plans are not subject to HHS regulations
- States that renewable plans would *not* be considered short-term limited duration plans, and therefore would be subject to the ACA
- Confirms that student health plans are subject to all individual market requirements of the ACA, with the following exceptions:
  - Guaranteed issue and guaranteed renewability
  - Annual limits, but only for policy years beginning on or after January 1, 2012, and before September 23, 2012 (when limit must be at least $100,000)
  - Student health fees that apply to all students are not considered cost-sharing as pertains to preventive coverage requirements
  - Mini-med MLR waivers are being considered for applicability to student health plans
- A notice is required noting which provisions of the ACA are not included in the student health plan (HHS will provide a model notice)

The following model language, or substantially similar language, can be used to satisfy the notice requirement:

> "Your student health insurance coverage, offered by [name of health insurance issuer], may not meet the minimum standards required by title XXVII of the Public Health Service Act. Specifically, the coverage will not be renewed when you are no longer enrolled as a student at [name of institution of higher education]; and the restrictions on annual dollar limits on your benefits may not be the same as other types of coverage.

"For policy years beginning before September 23, 2012, if a policy for student health insurance coverage applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $100,000.

"Your student health insurance coverage put an annual limit of: [dollar amount] on [which covered benefits notice should describe all annual limits that apply]. If you have any questions or concerns about this notice, contact [provide contact information for the health insurance issuer]."

See the proposed rule for student health insurance coverage.

These plans will have their own risk pool. They will be considered minimum essential coverage.

For 2014 all self-funded student health plans will be considered minimum essential coverage. Thereafter, each plan will need to seek specific approval and provide evidence that comprehensive coverage is being provided.

Student health plans will not be required to use a calendar year policy period.

Requirements for Non-Profit Hospitals

Creates four additional requirements that a hospital must satisfy to be tax-exempt under Internal Revenue Code Section 501(c)(3):

- Prepare a community health needs assessment (with input from a broad spectrum of the community and experts in public health) at least once every three years, adopt an implementation strategy to meet the community needs identified, and report annually to the IRS its progress in meeting those needs or reasons for not successfully addressing them.
- Adopt, implement, and widely publicize a written financial assistance policy, including non-discriminatory emergency care and discounted care.
- Limit charges (to amounts generally billed to insured patients) to individuals eligible for assistance
- Avoid certain billing and collections activities

The IRS is required to review a non-profit hospital's community benefit activities at least once every three years.

The Health Needs Assessment requirement carries a non-compliance penalty of $50,000.

Effective for taxable years beginning after March 23, 2010

Community Health Needs Assessment applies to taxable years beginning after March 23, 2012

Plans Not Subject to ACA Insurance Market Provisions

The following types of plans are not subject to the insurance market provisions of the ACA:

- Retiree-only plans
- Plans that provide HIPAA-excepted benefits:
  - Accident and disability insurance
  - Stand-alone dental and vision plans, defined in a final regulation issued October 1, 2014 as a plan that provides its benefits under a separate policy or which a participant may elect separately from medical (separate contributions are no longer required)

Effective March 23, 2010

  - Beginning with the 2015 plan year, if claims are administered under a separate contract from administration of the medical, that also will qualify as a "non-integrated" stand-alone benefit
- Supplemental coverage
- Stand-alone disease-only coverage
- Individual fixed indemnity plans, but per a final rule only if:
  - the individual attests in his application that he has other minimum essential coverage (or is deemed to have that coverage because he is in a U.S. territory)
  - there is no coordination between the indemnity and any other health coverage
  - benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service regardless of the actual expense incurred
  - a notice that coverage is limited is provided in the application
- EAPs that do not provide significant medical care or benefits, are not coordinated with the group health plan (e.g., completing EAP counseling cannot be a pre-requisite to mental health coverage under the medical plan) and have no participant contribution or cost-sharing
- Health FSAs if:
  - The employee is also eligible for non-excepted medical coverage
  - Any employer contribution does not exceed two times the employee's contribution plus $500
- Plans issued in a U. S. territory: U.S. Virgin Islands, Puerto Rico, Guam, American Samoa, Northern Mariana Islands

- On-site medical clinics (Important note: this coverage is specifically included for purposes of aggregate benefit reporting on Form W-2 and under "Cadillac Plan" tax requirements.)
- On March 18, 2015, a Final Rule was published to provide for two pilot programs under which an employer could offer wraparound coverage in limited circumstances. One pilot program allows wraparound benefits only for multi-state plans (MSPs) in the Health Insurance Marketplace. The second pilot program allows wraparound benefits for part-time workers who enroll in an individual policy or in Basic Health Plan (BHP) coverage for low-income individuals. The wraparound coverage would be an excepted benefit.
- Generally both pilot programs require that the wraparound coverage must be specifically designed to provide meaningful benefits such as coverage for expanded in-network medical clinics or providers, or reimbursement for the full cost of primary care. Furthermore the cost cannot exceed the greater of:
  - The maximum annual contribution for health flexible spending accounts ($2,550 for 2015) or;
  - 15% of the cost of coverage under the primary plan.
- Under the MSP pilot program, which provides for limited coverage wrapping around MSPs the coverage must be reviewed by the Office of Personnel Management (OPM) and is intended to be offered by employers that were

offering reasonably comprehensive coverage prior to the Final Rule and wish to offer limited wraparound coverage while still contributing roughly the same total towards their employees' health benefits. To qualify:

  - The employer must have offered coverage (in a plan year that began in either 2013 or 2014) that is substantially similar to coverage that the employer would have had to offer its full time employees in order to avoid pay-or-play penalties.
  - The employer's aggregate annual contributions for both primary and limited wraparound coverage must be substantially similar aggregate contributions for coverage offered to full time employees in 2014, which is set if they are at least 80% of contributions made in 2013 or 2014.

- Under the part-time employee pilot program, an employer must offer group health insurance coverage that is not limited to excepted benefits and provides minimum value to the class of participants offered wraparound coverage, which means limited wraparound coverage can only be offered to part-time employees that are eligible for group coverage from their employer but instead have purchased individual insurance. Furthermore:
  - The benefits must wraparound eligible individual insurance, which cannot be grandfathered, cannot be transitional, and cannot be composed entirely of excepted benefits.
- Limited wraparound coverage is contingent upon reporting requirements for group health plans, and details on specific reporting requirements will be released. To participate in a pilot program, the wraparound coverage must be offered no earlier than January 1, 2016, and no later than December 31, 2018. For more details on limited wraparound coverage, read the ACA Advisor on limited wraparound benefits.

Conforming Amendments to IRC PHSA, and ERISA

Makes a number of conforming amendments throughout the Public Health Service Act (PHSA) to further consistency with new ACA substantive provisions, and reorders and renumbers PHSA subparts and sections.

Effective March 23, 2010

Conforming amendments include:

- Applying mental health parity to the individual market
- Eliminating small group market guaranteed issue exceptions for lack of association membership or failure to meet contribution/participation requirements
- Making small group market size 1 to 100 lives (states may opt to use 50 for 2014 and 2015).

Also incorporates PHSA requirements into ERISA and the Internal Revenue Code (IRC).

Hawaii's Prepaid Health Care Act

Provides a rule of construction to clarify that the existing ERISA exemption for Hawaii's Prepaid Health Care Act is not affected by this bill.

Effective March 23, 2010

Automatic Enrollment of Employees

The ACA's automatic enrollment provisions were repealed by the November 2, 2015, "Bipartisan Budget Act."

Repealed

Level Playing Field

Requires any state regulation or amendment adopted under the ACA to apply uniformly to all health plans in each insurance market to which it applies.	Effective January 1, 2014

Exchanges – General Provisions

Grants to Establish Exchanges

Not later than one year after date of enactment, HHS will give states grants to establish exchanges. Such grants are not available past January 1, 2015.	Effective on or before March 23, 2011

Exchanges – General Provisions

Requires each state to establish an exchange as part of a new or existing state agency or independent public authority, and to be administered by a governmental agency or "eligible" non-profit entity to offer qualified health plans to individuals and small (100 employees or less) employers. States may require the individual and small group markets within the state to be merged. Requires HHS, in conjunction with NAIC and other applicable organizations, to set standards for: • The establishment and operation of exchanges • The offering of qualified health plans (QHPs) through the exchanges • The establishment of the reinsurance and risk adjustment programs created by the ACA Provides for the federal government (either directly or through an agreement with a non-profit entity) to implement an exchange in states that either elect not to establish their own exchange, or states for which HHS determines, by January 1, 2013, that the state will not have an operational exchange by January 1, 2014. States were required to notify HHS by December 14, 2012, if they will operate an exchange, and provide a “blueprint” that describes how they will do so. States had until February 15, 2013, to elect a state-federal partnership exchange for 2014. A state must notify HHS if it wishes to establish a state exchange and provide a Blueprint for 2015 (or a later year) six and one-half months prior to the start of the year for which the exchange would be state-run. Note: HHS has virtually unlimited funding to help states create their own exchanges, but a quirk in the ACA is that it did not appropriate *any* funds to HHS for the federal government to develop its own infrastructure to fulfill the ACA requirement to create and operate exchanges in all the states that do not establish their own. States may allow more than one exchange (Subsidiary Exchange) if each exchange serves a distinct geographic area and is approved by HHS. U. S. territories would be allowed to create exchanges, and be treated like a state for funding purposes, if they establish an exchange. Exchanges will be voluntary, with insurers allowed to sell coverage, and individuals and employers allowed to purchase coverage, in the outside market. There is no penalty for switching to minimum essential coverage outside of an exchange. Coverage in the exchange can only be on a pre-tax basis *if* it is purchased through the small business/SHOP exchange. **Note:** On March 12, 2012, HHS released a revised version of the federal rules regarding the “Establishment of	Effective January 1, 2014

Exchanges and Qualified Health Plans and Exchange Standards for Employers." The new document covers both the establishment of exchanges by the states, as well as eligibility standards for employers.

- Parts of the regulation have been issued as a final rule, meaning that they will have the full force of law within 60 days of the regulation's publication in the Federal Register on March 13, 2012.
- Other sections, including section 155.220(a)(3), which addressed the ability of a state to permit agents and brokers to assist qualified individuals in applying for exchange-based premium subsidies and cost-sharing reductions, have been issued as an interim final rule, meaning that they may be changed at a later date and are still open for public comment within 45 days.

Some of the areas the rules do cover include:

- Standards for Exchange Navigator programs
- Requirements about the awarding of Navigator grants
- Navigator training requirements and conflict of interest standards
- Clarification of the role of agents and brokers in state exchanges outside of the Navigator program
- HHS' decision to *not* create detailed federal marketing oversight requirements for state exchanges, as was suggested might be a possibility in the original proposed rule.

See the Proposed Rule for Establishment of Exchanges and Qualified Health Plans, July 15, 2011

On August 14, 2012 HHS issued the final Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges. The Blueprint consists of a declaration letter from the state outlining the type of exchange it intends to pursue and an exchange application, which is essentially a checklist of the activities and elections of the exchange.

States may operate all activities, partner with the federal government, or defer to the federal government entirely on:

- Plan management
- Consumer assistance
- Premium tax credit and cost sharing calculations
- Exemptions
- Risk adjustment program
- Reinsurance program
- Medicaid and CHIP eligibility assessment and determination

A user fee of 3.5% of premium will apply in the federally facilitated exchanges in 2014, 2015, and 2016.

See the Kaiser Family Foundation summary of State Decisions for Creating Health Insurance Marketplaces.

None of the U.S. territories has created a state exchange, and they are not eligible for federally-facilitated exchanges.

Exchange Eligibility

Effective January 1, 2014

Individuals may enroll in a plan through their state's exchange if they are:

- Residing in a state that established an exchange
- Lawful residents of that state
- Not incarcerated, except individuals in custody pending disposition of charges

Most individuals who are lawfully in the U.S. are eligible to enroll in the exchange, including a wide range of immigrants (called “qualified non-citizens”).

Per a CMS FAQ, issuers may not refuse to cover same-sex spouses who were legally married in a state or country that recognizes same-sex marriage, even if the insured is now living in or the policy is issued in a state that does not recognize same-sex marriage.

The Small Business Health Option Program (SHOP) exchange is available to the small group market, which the bill defines as 1 to 100 workers (with the option for states to define the market as 1 to 50 workers) until January 1, 2016, at which time employers with up to 100 employees must be allowed to purchase coverage through the exchange.

Starting in 2017, states may allow employers with more than 100 employees to participate in the exchange, at the discretion of HHS.

Note: If a state allows employers with more than 100 employees to participate in the SHOP exchange and one such employer elects to enroll in the exchange, all of the SHOP exchange requirements will apply to every insured large group in that state. Examples: modified community rating rules (no more experience rating for a large employer group plan); minimum benefit requirements; guarantee issue; etc.

Members of Congress and congressional staff may only be offered health plans created by the ACA or offered through an exchange. If coverage is purchased through a SHOP, the federal government will continue to contribute toward the cost of coverage.

Applications are available on the healthcare.gov website.

On June 26, 2014, HHS issued a Letter that explains that an individual who is currently enrolled in an exchange plan will automatically be reenrolled in that plan. If the plan no longer exists the person will be enrolled in the same metal level as the current plan. If that is not available, the person will be enrolled in a plan that is one metal level higher or lower than the current plan in the same product type (e.g., HMO or PPO). Additional rules apply if none of these options are available. Insurers are not required to reenroll enrollees in plans or products that are no longer available for renewal.

In an FAQ issued August 1, 2014, CMS reiterated that an individual may not be covered by both an individual exchange policy and Medicare.

Exchange Functions

Effective January 1, 2014

Requires exchanges to:

- Offer qualified health benefits plans (allows states to require additional benefits, but if they do so, they must assume the costs incurred by such additional benefits)

- Offer limited scope pediatric dental benefit plans, either separately or as part of a qualified health plan (QHP)
- Implement certification, re-certification, and de-certification procedures and policies
- Enroll applicants in the plan of their choice
- Provide a toll-free telephone hotline for exchange assistance
- Develop a website for standardized comparative information on plans
- Assign a rating based on cost and quality to each participating exchange plan
- Use a standard format for presenting health plan options in the exchange, including the use of the uniform outline of coverage established under the new Public Health Service Act (PHSA) § 2715
- Inform individuals of eligibility requirements for Medicaid, CHIP, and any applicable state or local program and if, through screening of exchange applications, the exchange identifies individuals who are eligible for such programs, to enroll such individuals in such programs
- Make a calculator available to determine individuals' cost of coverage, taking into account any premium tax credits or cost-sharing reductions for which they may qualify
- Notify the employer if an eligible individual is eligible to receive a premium tax credit
- Grant certifications that individuals are exempt from the individual mandate requirement because there are no affordable plans available through the exchange or the individual's employer, *or* the individual meets other mandate exemptions
- Notify employers and the Treasury of such exemptions and of information (name, taxpayer ID, etc.) on employees who were determined eligible to enroll in the exchange
- Provide each employer with the name of each of its employees who cease coverage under a QHP during the plan year and the effective date of such cessation
- Establish the Navigator program
- Create a Certified Application Counselor program
- Participate in the temporary risk corridor program established by HHS to operate from 2014 to 2016
- Be self-sustaining by January 1, 2015
  - Exchanges may charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding to support its operations. It is unclear whether or not states could apply such fees to plans outside an exchange as well.
  - Exchanges may not use funds intended for administrative or operational expenses on staff retreats, promotional giveaways, excessive executive compensation, or promotion of state or federal legislative and regulatory modifications.
- Consult with stakeholders, including consumers, representatives of small business and self-employed individuals, state Medicaid offices, those with experience in facilitating health plan enrollment, and advocates for enrolling hard-to-reach populations

- Publish on a website:
  - the average costs of licensing, regulatory fees and other payments required by the exchange
  - the administrative costs of the exchange
  - monies lost to waste, fraud, and abuse
- May negotiate rates with all insurers
- May act as a clearinghouse that is open to all insurers
- May allow an insurer's customer service representatives to assist with applying to the exchange or for financial assistance if the state allows it
- Determine the method for partial months of coverage. FFMs will use a daily rate.

Exchange Enrollment Periods

Requires exchanges to provide for enrollments. Regulations issued March 27, 2012 (at 45 CFR 410) provide

Effective January 1, 2014

- An initial open enrollment period will run from October 1, 2013, through March 31, 2014. Coverage will be effective January 1, 2014, for those enrolling by December 24, 2013. Coverage for those enrolling after that date will be effective on the first of the month for applications received by the 15th of the month. Coverage for those enrolling between the 16th and the last day of the month will be effective the first of the next month or the first of the subsequent month, as set by the exchange. Premiums for January 1, 2014, coverage can be paid until December 31, 2013, and most carriers have agreed to accept premiums after January 1.
- Open enrollment for 2016 will be run from November 1, 2015 through January 31, 2016. Open enrollment for 2015 will be from November 15, 2014 through February 15, 2015. (Individuals who enroll December 16, 2014, through January 15, 2015, will be covered as of February 1, 2015 and those who enroll January 16 - February 15, 2015, will be covered as of March 1, 2015.)
- Special enrollment periods (SEPs) under HIPAA (IRC § 9801) and other SEPs "under circumstances similar to SEPs under Medicare Part D" will be 60 days from the date of the triggering event in the individual exchange and 30 days in the SHOP exchange. Coverage will be effective the first of the next or subsequent month as described under the initial open enrollment rules, except coverage for dependents eligible due to birth, adoption, or placement for adoption will be the date of the triggering event. Special enrollment events include:
  - Gaining a dependent (or becoming a dependent) through marriage, birth, adoption, or placement for adoption
  - Newly gaining status as a citizen, national or lawfully present individual
  - Losing other health coverage, as long as the coverage was minimum essential coverage
  - Unintentionally or inadvertently failing to enroll due to an error on the part of the marketplace
  - Demonstrating to the marketplace that the plan in which the individual is enrolled substantially violated a material provision of its contract in relation to the enrollee (this would permit an individual to change marketplace plans)

  - Demonstrating that enrollment is necessary to remedy errors committed by non-exchange entities such as a navigator or agent (starting in 2016)
  - Being determined newly eligible (or experiencing a change in eligibility) for subsidized coverage (regardless of whether the individual is already enrolled in marketplace coverage)
  - Changing residence such that the individual gains access to new marketplace options
  - Demonstrating that the individual meets other exceptional circumstances as the marketplace may provide
- Voluntary termination of coverage and failure to pay premiums are not special enrollment events.
- Pregnancy, domestic violence, and changes in a provider network or formulary do not trigger special enrollment periods
- Special monthly enrollment periods for Native Americans
- Individuals whose individual or group health plan renews on a non-calendar year basis (starting in 2016)
- Individuals must be allowed to select a QHP up to 60 days before – and after – a loss of minimum essential coverage
- Individuals who applied for but were denied Medicaid
- Individuals with court orders must be able to gain coverage that is effective for a qualified individual on the date the court order is effective (starting in 2016)
- Special enrollment is available upon the death of an enrollee or the dependent of an enrollee, and would allow a coverage effective date of the first of the month following plan selection by the surviving enrollee or dependent whose coverage is affected by the death, or the Exchange could permit the choice of the normal effective date (starting in 2016)
- Individuals who are losing a dependent or lose dependent status due to a legal separation, divorce, or death (starting in 2016)
- Individuals with an income below 100 % of the FPL in a state that has not expanded Medicaid has an increase in income or change in household composition or size bringing them above 100 % of the FPL (starting in 2016)
- HHS has announced a special open enrollment period from March 15, 2015, to April 30, 2015. This period is only for individuals who discover (in the process of filing their taxes) that they owe a fee for not purchasing coverage for 2014. The special enrollment period will not affect penalties assessed for 2014, but will allow those who take advantage of it to avoid being assessed the penalty again for this year. It applies only to people who live in the states that use the federally-facilitated Marketplace, though several states with their own Marketplaces are similarly extending enrollment periods.
- Some previously open special enrollment periods have expired, including:
  - Extension to April 15, 2014, for those “in line” on March 31, 2014
  - Individuals whose individual policies renew between April 1, 2014 and December 31, 2014 Individuals currently on COBRA (special enrollment period ends July 1, 2014)

  - Individuals currently covered by the Pre-Existing Condition Insurance Plan (60-day special enrollment period starts May 1, 2014 and will be retroactive to May 1, 2014)

CMS has posted information about special enrollment periods.

States can allow, under HHS procedures, insurance agents and brokers to help individuals and employers enroll in QHPs offered through an exchange and to apply for premium tax credits and cost-sharing reductions. Agents and brokers who complete an application and training may assist consumers enrolling in federally facilitated exchanges. See Details for CMS Form Number: CMS-10464. Registration and training is expected to begin around July 1, 2013. (States running their own exchange may choose whether to recognize brokers as consumer advisors.)

Employers with non-calendar year plans may amend their Section 125 plan the 2013 - 2014 plan year only to allow employees to drop and/or add coverage to enroll in the exchange or the employer plan. The plan amendment must be signed by December 31, 2014. (Note that this was liberalized – see the next paragraph.)

Beginning with the 2014 plan year a Section 125 plan:

- May be amended to recognize enrollment in the exchange, either during open enrollment or as a special enrollment event, as a change in status event. Exchange coverage must begin on the day after coverage under the employer's plan ends.
- May be amended to provide that if due to application of measurement and stability periods the employee remains eligible for group medical coverage, even though he or she is now working fewer than 30 hours per week, the employee may revoke the group medical coverage election mid-year to enroll himself or herself (and any covered dependents) in either exchange or other employer-provided coverage. The employee may not discontinue all medical coverage, and the new coverage must provide minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month that includes the date the original coverage is discontinued.
- The employee may not change any election of dental or vision coverage or any HFSA election.
- The employer may rely on the employee's statement that the individuals dropping coverage are moving to exchange or other minimum essential coverage – the employer does not need to obtain proof that this coverage was put into place.
- The plan must be amended by December 31, 2015 (or by the end of the year the amendment is adopted if after 2015).

QHP insurers who are directly contacted by a potential applicant may directly enroll the applicant in a QHP through the exchange. The QHP insurer's website must:

- Permit an applicant to view comparatively all QHPs offered by the insurer
- Distinguish between QHPs for which premium tax credits are available and non-QHP plans for which they are not available
- Include a universal disclaimer provided by HHS stating that other QHP products are available through the exchange and link to the exchange website

Student health plans, which technically are individual plans, may operate on a school year.

Small Business Health Options (SHOP) Exchange

Effective January 1, 2014

Requires states to establish an exchange for the individual market and a Small Business Health Options (SHOP) exchange for the small group market, *or* to establish a single exchange for both markets.

The SHOP exchange is to be administered by a governmental agency or "eligible" non-profit entity to offer qualified health plans to individuals and small (100 employees or less unless the state opts to use 50 in 2014 and 2015, which all have for 2014) employers.

The SHOP exchange may be included with or separate from the individual exchange. Employers must offer coverage to all eligible full-time employees.

HHS is required to provide technical assistance to states to facilitate small business participation in SHOP exchanges.

Employers participating in SHOP will be required to make disclosures to their employees about the methods for selecting and enrolling in a QHP. Employers in a SHOP exchange will choose a level of coverage (Bronze, Silver, Gold, or Platinum) and contribution rate (if any) for employee and dependent coverage. Ultimately, employers will have the option to select a single SHOP plan that all employees must take, or allow employees to elect any plan available at the chosen level; for 2014 in the federal SHOP, and any state SHOP that wishes, there will be no employee choice – the employer will select one plan for all participating employees. This may be delayed until 2016 if the state demonstrates it would be a hardship to provide this option for 2015. A listing of states that will and will not be implementing employee choice was released by HHS on June 10, 2014. (If employees may choose the plan, the employer would determine its contribution level and a basis plan; this will determine the contribution the employer will make regardless which plan the employee chooses.)

Insurers who choose to participate in the individual exchange also must participate in the SHOP exchange, unless its market share in the state's small group market is less than 20%. If an insurer does not offer coverage in the small group market, another member of the insurer group may provide the SHOP coverage.

If a small group does not meet the participation rate, an open enrollment period (November 15 to December 15) must be offered. Note that this only applies to initial enrollment and not renewals (which may impose participation requirements).

In states with federally facilitated exchanges:

- For 2014 and 2015, the state definition of a "small employer" (50 or 100 employees; it appears that all states have opted to use 50 as the threshold for 2014) will determine which employers are eligible to participate in the exchange; however, regardless how the state defines "employee," full-time will mean 30 or more hours per week and employees will be counted in the same manner as employees are counted for purposes of the free rider/play or pay penalty (including the exclusion of seasonal employees who work less than 120 days and counting of part-time employees pro rata as "full-time equivalent" employees). SHOP exchanges must accept a group of one.
- The Protecting Affordable Coverage for Employees Act (PACE Act) amended the ACA and redefined small employers as those with 50 or fewer employees and gave states the option to expand the definition to include employers with up to 100 employees (or, practically speaking, those with 51 to 100 employees, also called "mid-size employers"). Employers should check their state statutes to determine the group size in place for January 2016.
- Minimum participation levels of 70% (excluding those with other coverage) will be used unless the state regularly uses a different participation level. The 70% applies to enrollment in the SHOP, not a particular plan. See above regarding special open enrollment rules for groups that don't meet participation requirements.

  - Participation only needs to be met as of the enrollment/renewal date
  - As of December 4, 2013, all states with FF-SHOPs were using 70% except for Tenn. (50%) and Ark., Iowa, N.H., N.J., S.D., and Texas (all using 75%)
  - HHS has said in an FAQ that it will allow an insurer to waive the 70% requirement in a FF-SHOP if it can demonstrate to CMS that it is operationally impractical to impose that requirement at this time.
- For 2014 employers must contribute a uniform percentage for all employees
  - Retirees are eligible if the employer will contribute the standard amount
  - COBRA participants are eligible and may be required to pay the full premium (to the employer)
  - HHS has proposed allowing different employer contributions for full-time and non-full-time employees, and for employees and dependents, beginning in 2015 in the FF-SHOP
  - Composite premiums would not be allowed after 2014
- No minimum contribution will be required (at least during open enrollment)
- For 2014, employees will not have the option to choose plans; the employer will choose the metal level/plan for the whole group
- Brokers must be paid the same compensation on sales inside and outside of the SHOP**;** however, the carrier may require that the broker be appointed to receive a commission
- Only brokers registered with the exchange will be listed on the website
- The geographic premium rating will be based on the employer's principal business address in the state
  - An employer with multiple locations may enroll all employees in the exchange for the state in which it has its principal location, or may enroll employees in the SHOP for the state in which they are assigned
  - For 2014 only, a state SHOP may use the employee's address instead
- If the employer uses a different SHOP in different states, participation will be based on each state's employee count
- An employer may only enroll in one SHOP per state
- States (including those with FF-SHOPs) may request a delay of employee choice within the exchange until 2016 if 1) it would result in significant adverse selection against the state's small group market, or 2) there are an insufficient number of QHPs or stand-alone dental plans to allow for meaningful plan choice within the SHOP. See above for a listing of states that are delaying this option.
- At least for 2014, all employees must be in one coverage/contribution class
- At least for 2014, dependents must enroll in the same plan as the employee
- Waiting periods may be 0, 15, 30, 45, or 60 days. Coverage will always be effective the first of the month.
- The renewal process will begin 90 days in advance. The employer will have 30 days to renew or change its election; then employees will have 30 days to make elections; all information must be submitted at least 15 days before the effective date.

- Coverage can be terminated if premium is not received by last day of coverage month, but coverage must be reinstated if premium is received within the next 30 days
- For 2014, if a group purchases a FF-SHOP QHP directly with an issuer and that product doesn't contain pediatric dental, the issuer of the medical plan does not need to obtain reasonable assurance that pediatric dental was purchased somewhere. (This requirement does apply to off SHOP QHPs unless the state has passed a law to allow a similar approach off-exchange.)
- QHP insurers can only change their premiums quarterly and can only change rates affecting a particular employer once a year.
- For 2015 employers can pay a fixed percentage of premiums, which can vary depending on whether employees are full- or part-time and on whether employees or dependents are covered, although this option will not be available in the federal exchange until sometime after January 1, 2015. Insurers may not offer composite premiums to employers where employee choice is permitted, but employers may offer their employees what is essentially a composite premium, for which the employer contributes a fixed dollar amount.

Online enrollment will not be available for 2014 in the FF-SHOP, so everyone must use a paper SHOP Employer Application. (State SHOPs may use online enrollment if they choose to do so.)

HHS issued a supplemental FAQ about the FF-SHOP on July 25, 2013 and a piece on the FF-SHOP paper enrollment process on December 2, 2013. A comprehensive Federal SHOP FAQ also is available.

Within the FF-SHOPs, this process will apply:

- Employers may apply for coverage at any time during the calendar year (although they must meet participation requirements if they do not apply from November 15 to December 15), and may choose an effective date up to two months later, as long as it is in the same quarter. The earliest date coverage can begin is the first day of the following month if an enrollment process is completed between the 1st and 15th of the month, and the first day of the second-following month for enrollments completed between the 16th and the end of the month.
- The employer completes the FF-SHOP application, providing a roster of all full-time employees;
- The FF-SHOP determines if the employer is eligible (and offers an appeal if the employer is determined ineligible);
- The employer chooses a coverage effective date, which must be the first of a month and within the coverage quarter (as insurers may change their rates prospectively very quarter);
- The employer selects an end-date for employee enrollment and decides whether to offer stand-alone dental coverage and coverage for dependents (which are not mandatory for small employers);
- The employer decides whether to offer employee choice, and at which single level (bronze, silver, gold, or platinum), and determines the level of employer contribution for medical, dental, and dependent coverage;
- The employer offers coverage to employees and others eligible for coverage (such as business owner and spouse) and specifies the deadline to enroll;
- The FF-SHOP notifies persons offered coverage of their eligibility (and offers an appeal to those determined ineligible);
- Employees select a plan or waive coverage;

- After the employee election period closes, the first month's premium is determined if the group has met the participation requirement and is thus able to complete enrollment; and, finally,
- An xml file is established for the group reflecting the qualified health plans and stand-alone dental plans chosen by employees. Communications between the FF-SHOP and employers take place online through the employer's MyAccount;
- Employers can add new employees after the initial enrollment process is completed. The FF-SHOP portal allows employers to impose waiting periods for new hires of 0, 15, 30, 45, and 60 days, after which the employee must elect coverage within a fixed period of time, such as 30 days;
- Employees and dependents may enroll outside of the annual renewal period if they qualify for special enrollment periods because of marriage, loss of minimum essential coverage, relocation that result in access to new QHPs, birth, or for other specified reasons;
- Rates charged employers in the FF-SHOP will be based on approved rates for the quarter for which coverage or renewal of coverage begins. Each month, the FF-SHOP will provide each qualified employer with an invoice showing the amount owed by the employer, by employees, and the total amount owed. The FF-SHOP will invoice the employer around the 10th of the month before a coverage month begins. Between the 15th and 26th of the month prior to coverage, the FF-SHOP will post two notifications on the employer's MyAccount and telephone the employer informing the employer that coverage will not be effectuated for the following month if payment is not received by the 26th.
- Employers must pay their first premium to the FF-SHOP before the initial coverage effective date. After initial enrollment, premiums are due on the first of a coverage month and must be paid to the FF-SHOP within 31 days thereafter to avoid termination. Insurers may, subject to applicable law, pend claims prior to receipt of payment from the FF-SHOP. If payment is not received by the first, a past due notice will be posted on the employer's MyAccount. If payment is still not received by the 15th, a second past-due notice will be sent and a letter mailed followed by another phone call on the 20th. If payment is not received by the 30th, coverage will be terminated but can be reinstated by full payment of all premiums due and the premium for the next month's coverage to the FF-SHOP within 30 days.
- Employers may voluntarily terminate coverage. If an employer voluntarily terminates, a notice must be sent to all employees. Employees may also voluntarily terminate coverage. Notice must then be sent to the employer.
- The HHS Benefit Payments and Parameters for 2016 final rule confirmed that former employees (and their dependents) such as retirees and COBRA participants may be offered SHOP coverage.

In states with state exchanges:

- For 2014 and 2015, the state definition of a "small employer" (50 or 100 employees) and the state definition of covered employee will determine which employers are eligible to participate in the exchange
- The state may set participation levels, subject to the special rules above for groups that don't meet minimum participation requirements
- Employers must contribute a uniform percentage for all employees
- No minimum contribution will be required

- The state may allow employers to offer a single plan to employees or to require employers to allow employees to choose a plan within a the chosen metal level
- Open enrollment does not need to start when open enrollment starts for the individual Marketplace (as is required for the FF-SHOP)

Note: Private group exchanges are not subject to the regulations applicable SHOP exchanges.

A state may elect to only operate the SHOP exchange, and have the federal government operate the individual exchange, as long as separate risk pools apply to these markets. Utah has exercised this option for 2014.

A full-time employee calculator is available.

CMS provided information on the impact of the PACE Act on small group expansion and SHOPs. CMS clarified that states that choose to expand the definition of small employer up to 100 employees beginning January 1, 2016, were required to notify CMS of the decision by October 1, 2015. States with other effective dates should notify CMS of the decisions as soon as is practical. A state's definition is legally binding on health insurance issuers.

Navigators, Certified Application Counselors, and Brokers

Effective January 1, 2014

Exchanges **must** establish and award grants to entities to increase public awareness and education about QHP choices, with impartial information and services ("Navigators").

Such entities must demonstrate that they have existing relationships (or could readily establish relationships) with employers, employees, consumers, or self-employed individuals likely to be qualified for exchange coverage, and could include:

- Trade, industry, or professional associations
- Commercial fishing, ranching, or farming organizations
- Community and consumer-focused non-profit groups
- Chambers of Commerce
- Unions
- Resource partners of the Small Business Administration
- Other licensed insurance agents and brokers
- Other entities

No health insurer or entity receiving direct consideration from a QHP-offering insurer is eligible to be a Navigator.

Duties for Navigators include:

- Conducting public education activities
- Distributing fair and impartial information about QHP enrollment and availability of subsidies
- Facilitating exchange enrollment

- Referring individuals to offices of health insurance consumer assistance or other state agencies regarding grievances, complaints, or questions about their health plans or coverage
- Providing information in a culturally and linguistically appropriate manner

In July 11, 2011, HHS issued proposed regulations containing significant information about the role of agents, brokers, and Navigators in state-based exchanges. The regulations propose:

- A pathway for states to ensure that individuals and small groups have access to information about agents and brokers, should they wish to use one, on state exchange websites and in other publicly available materials
- Navigators, including agents and brokers acting as Navigators, may not receive commissions or other payments directly from health insurance carriers, but specifies that these requirements only apply to health insurance exchange products.
- A Navigator is not precluded from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in products sold outside of the exchanges
- Navigators must meet any licensing, certification, or other standards prescribed by the state or exchange, as appropriate, which will allow the state or exchange to enforce existing licensure standards

For an analysis of the July 11, 2011, regulations of most consequence to brokers see Appendix 15: NAHU Overview of Proposed Exchange Regulations

On July 17, 2013, HHS published a final rule on Navigators, Non-Navigator Assistance Personnel and Certified Application Counselors. The rule is similar to the proposed rule and requires:

- All Navigators and non-Navigator assistance personnel to be trained regarding:
  - QHPs (including the metal levels), and how they operate, including benefits covered, payment processes, rights and processes for appeals and grievances, and contacting individual plans
  - The range of insurance affordability programs, including Medicaid, the Children's Health Insurance Program (CHIP), and other public programs
  - The tax implications of enrollment decisions
  - Eligibility requirements for premium tax credits and cost-sharing reductions, and the effects of premium tax credits on the cost of premiums
  - Contact information for appropriate federal, state, and local agencies for consumers seeking additional information about specific coverage options not offered through the exchange
  - Basic concepts about health insurance and the exchange, the benefits of having health insurance and enrolling through an exchange, and the individual responsibility to have health insurance
  - Eligibility and enrollment rules and procedures, including how to appeal an eligibility determination
  - Providing culturally and linguistically appropriate services
  - Ensuring physical and other accessibility for people with a full range of disabilities
  - Understanding differences among health plans

  - Privacy and security standards for handling and safeguarding consumers' personally identifiable information
  - Working effectively with individuals with limited English proficiency, people with a full range of disabilities, and vulnerable, rural, and underserved populations
  - Customer service standards
  - Outreach and education methods and strategies
  - Applicable administrative rules, processes and systems related to exchanges and QHPs
- Navigators, including agents and brokers acting as Navigators, may not receive commissions or other payments directly from health insurance carriers, but specifies that these requirements only apply to health insurance exchange products
- A Navigator is not precluded from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in products sold outside of the exchanges
- States and exchanges may impose licensing or certification requirements, eligibility rules, perform background checks and fingerprinting, etc., but only if the requirements do not prevent the application of the ACA. This includes prohibitions on:
  - Requirements to refer consumers to agents and brokers or to others sources not required to provide impartial advice
  - Requirements that would prevent providing services to all persons to whom they are required to provide assistance
  - Requirements that would prevent advising on terms of coverage or the comparative benefits of different health plans
  - Requirements that navigators be agents or brokers (although this can be required of non-navigators and CACs)

Under the rules navigators, non-navigators and CACs (Certified Application Counselors) would not be allowed to charge for application or enrollment services but they can charge for non-navigator services, like legal or medical, the entity provides. Navigator and navigator assistance programs would be prohibited from compensating individual navigators or non-navigators assisters on a per-application, per-person assisted, or per-enrollment basis. Navigators and non-navigator assisters would be prohibited from providing any applicant or potential enrollee with promotional items as an inducement for application assistance or enrollment unless they are of nominal value, defined as worth $15 or less.

Certified Application Counselors must be trained on, and pass a test on:

- QHP options
- Insurance affordability programs
- Eligibility and benefits and rules governing all insurance products in the state

CACs must be prepared to work with the disabled, but are not limited to English-speaking populations. They must meet privacy and security standards. CACs may not charge a fee. They may be a broker or agent if disclosed as a conflict of interest. See Additional guidance for CACs.

On August 30, 2013, HHS issued final regulations that address web-brokers.

- Web-brokers must prominently display a standardized disclaimer provided by HHS and a link to the federal exchange website.
  - The Disclaimer must state that 1) the Web-broker's website is not the exchange website; 2) the Web-broker's site may not contain all QHP information available on the exchange website; 3) the Web-broker must comply with federal standards governing Web-brokers; and 4) the Web-broker is subject to HHS privacy and security standards.
  - State exchanges have discretion to apply similar or more stringent requirements.
- Web-brokers must provide consumers with the opportunity to view all QHPs offered through the exchange, even if their information on certain QHPs is incomplete.
- Web-brokers must work with all consumers who come to them, including those eligible for Medicaid or CHIP.
- Agents and brokers who are not employees or subcontractors of Web-brokers may use a Web-broker's website in the federal exchange, but they are subject to direct regulation by HHS.
  - A Web-broker must ensure that any agent or broker accessing its website is properly licensed and trained and is registered and has signed all required agreements with the federal exchange.
  - The Web-broker must provide the federal exchange with a list of agents and brokers who have an arrangement to use the Web-broker's website, terminate arrangements with an agent or broker who violates federal requirements, notify HHS of any violations of regulatory requirements by agents and brokers using the website, and cooperate with HHS in taking action against a non-compliant agent or broker using the website, including facilitating terminating temporarily any connection between the Web-broker's website and the exchange while privacy and security breaches are investigated.
- The Web-broker must display its name and identifier on the website and on all materials printed from the website, so that consumers working with another agent or broker will know that they are using a Web-broker website. It may not include "marketplace" or "exchange" in its name. It must link to all available plans in the exchange, but is excused from including information it cannot access such as competitor's pricing.
- Web-brokers must comply with privacy and security standards and may only use personal information collected through the exchange application and enrollment process for exchange purposes. The purposes for which personal information can be used will be specified through Web-broker agreements.

Agents and brokers will be required to complete training and pass a test. They will access QHPs through either the carrier's, web-broker's or exchange's portal. Agents and brokers may enroll individuals in an exchange plan, but they may not make determinations of eligibility for premium tax credits or cost-sharing reductions. Beginning in 2016, HHS has set standards for HHS-approved vendors of federally facilitated Marketplace training for agents and brokers.

Agents and brokers in a federally facilitated exchange (FFE) must meet privacy and security requirements and must give HHS 30 days' advance notice of intent to terminate. HHS has the right to terminate an agent or broker's exchange access for cause. Agents and brokers who terminate must notify their clients of the termination, refer them to the exchange for assistance, and continue to assist their clients during the 30-day period. States retain primary authority for regulating agents and brokers, but HHS may terminate their participation in the federal exchange for failure to meet federal requirements.

On September 19, 2013, CMS issued an FAQ about agent and broker registration for the federally-facilitated marketplaces.

A Proposed Rule on Exchange and Insurance Market Standards addresses a variety of issues.

A person who knowingly and willfully uses improperly or discloses personal information received from or about an applicant for purposes other than ensuring the efficient operation of the exchange is subject to a penalty, generally of up to $100 per day per affected individual. Use of personal information for marketing activities without express, specific consent is prohibited. “Persons” include not only navigators, non-navigator assisters, and CACs, but also brokers, agents, web-brokers, QHP insurers, and other third-party contractors, and their agents and employees.

Consultation with Consumers

Effective January 1, 2014

Exchanges must consult with:

- “Educated health care consumers,” defined as “an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters”
- Persons or entities with enrollment experience
- Representatives of small businesses and the self-employed
- State Medicaid offices
- Advocates for enrolling hard-to-reach populations

Exchanges and Small Group Market – Benefit Designs and Qualified Plans

Minimum Essential Benefits for Exchange and Small Group Market

Establishes standards for qualified coverage for individual and small group (100 or fewer employees, unless the state opts to use 50 as the threshold until 2016) markets, including:

- Mandated benefits
- Cost-sharing requirements
- Out-of-pocket limits (tied to HSA limits for 2014 only)
- A minimum actuarial value of 60%

Self-insured plans, large group plans, grandfathered plans**,** and MEWAs are **not** "health plans" for this purpose, and thus will **not** have to comply with the requirements of the essential health benefits, except with respect to the prohibition on limiting coverage for EHBs. (**Note:** Self-funded plans that do not provide most of the essential health benefits may be subject to the employer penalty for not providing “minimum value” and “affordable” coverage.)

An Essential Benefits Package must include the following services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services “including behavioral health treatments”
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care (beginning in 2016 “pediatric” will mean through age 19)

The scope of these essential benefits will be equal to the scope of benefits provided under a “typical employer plan,” according to HHS.

- To inform the decision, DOL conducted a survey of employer (and multi-employer) plans
- Certification will be conducted by the CMS Actuary
- Each state will determine its own essential health benefits (EHBs)

Effective January 1, 2014 unless state insurance department allows and insurer chooses to renew policy using 2013 rules; option now available through October 1, 2016 renewals

Initial open enrollment period starts October 1, 2013

Note that these requirements also apply to the individual and small group market outside the exchange

In defining the essential benefits these criteria must be met:

- Make sure all benefits are given equal importance and emphasis.
- Make coverage decisions, determine reimbursement rates, establish incentive programs, or structure benefits in a way that does not discriminates based on age, disability or expected lifespan. (e.g., utilization management may not be used in a manner that disadvantages this group)
- Take into account the diverse health care needs of the population.
- Make sure that essential benefits are not involuntarily denied to anyone on the basis of age or expected lifespan or disability, medical dependency, or quality of life.
- Meet emergency coverage requirements (e.g., does not require prior authorization and charges the same cost-sharing for out-of-network emergency services as in-network).
- If a stand-alone dental plan is offered through the exchange, other health plans offered through that exchange need not provide for the pediatric dental care that is otherwise considered an essential health benefit; a separate "reasonable" cost-sharing limit and two unique benefit levels (70% and 85%) would apply to stand-alone pediatric care.
- Benefit-specific waiting periods are not allowed, except for pediatric orthodontia.
- Cost-sharing (primarily out-of-pocket) limits apply
- Deductible limits for small group employer plans of $2,000 for single coverage and $4,000 for family coverage were in the original law but this provision was repealed on April 1, 2014. A higher deductible was permitted if needed to reasonably meet a metal tier (e.g., Bronze).
  - The limits **could not** be raised by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement (FSA).

Note: Employees may not pay under employer's cafeteria plan for individual coverage offered through an exchange.

HHS must periodically review and update essential health benefits. The review and subsequent report to Congress must assess:

- Whether and how the benefits package needs to be modified
- How any potential change in benefits will affect both costs and actuarial limitations
- That the benefits still meet the "typical" plan requirement
- Per the February 25, 2013, final rule, the EHBs will remain the same for 2014 and 2015.

On February 25, 2013, HHS issued a final rule that:

- Confirms that non-grandfathered plans in the exchanges and the small group market will be required to cover the 10 essential health benefits (ambulatory/outpatient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including pediatric dental and vision care, up to age 19)

- Confirms that non-grandfathered plans in the exchanges and individual and small group markets must meet the "metal" standards (provide an actuarial value of 60%, 70%, 80%, or 90%), except for a permitted catastrophic plan
- Provides that if the base-benchmark plan does not cover all ten EHBs, the supplemented benefits must be the full benefit for that category from another plan eligible to be the base-benchmark plan in that state
  - Provides that if no plan covers pediatric oral and vision, either the benefit provided through the Federal Employee Dental and Vision Insurance Program with the largest enrollment, or the benefit available under the state's CHIP program may be used to define that benefit
  - Provides that if the base-benchmark plan does not cover habilitative services, the state may determine the required services; if the state does not set a standard issuers must either provide coverage consistent with benefits for rehabilitative services, or design a benefit and report on it to HHS
  - Provides that other policies in the exchange and small group market must generally provide the same coverage within each EHB category as the baseline plan, but that they may substitute an actuarially equivalent benefit within a category; certification of comparability would be needed from a member of the American Academy of Actuaries
  - Special rules apply to prescriptions – any substitution must cover the greater of one drug in each category and class of the U.S. Pharmacopeial Convention (USP) or the same number of drugs in each category and class as the EHB-benchmark plan; the drugs must be chemically distinct; the drug list must be reported to the exchange by a QHP, to the state by an EHB plan outside the exchange and to OPM by a multi-state plan; and participants must have access to clinically appropriate drugs that are not on the list
- Provides that state mandates in effect as of December 31, 2011, would be considered EHBs
- Provides that current year employer contributions to a health savings account (HSA) or a health reimbursement arrangement (HRA) will be considered as part of the actuarial or minimum value calculation (essentially as a first-dollar benefit)
- EHBs may not include routine adult dental, routine adult eye exams, cosmetic orthodontia, or long term/custodial nursing home benefits care

Full text of the final rule on EHBs: Essential Health Benefits, Actuarial Value & Accreditation - Final Rule

On November 14, 2013, HHS issued a Letter to Insurance Commissioners allowing renewal of individual and small group policies between October 1, 2013, and October 1, 2014, even though those policies do not satisfy many of the 2014 insurance reforms. States and insurers are not required to offer these renewals. On November 22, 2013, HHS issued text for the Standard Notices that must be provided to the policyholder if a 2013 policy is renewed for 2014. On March 5, 2014, HHS issued a Bulletin that extends this option through October 1, 2016, renewals. States have the option to allow renewals of individual policies only, small group policies only, or both types of policies, and to allow this for 2015 only or for both 2015 and 2016. In 2016, when the definition of small group changes to 1 to 100 employees, states may extend the option to renew existing policies to employers with 50 to 100 employees.

The extended policy for mid-size plans only applies to renewals for plan years beginning January 1, 2016, through October 1, 2016 (i.e., when these policies first become subject to the small group insurance requirements). It must comply with applicable ACA requirements for 2014 and 2015. Changing carriers between 2013 and 2016 will not disqualify a mid-size employer from the 2016 relief. The mid-size employer will need to renew its 2015 coverage for 2016.

An individual or small group that purchased a 2014 policy may not cancel that policy and reinstate 2013 coverage.

In the 2016 final rule on Benefit and Payment Parameters HHS determined that states should retain their current benchmark plans through 2016. Thereafter, 2014 benefits and usage will determine the benchmark for 2017 plans. Under the final rule, HHS will also require the use of pharmacy and therapeutics committees (P&T) (with specific credentials) and must satisfy the current USP drug count standard. More details were provided for the standard review process for the drug exceptions process, and the final rule requires that issuers have a process in place so enrollees can request and independent external review if a health plan denies an initial request made on a standard or expedited basis. Putting most or all drugs that treat a specific condition in the highest cost tiers is considered unlawful discrimination based on a health condition.

Optional Additional Required Benefits

States may require a QHP offer benefits in addition to essential health benefits. In such instance, the state must assume the cost to defray the additional benefits by:

- Making payments to an individual enrolled in a QHP, or
- Making payments on behalf of such individual directly to the QHP in which such individual is enrolled

The February 25, 2013, the final rule on EHBs provides that all state mandates enacted by December 31, 2011, (even if not effective by that date) will be considered EHBs (and therefore the state will not be responsible for the cost). If mandated benefits are enacted after that date, issuers will be responsible for calculating the cost of the additional benefits and states will be responsible for paying for them. To the extent the state mandate only applies in the individual or small group market, that limitation will carry forward. For the purpose of federal reimbursement, only benefits related to care and treatment are considered state-required benefits; while a state may still impose requirements for cost-sharing, provider types, reimbursement methods, etc., there will be no federal reimbursement for these mandates.

Effective January 1, 2014

Qualified Plans – Levels of Coverage (Plan Designs)

Qualified health plans (QHPs) must meet one of the four specified actuarial value tiers (determined by standard population, not the plan's actual population):

- **Bronze**: Coverage of 60% actuarial value
- **Silver**: Coverage of 70% actuarial value
- **Gold**: Coverage of 80% actuarial value
- **Platinum**: Coverage of 90% actuarial value

"Actuarial value" means the anticipated amount of all eligible expenses (including deductibles, co-pays, etc.) that will be paid by the plan. Under the February 25, 2013, final rule on EHBs, a *de minimis* variation of plus or minus 2% will be permitted in actuarial assessments (so, for instance, a plan with an actuarial value of 68% to 72% would be considered a "silver" plan). However, the minimum for a bronze plan is 60%, not 58%.

Under the February 25, 2013, final rule on EHBs, current year employer HSA and integrated HRA contributions may be taken into account (as a first dollar benefit) when determining actuarial value.

Effective January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016, renewals

A QHP may also be a catastrophic plan if it:

- Makes this plan available only in the individual market to individuals between age 21 and age 30 at the time of enrollment/reenrollment (an individual may remain on the catastrophic plan until the end of the year in which he turned 30) and to individuals who have received certification that they are exempt from the coverage mandate by reason of affordability or hardship.
- Sets the deductible at the high-deductible health plan (HDHP) limit indexed to per capita premium increases after 2014.
- Covers essential health benefits after the deductible is met (excluding coverage for preventive services, which must be first dollar).
- Covers three primary care visits per year, which may have cost-sharing.

Requires all QHPs to offer the same plan package(s) as a separate Children-Only (Under 21) Plan.

The February 25, 2013, final rule on EHBs provides a calculator that must be used to determine actuarial value (with exceptions for unique plan designs):

- For 2014 everyone must use a prescribed national standard population in the individual and small group markets
- For 2015 and later a state may elect to use a state standard population
- HHS has proposed updates to the calculator for 2015. The 2015 calculator and methodology are available under "Premium Stabilization Programs" (HHS does not intend to update the calculator annually; the 2015 update is just for increased OOP)

State benchmark plans are listed at the end of the Essential Health Benefits final regulation.

Special Rules Relating to Abortion Coverage in Exchange Plans

Effective January 1, 2014

Qualified health plans (QHPs) offered through an exchange are **not** required to provide coverage of abortion services as part of its essential benefits.

Subject to the state opt-out provision (passing a law banning abortion coverage in QHPs offered through its exchange), the inclusion of abortion coverage is determined by the health plan issuer.

Executive Order 1535 specifically prohibits the use of federal funds, tax credits, and cost-sharing reduction payments to pay for abortion services (except in the case of incest, rape, or when the life of the mother is endangered) in the exchanges.

In situations where federal funds cannot be used for abortion services, the plan issuer must set up a separate payment and allocation account for benefits related to abortion services.

- When an enrollee's premium is paid via payroll deposit, these separate payments are required to be paid by a separate deposit.
- Affected QHPs are required to provide a notice of such coverage to employees at enrollment as part of the Benefits Summary.

- QHP insurers that elect to cover abortions must estimate the cost of providing such services (which must be at least $1 a month) and collect a separate premium for abortion coverage. The insurer can send a separate invoice for these services, a single invoice that separately itemizes the cost of these services, or a single notice at the time of enrollment that monthly premium invoice includes a separate charge for this service. The insurer must, upon receipt of the premium, deposit the abortion-related funds in a separate allocation account.

QHPs offered through an exchange may not discriminate against any health care provider or facility on the basis of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

The ACA does not preempt or have any other effect on any state laws related to abortion, nor relieve any health care provider from providing emergency services required by state or federal law.

Health Care Quality Rewards via Market-Based Incentives

Effective January 1, 2014

Health care quality is to be rewarded (increased reimbursement or other incentives) through market-based incentives, such as:

- Improvement of health outcomes via:
  - Quality reporting
  - Effective case management
  - Care coordination
  - Chronic disease management
  - Medication and care compliance initiatives (including via the medical home model)
- Prevention of hospital readmissions via:
  - Comprehensive discharge planning
  - Patient-centered education and counseling
  - Post-discharge reinforcement by an appropriate health care professional
- Improved patient safety and reduced medical errors via:
  - Appropriate use of best clinical practices
  - Evidence-based medicine
  - Health information technology
- Reduced health care disparities via:
  - Use of language services
  - Community outreach
  - Cultural competency training

Guidelines are to be developed by HHS in consultation with health quality experts and stakeholders.

Qualifications for Health Plan Participation in Exchanges

Requirements established by HHS for participating plans:

- Meet marketing requirements and not employ marketing practices or benefit designs that have the effect of discouraging enrollment by those with significant health needs.
- Ensure sufficient choice of providers and provide information on the availability of in- and out-of-network providers.
- Include "essential community providers" who serve low-income and underserved communities in plan networks.
- Be accredited for clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) and patient experience ratings by:
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
  - Consumer access
  - Utilization management
  - Quality assurance
  - Provider credentialing
  - Complaints and appeals
  - Network adequacy and access
  - Patient information programs by an accreditation entity recognized by HHS
- Implement and report on a quality improvement strategy described as a payment structure that provides increased payment or other incentives for the following kinds of activities (to be described in further detail in HHS guidelines):
  - Improving health outcomes
  - Preventing hospital readmissions
  - Improving patient safety and reducing medical errors
  - Implementing wellness and health promotion activities
  - Reducing health care disparities through language services, community outreach, and cultural competency training
- Utilize uniform enrollment forms for qualified individuals and employers, that takes into account NAIC criteria for paper and electronic forms.
- Utilize a standardized format for explanation to customers of health benefits and plan options.
- Provide information to enrollees and exchanges on any quality measures for health plan performance.
- Report to HHS at least annually on pediatric quality reporting measures established under Section 1139A of the Social Security Act.
- Meet Mental Health Parity Requirements.

Effective January 1, 2014

- Contract with "Navigators" to conduct outreach and enrollment services.
- Meet Transparency and Disclosure Requirements.
- Before raising premiums, submit justification to the exchange and post such justification on the plan's website. Exchanges can consider such information in determining exchange participation status for health plans.
- Beginning January 1, 2015, plans are prohibited from contracting with
  - Hospitals with fewer than 50 beds *unless* such hospitals: use a patient safety evaluation system as described in the Medicare Advantage statute, and implement a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional
  - Providers, unless they implement "such mechanisms to improve health care quality" as HHS requires by regulation.

Qualified Health Plan (QHP) Requirements

Effective January 1, 2014

A QHP must:

- Be certified by each exchange in which it operates.
  - A QHP may operate outside the exchange if it offers a benefits package, network, service area, cost-sharing structure and premium as the exchange plan. Differences in appeals processes are allowed. Differences in state and federal requirements may impact the premium.
- According to the 2015 Letter to Issuers in the FFE in states where CMS is conducting the plan review, QHP applications are initially due between May 27 and June 27, 2014. CMS will send a first notice to the QHPs as to needed corrections on July 29. Plans must submit reviewed QHP data for review by August 7. CMS will send a second correction notice on August 26. Final submission of QHP data is due on September 4, with a re-review completed by September 22. QHP agreements will be sent to insurers and the agreement finalized between October 14 and November 3, with open enrollment beginning November 15.
  - Insurers in states in which CMS performs certification functions must submit their applications and data through the Health Insurance Oversight System (HIOS). They must certify compliance with regulations for themselves and for their delegated and downstream entities and submit requested supporting documentation. They must also submit the Unified Rate Review Template (URRT) to allow CMS to review their rates. CMS will coordinate its reviews with state regulators, who have primary responsibility for reviewing compliance with state law and market-wide standards as well as for compliance with essential health benefit and actuarial value standards.
  - In states where the state performs plan management functions, a QHP insurer will generally submit an application through the System for Electronic Rate and Form Filing (SERFF). The state will set the deadline for application submission and review, but data must be transferred to CMS for review by August 8. The FFE will notify the states of any needed corrections by August 26, and insurers must resubmit data to SERFF by September 4, to be transferred to CMS between September 5 and September 10. CMS will make a final determination based on the state's recommendation, and from that point the review will follow the timeline set out above. QHP insurers must submit the URRT to both the state and CMS.

- Provide the essential benefits package, including providing essential benefits and meeting cost-sharing and actuarial value requirements.
- Be offered by a health insurer that:
  - Is licensed and in good standing
  - Agrees to offer at least one QHP in the Silver level and at least one plan in the Gold level in each exchange in which it operates
  - Agrees to charge the same premium for the same plan whether offered in or out of an exchange and whether or not it is issued directly or through an agent (i.e., if insurers build in commissions for sales outside the exchange, the exchanges retain the commissions if no broker is compensated for exchange plans)
  - Complies with regulations HHS establishes and any other requirements an exchange may establish.
  - For 2015, plans will be required to also meet network adequacy standards (by submitting a list of network providers) and include access to additional essential community providers.

Coverage transparency requirement for exchange plan certification:

- The following information must be submitted "in plain language" to the exchange, HHS, the state health insurance commissioner, and be disclosed publically:
  - Claims payment policies and practices
  - Periodic financial disclosures
  - Data on enrollment
  - Data on disenrollment
  - Data on the number of claims denied
  - Data on rating practices
  - Information on cost-sharing and payments with respect to any out-of-network coverage
  - Information on enrollee and participant rights
  - Other information as deemed appropriate by the Secretary of HHS
- Plans are required to permit individuals to learn, in a timely manner upon request, the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that they would be responsible for paying for a specific item or service by a participating provider via a website and other means for individuals without Internet access.

A "screen and enroll" provision is required whereby individuals who are eligible for Medicaid or CHIP must be identified at the time of application and enrolled in those programs rather than the exchange.

Certain plans *not* offered via an exchange will generally also be treated as a qualified plan, including:

- Non-profit plans offered through the Consumer Operated and Oriented Plan (CO-OP)
- Multi-state plans

- Qualified direct primary care medical home plans

See the draft letter from HHS to issuers on federally-facilitated and state partnership exchanges.

QHP issuers are responsible for entities that perform services on its behalf meet all applicable standards (e.g., privacy and security).

Limits Placed on Participating Plans

Allows states to exclude some plans that otherwise appear to meet the requirements of a qualified plan.

Effective January 1, 2014

- Exchanges must determine that allowing a plan to participate is "in the interests of" eligible participants. For 2015 and later this includes a requirement that there be a "meaningful difference" between the plans offered by an insurer. (QHPs in the same plan type, metal level, and service area must differ from each other at least with respect to having different networks, different formularies, a difference of at least $50 in both individual and family in-network deductibles, a $100 or more difference in both individual and family in-network limits on cost-sharing, differences in covered benefits, difference in Health Savings Account eligibility, or differences in child-only, adult-only, or child and adult coverage offerings). Also if QHP issuers merge, they will have a 2 year transition period to eliminate plans that are not meaningfully different.
- However, the exchange **cannot** exclude a health plan:
  - On the basis that it is a fee-for-service (FFS) plan
  - Through the implementation of premium price controls
  - On the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances that the exchange determines are inappropriate or too costly
- Requires plans to submit justification for **any** premium increase prior to implementation, and to post such information on plan websites and gives exchange authority to use this information (and recommendations provided by states related to patterns of excessive or unjustified premium increases) in determining whether to make a plan available in the exchange.
- Provides for the exchange to also take into account any "excess of premiums growth outside the exchange as compared to the rate of such growth inside the exchange," including information reported by states.
- Exchanges are also required to consider reasonableness of premium increase when deciding whether to allow plans to participate.
- Exchanges may reject bids by insurance companies with "excessive" premium increases.
- For 2015 HHS will impose increased requirements for network adequacy, more stringent requirements for contracting with "essential community providers" (ECPs are providers that serve predominantly low-income and medically underserved individuals including federally qualified health centers (FQHCs), Ryan White HIV/AIDS providers, family planning providers, Indian health provides, and safety net hospitals) and expedited review of formulary appeals.

Exchanges – Other Provisions

Procedure for Determining Eligibility

Effective as soon as practical after March 23, 2010

Requires HHS to establish procedures for determining eligibility for:

- Exchange participation
- Premium tax credits
- Cost-sharing reductions
- Individual responsibility exemptions

On August 15, 2011, HHS released proposed rules outlining exchange eligibility and employer standards.

The IRS also released a proposed rule that provides guidance on premium subsidies for coverage obtained through exchanges.

Additional proposed rules were released by HHS on February 1, 2013.

Applicants must furnish the following information (and HHS must verify to the extent possible through available electronic data bases):

- Name
- Address
- Date of birth
- Social Security number
- Immigration papers
- Information for the tax year ending with (or within) the second calendar year preceding the calendar year in which the plan year begins:
  - Taxpayer ID
  - Filing status
  - Number of individuals allowed a deduction
  - Modified gross income
  - The tax year to which the information relates
  - Information regarding significantly changed circumstances (if applicable)
- Employer's name
- Employer's address
- Employer's ID number

- Full-time employee status
- Employer's minimum essential coverage
- Employer's lowest cost option plan
- Required contribution to employer's lowest cost option

If inconsistencies are determined to exist, the individual has generally 90 days following notification by HHS to provide additional documentation.

Penalties for individual violations are:

- $25,000 for providing incorrect information or violating confidentiality requirements
- $250,000 for knowingly and willfully providing false or misleading information

Exchange application forms:

- Application for Health Coverage & Help Paying Costs (standard form)
- Application for Health Coverage & Help Paying Costs (short form)
- Application for Health Coverage

In the FFEs an individual may drop exchange coverage by providing 14 days' notice. A 30-day grace period will be provided to pay premiums.

Health and Human Services Responsibilities

Effective as soon as practical after March 23, 2010

Requires HHS, in conjunction with NAIC and other applicable organizations, to set standards for:

- The establishment and operation of exchanges
- The offering of qualified health plans (QHPs) through the exchanges
- The establishment of the reinsurance and risk adjustment programs created by the ACA

Requires HHS to:

- Establish criteria for the certification of QHPs
- Develop a system to rate QHPs in each exchange and each benefits level, based on price and quality
- Develop an enrollee satisfaction survey system to evaluate enrollee satisfaction with participating plans that had more than 500 enrollees in the previous year
- Continue to operate, maintain, and update the Internet Portal developed by HHS by July 1, 2010, and make available a model template for Internet portals that state exchanges can use
- Present quality ratings information in the new Internet portals
- Audit exchanges annually
- Provide for the efficient and non-discriminatory administration of exchanges

- Develop a single form that will allow individuals to apply for enrollment in Medicaid, CHIP, or exchange subsidies and receive a determination of eligibility
- Provide eligible individuals with a notice of eligibility for any state subsidy program
- Provide technical assistance to states to facilitate small business participation in Small Business Health Options Program (SHOP) exchanges

Allows HHS to:

- Investigate exchanges' records and properties
- Implement other financial integrity provisions to reduce and fraud and abuse
- Rescind up to 1% of payments otherwise due an exchange in the event of serious misconduct

Note: On July 11, 2011, HHS unveiled its initial proposed regulation governing the health benefit exchanges. The proposed rules offer states guidance and options to structure their exchanges, including:

- The minimum criteria for states to establish their own exchange
- Setting up a small business health options program (SHOP)
- Performing the basic functions of an exchange
- The process for health plans to be certified to sell in the exchanges
- Other provisions meant to promote market stability

A state does ***not*** have to be completely ready for federal certification as an independent state exchange on January 1, 2013, but could be provisionally certified by HHS instead.

On August 14, 2012, HHS released the final "Blueprint" each state must submit to validate its ability to provide the required services in the exchange. States that intend to operate an exchange as of January 1, 2014 must provide an acceptable Blueprint to HHS by December 14, 2012. A Blueprint consists of a declaration letter from the state outlining the type of exchange model the state will follow, and a completed application.

States may opt to perform all exchange functions themselves, not set up an exchange (in which case HHS will run an exchange on behalf of the state), or share responsibilities with the federal government.

The National Committee for Quality Assurance (NCQA) and URAC have been appointed as accrediting entities. See Recognition of Entities for the Accreditation of Qualified Plans.

Direct Payment of Premiums

Allows enrollees to be allowed to pay premiums directly to their health plans.

Effective January 1, 2014

CMS is discouraging (but has not yet prohibited) payment of exchange premiums by third parties through a CMS November 4, 2013 Q&A.

Deeming of Existing Exchanges

Requires HHS to "presume" that exchanges in existence before January 1, 2010, that insure a percentage of the population that is at least as high as the percentage projected to be covered nationally after the implementation of this law, meet the standards for exchanges, unless HHS determines that the exchange does not comply with such standards.	Effective January 1, 2014

CO-OPs, Multi-State Plans, and Interstate Compacts

Consumer Operated and Oriented Plan (CO-OP) Program – General

Effective March 23, 2010

Requires HHS to establish the Consumer Operated and Oriented Plan (CO-OP) program, under which loans and grants will be provided to foster the creation of qualified non-profit health insurance issuers to offer coverage in the individual and small group markets through the exchanges.

Does ***not*** require states to establish such cooperatives.

Provides for the Comptroller General to appoint the 15 unpaid members of the CO-OP Advisory Board, with initial appointments made on or before June 23, 2010. The Advisory Board will terminate upon the completion of its duties, but no later than December 15, 2015.

To qualify for Advisory Board appointment, individuals must:

- Have national recognition for their expertise in:
  - Health care finance and economics
  - Actuarial science
  - Health facility management
  - Health plans and integrated delivery systems
  - Allopathic and osteopathic physicians and other providers of health services
  - Other related fields
- Provide a mix of different professionals, broad geographic representation and a balance between urban and rural representatives
- Meet ethical standards
- Guard against insurance industry interference

Representatives of any health insurer in existence as of July 16, 2009, or of any federal, state or local government are prohibited from serving on the CO-OP Advisory Board.

On July 18, 2011, CMS released proposed regulations creating standards for health care cooperatives.

- CO-OPs will meet the same standards as all other health insurers in the state where they offer coverage.
- CO-OPs will also demonstrate that premiums and any federal loans are being used appropriately and for the benefit of enrollees.
- CO-OPs must have a management team with expertise in health insurance, and the board must include individuals with expertise in the business of insurance.

See the full text of the proposed regulations establishing the CO-OP program.

Collective purchasing and rate setting by CO-OPs:

- Allows participating plans to establish a "private purchasing council" to enter into collective purchasing arrangements for services that increase administrative and other cost efficiencies (e.g., claims administration, HIT, actuarial services).
- Prohibits such councils from setting payment rates for health care providers
- Continue to be subject to existing antitrust laws
- Prohibits representatives of existing health insurers or of federal, state or local governments from serving on the council
- Prohibits HHS from "interfering" with competition with respect to non-profit issuers
- Prohibits HHS from participating in any negotiations between participating plans and providers
- Prohibits HHS from establishing or maintaining a price structure for reimbursement of covered benefits

Grants a federal income tax exemption (IRC § 501(c)(29)) to entities receiving grants or loans, if in compliance with CO-OP and grant agreement requirements, subject to prohibitions against participating or intervening in any political campaign of any candidate for public office, and participating in a substantial manner in activities relating to propaganda or otherwise attempting to influence legislation.

Prohibitions against individual inurement of an individual or shareholder will *not* apply when all the profits of an issuer are required to lower premiums, improve benefits, or improve the quality of health care delivered to its members.

CO-OPs are subject to annual tax on health insurers; however, only 50% of premium arising from tax-exempt business is considered in calculating their market share, which in turn determines their share of the annual tax.

Note: In an FAQ published October 6, 2011, the CIIO stated that CMS did not anticipate publicly posting the names or locations of organizations filing letters of intent. However, letter of intent applicants should remember that all materials submitted to CMS are subject to the Freedom of Information of Act (FOIA) and any FOIA request will be examined against exceptions such as trade secrets outlined in the HHS FOIA regulation.

On December 9, 2011, the HHS issued a final rule to establish at least one health insurance cooperative in every state. The following are some of the highlights.

- "Substantially all" requirement
  - The Final Rule confirms that many larger employers will be able to participate in CO-OPs by permitting up to one-third of all CO-OP contracts to be purchased by such large employers.
  - It provides that Section 1322's requirement that "substantially all" health insurance issued by the CO-OP is placed in the individual and small group markets is satisfied where two-thirds of its contracts are in those markets. The Final Rule confirms also that the two-thirds standard applies to all of the activities in the CO-OP; an interpretation that HHS believes properly encourages providers who may want to offer a CO-OP option to their employees to participate in CO-OP provider networks.
  - In response to concerns regarding extensive state licensure requirements and in an attempt to provide flexibility for and ensure the viability of CO-OP providers, the Final Rule significantly extends the timeline when CO-OPs are required to be offering qualified health plans (meeting the "substantially all" requirement). As a result of this

change, a loan recipient will now have two years from the solvency loan draw down dates to begin providing health care coverage in the exchanges and to meet all minimum CO-OP requirements.

- CO-OP Governance
  - The Final Rule extends the transition period from the formation to the operational board from one to two years after the CO-OP enrollment begins, permits the staggered election of the operational board, and permits the formation board to fill its vacancies, without a contested election.
  - Providers are prohibited from composing a majority of the CO-OP board of directors unless, as will sometimes be the case, the provider-board members purchase the product themselves, in which case they can serve as board members in their capacity as CO-OP members.

See the full text of the Final Rule implementing the Consumer Operated and Oriented Plan (CO-OP).

Consumer Operated and Oriented Plan (CO-OP) Program – Eligibility

Effective March 23, 2010

To be eligible for the CO-OP program, qualified plans must:

- Be not-for-profit member organizations
- Have substantially all their activities involve providing health insurance coverage in the individual and small group markets
- Not be an existing organization that provides insurance as of July 16, 2009, nor an affiliate or successor to any such company
- Not be "sponsored" by a state government
- Meet all the requirements that other QHPs must meet in any state, including licensure, solvency, provider payment, network adequacy, rate and form filing, and state premium assessments
- Use any profits to lower premiums, improve benefits or for other programs intended to improve the quality of health care delivered to members
- Offer coverage only after this law's market reforms are in effect in the state

The U.S. government will not treat an organization as a qualified non-profit issuer unless:

- Its governance is subject to a majority vote of its members
- Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference
- It operates with a strong consumer focus (according to HHS regulations), including timeliness, responsiveness and accountability to members

Also requires compliance with state laws, including:

- Guaranteed renewal
- Rating

- Pre-existing conditions
- Non-discrimination
- Quality improvement and reporting
- Fraud and abuse
- Market conduct
- Prompt payment
- Appeals and grievances
- Privacy and confidentiality
- Benefit plan material or information

Violation of these requirements and failure to correct them within a reasonable period result in repayment of 110% of the aggregate amount of loans and grants plus interest, and termination of tax-exempt status.

In an FAQ published October 6, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) stated that:

- An organization may not partner with an existing health insurance issuer to develop a CO-OP, since, under the ACA, if an organization is a health insurance issuer that existed on July 16, 2009, a related entity, or any predecessor of either, that organization is not eligible for loans under the CO-OP program and cannot become a CO-OP.
- A third party administrator (TPA) may not develop a CO-OP unless the TPA was also a licensed health insurance issuer on July 16, 2009.
- Whether or not an existing nonprofit entity has to form a separate entity to apply for funds and become a CO-OP, the CMS reiterated that:
  - As a statutory requirement under the ACA, a health insurance issuer that was in existence on July 16, 2009, cannot sponsor a CO-OP.
  - Under the proposed rule, the applicant must be the entity that will eventually become a CO-OP.
  - Unless the sponsor wants to become a CO-OP, it should form a separate entity.
- A CO-OP can be founded by a consumer-run nonprofit self-insured multiple employer welfare arrangement (MEWA) that does not have an insurance license, but that is currently licensed in its domiciliary state as a nonprofit, self-funded MEWA, because entities not licensed as issuers on July 16, 2009, may apply.

On December 8, 2011, the CMS released the Final Rule produced by HHS to establish the Consumer Operated and Oriented Plan (CO-OP) Program.

- Under the proposed rule, the following were listed as not eligible to apply for or receive a loan under the CO-OP program:
  - Pre-existing insurance issuers
  - Trade associations whose members consist of pre-existing issuers

  - Entities related to pre-existing issuers
  - Predecessors of pre-existing issuer or related entity
  - Organizations sponsored by a state or local governments
  - Foundations established by a pre-existing issuer
  - Holding companies that control pre-existing issuers
  - Organizations sponsored by pre-existing issuers
  - Organizations that receive more than 25% of their total funding (not including loans under the CO-OP program) from pre-existing issuers
- The Final Rule clarifies that private non-profit hospitals and physician hospital organizations, or other organizations that receive financial support from a state or local government are not instrumentalities of a state or local government, and are therefore eligible CO-OP participants, so long as:
  - The entity is not a government organization under state law
  - No employee of state or local government acting in his or her official capacity serves as a senior executive
  - State or local government employees acting in their official capacities do not comprise the majority of the CO-OP board of directors
- Additionally, the Final Rule permits applicants to receive up to 40% of CO-OP funding from a state or local government without being considered an instrumentality of such government entity.

Twenty-three CO-OPs have been approved for funding. Read more about the non-profits that have been awarded funding: New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers. Due to funding limits (see below) no other CO-OPs are expected to be in effect over the short-term. CO-OPs must be prepared to meet the October 1, 2013, open enrollment date.

Consumer Operated and Oriented Plan (CO-OP) Program – Funding

Effective March 23, 2010

Provides up to $6.6 billion in loans for start-up assistance and grants to help meet state solvency requirements, to be made available by HHS no later than July 1, 2013.

In April 2011, funding for 2011 was cut $2.2 billion. The balance of $4.4 billion in 2012 funding was left intact.

Criteria for awarding funds:

- HHS must take the recommendations of the CO-OP Advisory Board in making grant and loan award decisions.
- Gives priority to applicants that will offer statewide coverage, will use integrated care models, and that have significant private support.
- Requires HHS to ensure sufficient funding to establish at least one plan in each state. (If no issuers apply in a state, allows HHS to award grants to encourage establishment of a qualified nonprofit issuer within the state or the expansion of a qualified issuer from another state.)

- Prohibits using the grants or loans to fund legislative activity or other marketing efforts.
- Loans will only be made to private, nonprofit entities that demonstrate a high probability of becoming financially viable.

Grant or loan repayment:

- Requires HHS to issue regulations on the repayment of loans and grants no later than July 1, 2013, and prior to the awarding of any monies.
- Provides for loans to be repaid **(with interest)** within 5 years.
- Grants must be repaid within 15 years.

Audit oversight:

- Loan recipients are subject to strict monitoring, audits, and reporting requirements for the length of the loan repayment period plus 10 years.
- Recipients will submit semi-annual program reports and quarterly financial statements.
- CMS will conduct audits, including site visits, as appropriate.
- CO-OPs must meet a series of milestones as laid out in their loan term agreements before drawing down any money from the program.

Note: In an FAQ published October 6, 2011, the CCIIO stated that, whether or not approval will be available for start-up loan modifications necessary to satisfy the capital requirements associated with unexpected rapid growth or high enrollment, applicants should estimate their funding needs as accurately as possible in the business plan submitted as a part of the application, and should not assume that loan modifications will be available to provide additional funding.

State and Regional Options

Effective January 1, 2014

Provides flexibility for:

- Regional or other interstate exchanges if the states involved permit such operations and HHS approves such exchanges.
- Subsidiary exchanges, if each exchange serves a geographically distinct area that is at least as large as a rating area (as established by a state and reviewed by HHS).

Multi-State Plans

Effective January 1, 2014

Requires the Office of Personnel Management (OPM) to contract with at least two private insurer multi-state plans (including at least one non-profit) for individual and small group health coverage which must to be available as part of the exchange in each state.

Allows participation by a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark (i.e., the Blues).

Administration:

- Requires OPM to administer the program in a manner similar to the Federal Employees Health Benefits (FEHB) Program with regard to negotiation of loss ratios, profit margins, premiums and other terms and conditions of coverage "as are in the interests of enrollees," but does not require plans in the FEHB Program to participate.
- Treats enrollees in the new plans as a separate risk pool from the FEHB Program.
- Requires OPM to establish an advisory board (with a significant percentage of members composed of enrollees in multi-state plans or their representatives) to provide recommendations on this program.
- Requires OPM to ensure that at least one of the multistate plans offered in an exchange does not provide coverage of abortion services for which public funding is prohibited.

Insurers offering such coverage must:

- Be licensed in each state and subject to all state law requirements not inconsistent with this provision.
- Comply with minimum standards for FEHB Program plans. A 2015 final rule from OPM determined that insurers may choose to either use the state-selected benchmark plan for the state in which the plan is offered, or an OPM benchmark plan.
- Offer a uniform benefit package consisting of the essential benefits package. (Exempts plans from state benefit mandates that exceed requirements for federal essential benefits package unless a state agrees to assume the cost of these mandates for all state enrollees.)
- Meet all requirements for QHPs, including offering of different levels of coverage in each exchange. (The provision deems plans qualified to offer coverage under this provision to be certified as QHPs.)
- Agree to offer coverage in each exchange in each state (see phase-in schedule below).
- Comply with all Public Health Service Act (PHSA) rating requirements, while allowing states to apply age rating limits stricter than the bill's 3:1 requirement.

Requires coverage to be offered in all states (through state exchanges) on a phased-in basis, with coverage offered in:

- 60% of states in the first year (31 states)
- 70% in the second year (36 states)
- 85% in the third year (44 states)
- 100% in the fourth year and thereafter

Makes individuals enrolled in multi-state coverage eligible for premium tax credits and cost-sharing reductions.

Contract terms:

- One-year, annually renewable contracts, that may be made automatically renewable in the absence of notice of termination by either party.
- Permits approval of contracts to be withdrawn only after notice and opportunity for a hearing.
- Federal competitive bidding statutes do **not** apply.

Also requires compliance with state laws, including:

- Guaranteed renewal
- Rating
- Pre-existing conditions
- Non-discrimination
- Quality improvement and reporting
- Fraud and abuse
- Market conduct
- Prompt payment
- Appeals and grievances
- Privacy and confidentiality
- Benefit plan material or information

Provides for OPM to be appropriated funds to support these new duties.

Participants will have personal and claims-related data mandatorily collected by the federal government in a national database. The data will be shared with other entities for law enforcement and other purposes.

HHS issued a Final Rule on March 11, 2013, which reiterated the requirements described above and largely followed the proposed rule. The final rule also:

- Provides that there will be no user fee in 2014
- Provides that the multi-state plan (MSP) would need to follow all of the state rules that apply to the individual and small group market and would participate in the carrier's individual and small group risk pools
- Would allow the issuer to choose between offering the EHB package approved in each state in which it participates, or offer any of the three largest FEHB Program plans by enrollment (supplemented to cover all 10 EHBs plus state mandated benefits); the same method must be used in all states
- Provides that OPM would handle all external claims appeals
- Provides that OPM will negotiate rates; premiums would vary by state
- Provides that the state and OPM would review rates and policy forms, with OPM as the final word
- Would allow the issuer to state that OPM has certified its plan and will oversee its administration
- Confirms that approval as an MSP would constitute approval in all exchanges
- Confirms that MSPs would need to offer coverage in SHOP exchanges by 2018 unless exempted, by either the state if the state runs the exchange or because neither the carrier or an affiliate has at least a 20% small group market share prior to 2014

- Clarifies that the MSP does not have to be available in all parts of a state in 2014 if carrier has a plan to phase in full coverage (MSP would need to follow state's designated service areas)
- Clarifies that premium subsidy and cost-sharing reductions would be available on the same basis as they are in state exchanges
- Confirms that MSPs would need to provide reporting similar to that required of insurers participating in the FEHB Program
- Provides that the medical loss ratio (MLR) would be calculated on a state-by-state basis, using a hybrid of usual and special FEHB Program rules

Multi-State Plan - Final Rule

Multi-State Plan - Correction to Final Rule

OPM issued an issuer letter for 2016 on January 22, 2015.

On October 1, 2013, the OPM announced that it has entered into a contract with Blue Cross to offer 150 multi-state plan options. Initially the multi-state plan will be available in 30 states and the District of Columbia. For a list of the states included, see the OPM Multi-State Plan Program Fact Sheet.

OPM issued a final rule regarding multi-state plans on February 24, 2105. Among other changes the final rule requires that issuers of multi-state plans provide notice if an option excludes non-excepted abortion services from coverage. The final rule did not broaden the definition of "group of issuers" as anticipated.

Interstate Health Care Choice Compacts

Effective January 1, 2016

Requires HHS, in consultation with NAIC, to issue regulations on or before July 1, 2013, for the creation of "Health Care Choice Compacts," (a joint effort of two or more states) to facilitate the purchase of qualified individual insurance across state borders.

Requires all participating states to enact a law specifically authorizing the compact.

Subjects insurers selling coverage through these compacts only to the laws and regulations of the state where the policy is written or issued, with the following exceptions, which will still be enforced in the state where the consumer lives:

- Insurance rules related to market conduct
- Unfair trade
- Network adequacy
- Consumer protections (including rating rules)
- Contract disputes

Requires HHS to approve such compacts based on compliance with factors such as:

- Coverage comprehensiveness
- Coverage affordability (including cost-sharing protections)

- Coverage provided to a comparable number of residents as ACA provisions
- Deficit neutrality
- Compacts not weakening enforcement of insurance laws or regulations in any participating state

Insurers offering coverage through these compacts must:

- Be licensed in all states in which a compact plan is offered, or submit to the jurisdiction of each state with respect to the non-exempted state requirements
- Submit to each state with regard to the standards noted above, including access to records
- Disclose that the policies being sold may not be subject to all the laws and regulations of the state where the consumer resides

Insurer Provisions

Administrative Simplification

Health plans must adopt and implement the HHS-created uniform standards and business rules for the electronic exchange of routine health transactions and information.

The HHS is **required** to consult a qualified, multi-stakeholder, conflict-of-interest-free non-profit entity, as determined by the National Committee on Vital and Health Statistics, prior to promulgating the standards.

	Deadline for adoption	Effective date
Unique health plan identifier	Prior to Oct. 1, 2012	Oct. 1, 2012
Health plan eligibility and health claim status	July 1, 2011	Jan. 1, 2013
Electronic fund transfers	Jan. 1, 2012	Jan. 1, 2014
Electronic fund transfer mandate for Medicare	Prior to Jan. 1, 2014	Jan. 1, 2014
Electronic fund transfers, health care payments, and remittance advice	July 1, 2012	Jan. 1, 2014
Health claims attachments	Jan. 1, 2014	Jan. 1, 2016
Health claims, health plan enrollment and disenrollment, health plan premium payments, referral certification and authorization	July 1, 2014	Jan. 1, 2016

A review committee must be established by January 1, 2014, to update and approve the standards and operating rules, with initial recommendations due by July 1, 2014. Recommendations will be made biennially thereafter.

Health plans must provide HHS with documentation of compliance with these standards and operating rules, and ensure that any entities with which they contract to provide services also comply.

As of April 1, 2014, penalties of $1 per enrollee per day will be assessed against health plans whose major medical policies are not in compliance. The penalties are capped at $20 per enrollee per year. Penalties are doubled if knowingly inaccurate or incomplete information is provided.

Effective March 23, 2010, with specific components effective between October 1, 2012 and January 1, 2016

Minimum Medical Loss Ratio Requirements

Minimum medical loss ratio requirements (MLR) will be established for insurers in all markets, including grandfathered plans (self-insured plans are exempt).

The minimum MLR is:

- 85% for large group plans (101 employees or more)
- 80% for small group plans (100 employees or less)
- 80% for individual plans

States are permitted to set higher MLR standards.

Effective for plan years beginning on or after September 23, 2010

The standards and any potential rebates to policy-holders being applied to the 2011 plan year.

Allows HHS to:

- Set an MLR below 80% for the individual market in particular states if HHS determines that a higher level could "destabilize" the individual market in that state
- Adjust the individual market if appropriate on account of volatility due to the establishment of state exchanges
- Make adjustments to the percentage if it proves to be destabilizing to the individual market

Requires plans to calculate the ratio of total premium revenue (*after* accounting for risk adjustment, reinsurance and risk corridor payments) spent on reimbursement for "clinical services" plus costs for "activities that improve health care quality." All other non-claims costs (including costs associated with ACA compliance), minus federal and state taxes and licensing or regulatory fees

Congressional intent is only to exclude the taxes introduced in the ACA (tax on insurers, per enrollee tax, and Cadillac Plan tax) from the MLR calculation. Corporate income tax, payroll taxes, and all other existing taxes are not to be excluded.

Bases calculations on three years of data starting in 2014. Instructions for the 2014 reporting year are now available.

Requires loss ratio reporting. Required reports must be publically available on the HHS website.

Starting in 2011, carriers are required to issue a pro-rata **premium rebate to individuals** for plans that fail to meet the minimum MLR requirements.

- Rebates for current enrollees may be either a premium credit (i.e., a reduction in premium owed) or a lump sum payment
- Rebates to former enrollees must be a lump sum payment

By December 31, 2010, the NAIC, subject to certification by HHS, was required to establish:

- Uniform definitions of these terms
- Standardized methodologies for calculating MLRs, taking into account the special circumstances of smaller plans, different types of plans and newer plans
- How the rebate is calculated

On May 13, 2011, the Center for Consumer Information & Insurance Oversight (CCIIO) issued a bulletin which provided technical guidance regarding Medical Loss Ratio requirements for insurers.

On November 22, 2010, HHS issued interim final rules on the MLR provisions in the ACA. Some of the highlights from the rules include:

- Agent and broker commissions are included as part of the non-claims costs in the MLR calculation and no portion of the agent and broker commissions to be considered a passed-through expense and excluded from the MLR calculation.
- States are permitted to seek waivers from the MLR requirements, including the possibility of seeking a waiver to have agent and broker commissions taken out of the denominator of the MLR calculation for policies sold in that state.

- The effect of the MLR standard on agents and brokers will be a factor in considering whether a particular individual market would be destabilized. Furthermore, the regulation establishes a process by which stakeholders (specifically including agents and brokers) will have input on the waiver decision-making process.
- Separates MLR reporting for expatriate plans, and includes an adjustment factor for 2011 to account for expatriate plans' higher administrative costs. (The adjustment factor will be revisited for 2012 and succeeding years.)
- Applies a revised adjustment factor with regard to limited benefit (or "mini-med" plans), for 2011, with the MLR calculations for limited benefit plans to be revisited in 2012 and succeeding years.
- It follows the NAIC's suggestions regarding:
  - Aggregation
  - Requiring carriers to meet the MLR standards on a state-by-state basis
  - Which taxes should be excluded from the MLR calculation
  - Credibility (actuarial adjustments provided to smaller carriers because of the greater uncertainty associated with covering a smaller risk pool)
- The interim rule was effective on January 1, 2011

On December 2, 2011, CMS issued final regulations regarding medical loss ratios. The modifications made in the new rule (effective January 1, 2012) include:

- Rather than having insurers send checks that could be taxed, workers in group health plans can receive rebates tax-free.
- The new regulation proposes that all consumers receive a notice, showing not just the amount of any rebate, but what the insurer's MLR means regardless of whether there is a rebate, and how the insurer's MLR has improved under the new law. In addition, data on the special types of plans, mini-meds and expatriate plans, will be publicly posted in the spring of 2012.
- The final rule makes only a minor change to a quality improvement definition to promote insurer improvements in defining or coding of medical conditions for a limited window of time.
- The new regulations make no changes to the treatment of independent insurance agent and broker commissions and ignore the recommendation passed by the NAIC on November 22, 2011 that the agency take whatever steps legally available to accommodate producer compensation in any final MLR rule.
- In 2011, so-called mini-med plans received a special circumstances adjustment to their MLR in the form of a multiplier of 2.0 for 2011. The final rule phases it down from 1.75 in 2012 to 1.5 in 2013 to 1.25 in 2014. Mini-med plans will be banned by the prohibition on annual limits in the ACA starting in 2014.
- The final rule keeps the expatriate plan multiplier adjustment at 2.0 due to their unique structure. It also levels the playing field between nonprofit and for-profit insurers in states with premium taxes.

On April 20, 2012, the CCIIO issued additional Q&A guidance on MLR requirements. Some of the highlights include:

- Counting employees for determining market size

  - Identification of the small or large group market is to be made under applicable state law or, in the absence of a state-law rule, under the Public Health Service Act (PHSA) definition (using a 50-employee cutoff until 2016, and a 100-employee cutoff thereafter).
  - If the employer does not make the insurer's policy available in all the states in which it has employees, the insurer may not know the total number of employees. In that case, the insurer may determine the group size for MLR purposes based on the information available to the insurer.
- Offering a "premium holiday"
  - If during a MLR reporting year an insurer finds that its MLR is lower than the standard required, it may institute a "premium holiday" in order to avoid having to pay rebates—if this is permissible under state law. An insurer seeking to temporarily suspend or reduce premiums must first check with the appropriate state agency and also meet certain other requirements, such as operating the program in a non-discriminatory manner and refunding any overpayment of premium.
  - The MLR regulations already allow insurers to provide a required rebate in the form of a premium credit, applicable in the next policy year. This Q&A, however, contemplates avoiding the rebate issue by providing a premium holiday in a current policy year.
- States with a higher MLR standard
  - If a state requires a higher minimum MLR than that required by federal law, the higher state standard does not automatically apply to insurers in that state.
  - However, HHS will apply the higher MLR to insurers in states that have taken affirmative action since March 23, 2010 (the enactment of health care reform), to require insurers to meet a higher MLR standard for federal MLR purposes.
- Exchange user fees
  - An insurer may include user fees paid to an exchange as part of the licensing and regulatory fees that are subtracted from premium in calculating an insurer's MLR and rebate.

The final rule on Benefit and Payment Parameters provides that:

- If a MLR payment is used to reduce premiums, the next premium due must be reduced
- Starting in with 2014 rebates, MLR payments will be due September 30

An issuer may defer including premium collected during 2013 from non-calendar year plans for 2014 fees in its 2013 MLR and rebate calculations, but it must disclose it has done this. Additional risk corridor payments made for 2015 can be omitted from MLR calculations. The Benefit and Payment Parameters for 2016 final rule clarified that federal and state employment taxes should not be excluded from the premium in the MLR and rebate calculations. Subscribers of non-federal government or other group health plans not subject to ERISA must receive their MLR rebates within three months of receipt of the rebate by the group policyholder.

In May 2015 the Center for Consumer Information & Insurance Oversight (CCIIO) issued a technical guidance covering the limited circumstances in which a health insurance issuer may exclude agent and broker fees or commissions from earned premium; and premium rebate applicability for policy holders who use a premium tax credit.

CMS set the following seven conditions that must all be met in order to exclude agent or broker fees and commissions from premium:

- The law of the state in which the policy is issued does not deem the agent or broker to be a representative of the issuer;
- The policyholder is not required to utilize an agent or broker to purchase insurance and may purchase a policy directly from the issuer;
- The policyholder selects, retains, and contracts with the agent or broker on his or her own accord;
- The policyholder negotiates and is responsible for the fee or commission separate and apart from premium;
- The issuer does not include these agent or broker commissions and fees in rate filings submitted to the applicable regulatory agency;
- The policyholder voluntarily chooses to pass the fee or commission through the issuer and is not required to do so, or the policyholder pays the fees or commission directly to the agent or broker; and,
- The policyholder issues the 1099 to the agent or broker, if a 1099 is required.

In June 2015 the IRS clarified that Medicare Advantage and Medicare Part D insurers must meet the MLR requirements, and some states have additional requirements for Medicaid Managed Care Organizations (MCOs).

Value-Based Insurance Designs

HHS may develop guidelines to permit group health plans (including self-insured plans) and health insurance issuers offering group or individual coverage to use value-based insurance designs.

Effective September 23, 2010

Transparency and Disclosure Requirements

Requires plans in *all markets* to comply with transparency and disclosure requirements applicable to exchange-participating plans:

- **Transparency in coverage.** Submit the following information to HHS, the state insurance commissioner, the state exchanges (only if they are seeking certification as qualified health plans), and make it available to the public:
  - Claims
  - Payment policies and practices
  - Periodic financial disclosures
  - Enrollment/disenrollment data
  - Data on claims denial and rating practices
  - Information on cost-sharing
  - Information on payments for non-network coverage
  - Information on enrollee rights

Effective for plan years beginning on or after September 23, 2010

Delayed indefinitely

- **Cost-sharing transparency.** Permit individuals to learn the amount of cost-sharing with respect to specific items or services by a participating provider upon request; at minimum, such information must be available through a website.
- Indefinitely delayed in August 2015.

Quality of Care Reporting by Group Health Plans

Requires all group and individual plans (except grandfathered plans) to comply with annual quality reporting requirements to be established by HHS.

Effective for plan years beginning on or after September 23, 2010

Guidance was due by March 23, 2012 but has not been issued

(Not applicable to grandfathered plans.)

Required elements of a quality program:

- *Improve health outcomes* through activities such as quality reporting, effective case management, care coordination, case management and medication and care compliance initiatives, including through the use of the medical home model.
- Implement activities to *prevent hospital readmissions* through a hospital discharge program that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health professional.
- Implement activities to *improve patient safety and reduce medical errors*, through use of best clinical practices, evidence-based medicine and HIT.
- Implement wellness and prevention programs, which may include:
  - Smoking cessation or weight management
  - Stress management
  - Physical fitness
  - Nutrition
  - Heart disease prevention
  - Diabetes prevention
  - Healthy lifestyle support

All group health plans (including **self-insured** plans) and group and individual health insurance carriers must annually submit to the Secretary of HHS, and to plan enrollees during the annual open enrollment period a report on whether the benefits under the plan or coverage include the specified components. The Secretary of HHS will make the reports available to the public through a website.

Note: This section does *not* require that plans report outcomes, only that they report that they support these quality-related activities.

Allows HHS to provide exceptions to the reporting requirements for plans that “substantially meet the goals” of this provision.

Allows HHS to develop and impose appropriate penalties on employer groups and health plans for non-compliance.

HHS must issue guidelines for health provider reimbursement structure on or before March 23, 2012.

Within 180 days of the promulgation of these regulations, requires the Government Accounting Office (GAO) to review the regulations, and report to Congress on the effects of these activities on the quality and cost of health care.

Guaranteed Issue

For plan years beginning on or after January 1, 2014, health insurance issuers that offer health insurance coverage in the individual or small or large group market in a state are required to accept every employer and individual in the state that applies for coverage, except as permitted under the special rules for network plans and insurers that no longer have the financial capacity to underwrite additional coverage.

Where a health insurance issuer offers health insurance coverage in the group and individual market through a network plan, the issuer may:

- Limit eligible employers to those having eligible individuals who live, work or reside in the service area of the network plan
- Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated, if required, to the applicable state authority that:
  - it lacks the capacity to deliver services adequately to enrollees of any additional groups or additional individuals because of obligations to its existing group contract holders and enrollees
  - it is applying the denial of coverage uniformly to employers and individuals without regard to the claims experience of individuals, employers and their employees (and their dependents), or any health status-related factor related to those individuals, employees and dependents

Upon denying health insurance coverage in any service area, an issuer may not offer coverage in the group or individual market within that service area for a period of 180 days after the date that coverage is denied.

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable state authority that it:

- Lacks the financial reserves necessary to underwrite additional coverage
- Is applying this provision uniformly to all individuals and employers in the individual or group market in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers and their employees (and their dependents), or any health status-related factor relating to those individuals, employees and dependents.

A health insurance issuer, upon denying health insurance coverage in connection with group health plans in a state in accord with this provision, may not offer coverage in connection with group health plans in the individual or group market in the state for a period of 180 days after the date coverage is denied, or until the issuer has demonstrated to the applicable state authority, if required by state law, that the issuer has enough financial reserves to underwrite additional coverage, *whichever date* is *later.* An applicable state authority may provide that this provision be applied on a service-area-specific basis.

Insurers are not required to offer all of the same products in the small and large group markets.

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016, renewals

(Not applicable to grandfathered plans.)

Modifies current HIPAA provisions requiring guaranteed issue in the small group market. Applies to individual and small and large group markets (but not to grandfathered plans).

A final rule on market rules published February 27, 2013, reiterated these requirements, with the following clarifications and modifications:

- The open enrollment for individuals would be the same both through and outside the exchange
- Small employers could enroll at any time
- Insurers may not impose minimum participation and contribution requirements, although small employers that do not meet these requirements could be subject to an open enrollment period (November 15 to December 15)
- Thirty-day special enrollment periods must be offered following any COBRA qualifying event and 30-day "limited" open enrollment periods must be offered following loss or gain of eligibility for premium tax credits or cost-sharing or a change of residence
- All family members must be offered the chance to enroll/change coverage
- Insurers could not set commission rates so low it would discourage agents from enrolling those with significant health needs in qualified health plans

The IRS reiterated in the final play or pay regulations that guarantee issue applies in the large group market, and therefore minimum participation requirements are not permitted.

Guarantee issue and renewal requirements do not apply if doing so would violate another federal requirement.

Guaranteed Renewability

A health insurance issuer that offers health insurance coverage in the individual or small or large group market must renew or continue in force such coverage at the option of the plan sponsor or individual, as applicable, subject to the following general exceptions and provisions for:

- Uniform termination of coverage
- Uniform modification of coverage
- Coverage offered only through associations

An issuer may not renew, or may discontinue coverage offered in connection with health insurance coverage offered in the group or individual market *only* based upon one or more of one of the following:

- Non-payment of premiums or contributions or untimely payments
- Fraud or intentional misrepresentation of material fact by an individual or a plan sponsor as to a group health plan
- The plan sponsor has failed to comply with a material plan provision that relates to employer contribution or group participation rules, under applicable state law
- The issuer ceases to offer coverage in the market in accordance with the rules requiring uniform termination of coverage, and applicable state law

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016 renewals

(Not applicable to grandfathered plans.)

- When an issuer that offers health insurance coverage in the market through a network plan no longer has any enrollee in connection with the plan who lives, resides, or works in the issuer's service area (or in the area in which the issuer is authorized to do business), and in the case of the small group market, the issuer would deny enrollment with regard to such plan under the special rules for network plans
- For bona fide association coverage, cessation of association membership, but only if coverage is terminated uniformly without regard to health status of the individual
- For network plans, movement of the individual or employer outside the service area, but only if coverage is terminated uniformly without regard to health status of the individuals

This provision does not eliminate the HIPAA group participation and contribution requirements (which may be imposed at renewal).

An employer that increases or decreases in size may remain in its current plan both during the year of the head count change and subsequent years.

Drafts of Standard Renewal and Termination Notices, draft Standard Notices when Discontinuing or Renewing a Product and Instructions were issued on June 26, 2014.

Uniform Termination of Coverage Rules

When an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, it may be discontinued by the issuer in accordance with applicable state law in such market, **but only if***:*

- Notice of discontinuation is given to each individual or plan sponsor provided that type of coverage in such market (and covered participants and beneficiaries) at least 90 days prior to the date of discontinuation of coverage
- Each individual or plan sponsor provided that type of coverage in such market is given the option to purchase all (or in the case of the large group market, any) other health insurance coverage currently being offered by the issuer in that market
- In exercising the option to discontinue the particular type of coverage and in offering to plan individuals and plan sponsors the option to purchase other coverage offered by the issuer in such market, the issuer acts uniformly without regard to the claims experience of those individuals or plan sponsors, or any health status-related factor pertaining to any covered participants or beneficiaries, or new participants or beneficiaries who may become eligible for such coverage

If a health insurance issuer elects to discontinue offering *all* health insurance coverage in the individual or group market, or all markets, in a state, health insurance coverage may be discontinued by the issuer in accordance with applicable state law, **only if:**

- The issuer provides notice to the applicable state authority and to each individual or plan sponsor (and covered participants and beneficiaries) of such discontinuation at least 180 days prior to the date of the discontinuation of coverage
- All health insurance issued or delivered for issuance in such market(s) in the state are discontinued and such health insurance coverage in such market(s) is not renewed

Effective for plan years beginning on or after January 1, 2014

(Not applicable to grandfathered plans.)

When health insurance coverage is discontinued in a market, the issuer may not provide for issuance of any health insurance coverage in the state and market involved for a period of five years beginning on the date of discontinuation of the last health insurance coverage not so renewed.

Uniform Modification of Coverage Rules

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group plan:

- In the large group market without restriction, *or*
- In the case of the small group market, *only if,* as to coverage in such market, other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

The Final Rule provides that modifications made solely pursuant to federal or state law requirements – such as increases in annual limits on cost-sharing – would be considered modifications rather than product withdrawals. Modifications not required by law would be considered uniform/acceptable modifications of coverage in the small group market if they met all of the following criteria:

- The product is offered by the same insurer;
- The products is the same product type (PPO, HMO);
- The product covers the majority of the same counties in its service area;
- The product has the same cost-sharing structure, except for variations in cost-sharing related solely to the utilization or cost of medical care or necessary to maintain the same metal level of coverage; and
- The product provides the same level of covered benefits, except for changes in benefits not attributable to legal requirements, which cumulatively affect the rate for the product by no more than 2%.

If changes exceeded these limits, the insurer would be regarded as having withdrawn a product from the market and issued a new product. State law could allow for more extensive modifications, but state laws that narrowed permitted modifications would be preempted.

In the case of health insurance coverage made available by an issuer in the small or large group market to employers only through one or more associations, any reference in this section to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

The PACE Act amended the ACA and redefined small employers as those with 50 or fewer employees and gave states the option to expand the definition to include employers with up to 100 employees (or, practically speaking, those with 51 to 100 employees, also called "mid-size employers"). Employers should check their state statutes to determine the group size in place for January 2016.

Effective for plan years beginning on or after January 1, 2014

(Not applicable to grandfathered plans.)

Modified Community-Rating Requirements

Strict modified community rating standards must be adhered to by:

- All individual health insurance policies
- All fully insured small group policies
- Large groups if large groups may purchase through the exchanges

Experience rating would be prohibited.

Permits premium rating adjustments only for:

- Age (3:1 for adults), within standard age bands established by HHS in consultation with NAIC
  - The February 27, 2013, Health Insurance Market Rules final rule adopted the November 26, 2012, proposed rule on market reforms with virtually no changes. All carriers must use one year age banding, with one band for ages 0 to 20, one-year bands (with a prescribed factor) for ages 21 to 63, and one band for age 64 and over (due to concerns about Medicare Secondary Payer requirements); rates would be based on age on the policy issue or renewal date. The regulation includes an age curve table; states may elect different curves but must use one-year banding.
- Family composition (individual or family)
  - Under the final rule:
    - Each family member's rate would be calculated separately
    - A maximum of three children's rates would be considered per family using the three oldest children under age 21
    - The state definition of "family" will apply
- Tobacco (1.5:1) (unless the state chooses a smaller, or no, surcharge)
- Geography (rating areas to be established by states and reviewed by HHS)
  - Under the final rule, a state could designate multiple geographic areas
    - Any rate differences would need to be justified by a certified actuary
    - Rating areas could be based on either counties or three-digit ZIP codes or on metropolitan-statistical areas (MSAs) and non-MSAs
    - A rating area for each MSA with a separate region for all individuals living outside an MSA would be the default
    - Geographic rating areas in effect on January 1, 2013, are grandfathered
    - The rating area will be based on the residence of the primary insured in the individual market and the principal address of the employer in the SHOP exchange and small group market; however, employee addresses may be used for 2014 only
- Wellness discounts are allowed for group plans under specific circumstances

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules

(Not applicable to grandfathered plans.)

State-specific geographic rating areas can be found on the CCIIO website.

With respect to family coverage, the rating variations permitted for age and tobacco shall be applied to the portion of the premium attributable to each family member. Under the rule, while the carrier would have to determine each person's actual rate and then total the individual costs to determine the small group's premium, an employer could choose to charge employees their share of the group's composite rate or a percentage of the employee's actual cost of coverage. In addition a state may elect to require use of composite rates. If a state disallows rating based on age and tobacco use, carriers may use average rates.

Tobacco use is defined as using any tobacco product an average of four or more times per week within the prior six (or fewer) months. Small group plans must offer smoking cessation wellness programs to provide a way to offset the surcharge. Insurers may not rescind coverage based on a misrepresentation of non-use of tobacco, but they can collect back premiums.

These rating reforms (and any others adopted by a state) must apply uniformly to all health insurance issuers and group health plans in each insurance market to which the standards or requirements apply.

If permitted by the state, an insurer or employer may aggregate the individual employee rates and apply a composite rate. HHS has proposed that, starting in 2015, any composite rate must be fixed for the year, regardless of changes to the composition of the group.

Beginning in 2015 "composite premiums" will be allowed for small groups. Insurers must calculate premiums for the individual members of a small group considering age, geographic location and family size (but not tobacco use), but then may offer the small group an average or composite premium, charging the same premium for all members. If premiums are charged on this basis, the per-member premium must be determined at the beginning of a policy year and cannot be changed over the course of the year as new employees are added or current employees leave.

Insurers that offer composite premiums must offer these policies to all employers, although employers will have the choice to pay premiums on a per-member or composite basis. Where premiums are offered on a composite basis, two tiers of composite premiums must be offered—one for family members age 21 and older and another for family members below age 21. States can adopt, with HHS approval, other tiered rating approaches.

If a state permits large employers (101+ employees) to purchase coverage through an exchange (which they can do starting in 2017), the rating rules would extend to insured large employers as well.

Applies to individual and small group markets (but not grandfathered plans).

Benefit Requirements for Individual and Small Group Markets

Requires all insurers in the individual and small group markets to meet the same requirements as exchange plans with respect to:

- Providing coverage of the essential benefits package
- Meeting cost-sharing requirements for essential benefits
- If offering a Bronze, Silver, Gold, or Platinum level of coverage (or a catastrophic plan), must offer the same level of coverage in an under age 21-only plan

These provisions do not apply to dental-only plans.

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016, renewals

(Not applicable to grandfathered plans.)

Benefit Requirements for All Group Markets

The law originally required **small** group health plans to meet cost-sharing limits required under IRC § 1302(c)(1)-(2), which limited deductibles to $2,000 for individuals and $4,000 for families but the deductible limit was repealed on April 1, 2014. Requires all group health plans to limit annual out-of-pocket maximum ($6,250 single and $12,500 family for 2013; $6,350 single and $12,700 family for 2014; $6,600 single and $13,200 family for 2015).

Further clarification and some transition relief for 2014 and later on the out-of-pocket limit is provided in the Department of Labor ACA FAQ Part XII and Frequently Asked Questions - The Affordable Care Act Implementation Part XVIII.

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016, renewals

(Not applicable to grandfathered plans.)

Insurance Risk Pools

All enrollees in all non-group (individual) plans (other than grandfathered plans) offered by an issuer (*both within and outside an exchange, and including multi-state plans)* must be members of a single risk pool. This includes closed blocks. It excludes excepted benefits (such as standalone dental and vision and retiree only plans).

Issuers must also create a separate, single risk pool (under the same conditions as above) for all their small group plans.

Per the February 27, 2013, final rule on Health Insurance Market Rules, a state may combine the individual and small group pools.

All claims experience within the pool would be combined and an index rate created. The index rate would be adjusted based on total market-wide payments and adjustments under the risk adjustment and reinsurance programs within the state. The premium for any plan could only deviate from the adjusted rate based on:

- The actuarial value and cost-sharing design of the plan
- Network and utilization management
- Delivery system
- Distribution and administrative costs other than exchange user fees
- Benefits in addition to essential health benefits
- With respect to catastrophic plans, the effect of specific eligibility categories

Any deviation would need to be actuarially justified.

Effective January 1, 2014

Non-Discrimination Based on Race, Color, National Origin, Sex, Age, or Disability

On May 13, 2016, the HHS issued a final rule implementing Section 1557 of the ACA, which will take effect on July 18, 2016. If entities need to make changes to health insurance or group health plan benefit design as a result of this final rule, such provisions have an applicability date of the first day of the first plan year beginning on or after January 1, 2017.

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from HHS on

Proposed Regulations

the basis of race, color, national origin, sex, age, or disability. The rule applies to any program administered by HHS or any health program or activity administered by an entity established under Title I of the ACA. These applicable entities are "covered entities" and include a broad array of providers, employers, and facilities. State-based Marketplaces are also covered entities, as are Federally-Facilitated Marketplaces.

The final regulations are aimed primarily at preventing discrimination by health care providers and insurers, as well as employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administrator, or health insurer.

Affected employers include:

- Hospitals
- Nursing homes
- Home health agencies
- Laboratories
- Community health centers
- Therapy service providers (physical, speech, etc.)
- Physicians' groups
- Health insurers
- Ambulatory surgical centers
- End stage renal dialysis centers
- Health related schools receiving federal financial assistance through grant awards to support 40 health professional training programs

When determining if it receives federal financial assistance through Medicaid payments, meaningful use payments, or other payments a physician or physicians' group would not count Medicare Part B payments because that is not considered federal financial assistance. In the proposed rule, HHS estimated that most physicians will still be a covered entity because they accept federal financial assistance from other sources. The final rule includes the same estimate of physicians receiving federal financial assistance as in the proposed rule because almost all practicing physicians in the United States accept some form of federal reimbursement other than Medicare Part B. As a result, most physicians are reached by this rule.

Covered entities must take steps to notify beneficiaries, enrollees, applicants, or members of the public of their nondiscrimination obligations with respect to their health programs and activities. Covered entities are required to post notices stating that they do not discriminate on the grounds prohibited by Section 1557, and that they will provide free (and timely) aids and services to individuals with limited English proficiency and disabilities. These notices must be posted in conspicuous physical locations where the entity interacts with the public, in its significant public-facing publications, and on its website home page. In addition, covered entities that employ 15 or more persons must designate a responsible employee to coordinate the entity's compliance with the rule and adopt a grievance procedure.

Sex, Gender, and Sexual Orientation Discrimination

The final rule bans discrimination based on sex, gender, sexual orientation, and gender identity. Sex discrimination includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery from childbirth or related medical conditions.

The final rule prohibits discrimination faced by transgender individuals trying to access coverage of health services. The rule prohibits denying or limiting coverage, denying a claim, or imposing additional cost sharing on any health service due to the individual's sex assigned at birth, gender identity, or gender otherwise recorded by the plan or issuer which is different from the one to which services are ordinarily or exclusively possible.

For example, a pelvic or prostate exam could not be denied based on a person's sex assigned at birth, gender identity, or recorded gender, if it was medically appropriate. Medically appropriate coverage could not be denied for a pelvic exam or ovarian cancer treatment for an individual who identifies as a transgender man, or is enrolled in a health plan as a man.

Furthermore, blanket exclusions for coverage of care associated with gender dysphoria or associated with gender transition is prohibited. Categorical or automatic exclusion of coverage for services related to gender transition are unlawful. Denials for these services would be discrimination if the denial results in discrimination against a transgender individual. These provisions do not require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude neutral standards that govern the circumstances under which coverage will be offered.

The regulations do not prohibit single-sex toilets, locker rooms, or shower facilities so long as comparable facilities are provided regardless of sex. The final rule provides that sex-specific health programs are allowable only where the covered entity can demonstrate an exceedingly persuasive justification that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective. While the rule does not require a provider that operates a gynecological practice to add or change the types of services offered in the practice, it prohibits the providers of health services from denying or limiting services based on an individual's sex, without a legitimate nondiscriminatory reason.

For example, if a hospital has specific protocols in place for domestic violence victims and only engages that protocol for women, the provider must revise its procedures to require that protocol for all domestic violence victims regardless of sex.

The final rule does not resolve whether discrimination on the basis of an individual's sexual orientation status alone is a form of sex discrimination. The Office for Civil Rights (OCR) will evaluate complaints alleging sex discrimination based on sexual orientation status on a case-by-case basis to determine if they are the sort of discrimination that can be addressed under this rule.

Marketplace and Other Health Plans

A health insurance issuer seeking certification to participate in a Health Insurance Marketplace or a state seeking approval to operate a State-based Marketplace to which Section 1557 applies is required to submit an assurance that the health program or activity will operate in compliance with this rule.

Marketplaces must operate in a nondiscriminatory way. Issuers that participate in the Marketplace cannot deny, cancel, limit, or refuse to issue or renew any policies that employ practices or benefit designs that discriminate on any of the protected bases.

An insurer that participates in a Marketplace would be subject to the nondiscrimination rules in the Marketplace, in its individual market business, in the group market, or when it serves as a third-party administrator for a self-insured plan.

Third-Party Administrators (TPAs)

The OCR will investigate a TPA when the alleged discrimination is in the administration of the plan. However, if the alleged discrimination is in benefit plan design, OCR will process the complaint against the employer or plan sponsor. If the OCR lacks jurisdiction over the employer, it will refer the matter to the Equal Employment Opportunity Commission (EEOC).

Discrimination against Persons with Limited English Proficiency (LEP) and Disabilities

An individual with LEP is someone for whom English is not the primary language for communication, and who has a limited ability to read, speak, write, or understand English. The final rule increases assistance for individuals with LEP so that they can communicate with their health care providers and have meaningful access to health programs and activities.

Covered entities are required to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business. These taglines will alert LEP individuals to the availability of free language assistance services and how these services can be obtained. The proposed rule provided a list of relevant factors to consider when determining if language obligations have been met; whereas, the only relevant factor listed in the final rule is whether a covered entity implemented an effective written language access plan.

Covered entities are required to provide effective communication and facility access for individuals with disabilities. Covered entities must provide access to auxiliary aids and services, including alternative formats and sign language interpreters, unless the entity can show undue burden or fundamental alteration. The final rule requires reasonable modifications where necessary to facilities and technology to provide equal access for individuals with disabilities.

Enforcement

The enforcement mechanisms under Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975 apply for redress of violations of Section 1557, which include requiring covered entities to keep records and submit compliance reports to the OCR, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance.

If noncompliance cannot be corrected by informal means, enforcement mechanisms include suspension of, termination of, or refusal to grant federal financial assistance.

Non-Discrimination Based on Health Status

Extends to the individual market the current HIPAA rules prohibiting group health plans from establishing rules for eligibility to enroll in coverage based on status-related factors:

- Health status
- Medical condition (including both physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information

Effective for plan years beginning on or after January 1, 2014

(Not applicable to *individual* grandfathered policies.)

- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Any other health status-related factor determined appropriate by HHS

Extends current HIPAA rules prohibiting group health plans from charging enrollees higher premiums based on health status to the individual market.

Applies to insured plans in all markets.

The market rules require that all products that are approved for sale in a market be available to all applicants (including those in closed blocks).

According to a Frequently Asked Question issued November 6, 2014, employers may not provide employees with high claims an option of cash to decline group health coverage if a similar offer is not made to all employees regardless of their health.

Provider Non-Discrimination

Prohibits discrimination in terms of participation or coverage against health care providers acting within the scope of the license or certification.

Specifies that this provision is *not* an "any willing provider" requirement and that the provision does *not* prohibit reimbursement based on quality or performance.

Applies to all markets (but not to grandfathered plans).

In May 2015, the Department of Labor confirmed that enforcement of the ACA's provider non-discrimination requirements is delayed so long as the plan or issuer is using a good faith reasonable interpretation of the statutory provision.

Effective for plan years beginning on or after January 1, 2014, unless state insurance department allows and insurer chooses to renew 2013 policy using 2013 rules; option now available through October 1, 2016 renewals

(Not applicable to grandfathered plans.)

Delayed until further guidance is issued

State Government Provisions

State Health Insurance Premium Rate Review

Beginning with the 2010 plan year, requires HHS in conjunction with states, to establish a process for review of "unreasonable" premium increases. Applies to all individual and group health insurance coverage. The rate review process will not apply in the large group market.

This provision requires:

- Insurers to submit a justification for increases prior to implementation
  - In 2011, proposed rate increases of 10% or higher will be publicly disclosed and thoroughly reviewed to determine if the rate increase is unreasonable.
  - After 2011, state-specific thresholds would be set using data and trends that better reflect cost trends particular to each state.
- Insurers to "prominently" post such information on their websites and on www.HealthCare.gov
- State insurance commissioners to:
  - Provide HHS with information about trends in premium increases in different rating areas
  - Make recommendations as to whether issuers should be excluded from exchange participation due to patterns of excessive or unjustified premium increases
- Starting with plan years beginning in 2014, requires HHS (in conjunction with states) to monitor premium increases both inside and outside of exchanges
- States, in considering whether to allow large employers to purchase coverage through the exchange, to take into account any excess of premium growth outside of the exchange as compared to premium growth inside the exchange.

States with effective rate review systems would conduct the reviews. If a state lacks the resources or authority to do thorough actuarial reviews, HHS would conduct the reviews.

Note: Most reviews will be conducted by the individual states, but in six states (Alabama, Arizona, Louisiana, Missouri, Montana, and Wyoming) HHS will conduct all of the reviews and in Pennsylvania and Virginia the federal government will review group market rates.

Provides $250 million in state grants during 2010 to 2014 to help states carry out this provision and to fund Medical Data Reimbursement Centers. Limits grants to individual states to no less than $1 million and no more than $5 million for a grant year.

On May 19, 2011, HHS released final regulations regarding insurance rate increases. The effective date of the program is September 1, 2011. Starting in September 2012, the federal government will set a separate threshold for each state, reflecting trends in insurance and health care costs.

Effective March 23, 2010

(for 2010 plan year)

Insurers will be required to submit a seven-page document, justifying the increase to the Department of Health and Human Services (HHS). Also, information on any insurers that propose premium increases exceeding 10% will be posted on the HHS website.

Note: The amendment to the May 2011 final rule amends the definitions of individual and small group markets (the effective date of the amendment is November 1, 2011), as follows:

- The definition of small group market includes coverage that would be regulated as small group market coverage if it were not sold through an association.
- The definition of individual market also includes coverage that would be regulated as individual market coverage if it were not sold through an association.
- This approach follows the definition under which an association itself will only be considered to be a group health plan if it complies with and is regulated under ERISA.

This new review process does not preempt existing state premium review requirements in either the individual or small group markets, or both. As long as a state can conduct an effective review of proposed rate increases that meet or exceed the applicable threshold, HHS will adopt the state determinations.

The February 27, 2013, final rule adopted most of the November 26, 2012, proposed rule. It includes the above requirements as well as:

- Requires states that want to set their own “reasonable” rate increase rate submit their proposal to CMS) by August 1 of the year before the January 1 on which the increase would take effect; CMS would have until September 1 to approve or deny the request
- Would require issuers to submit information on rate increases on a standard form created by HHS for review (but not approval)
- Provides that all rate increase requests be submitted to HHS (and include data on claims experience in other markets)
- Expands the effective rate review requirements to include review of the reasonableness of assumptions regarding the effect of the federal reinsurance and rate adjustment programs and review of the issuer’s data on implementation and use of a single risk pool, EHBs and actuarial values
- Keeps the reasonable increase standard at 10%, unless the state requests and HHS approves a different level
- Requires rate examinations to consider the effect of proposed changes on other responsibilities under market reform
- For 2016 all increases of over 10% per plan (previously this was per product) will require evaluation. A “plan” means a combination of a particular benefit structure, cost-sharing, network and service area; product includes all plans within the product).

Insurers in the individual market may only revise their market-wide adjusted index rates and plan-specific pricing once a year. Small group pricing may be adjusted quarterly (although an employer’s rate would be set for a year).

Grants for State Insurance Ombudsman Programs

Allows the Secretary of HHS to award grants to states (or the exchanges operating in such states) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs.

To be eligible for a grant, a state must designate an independent office of health insurance consumer assistance or an ombudsman that receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and state law.

Such office or ombudsman must:

- Help file complaints and appeals, including the internal appeals process
- Provide information about the external appeal process
- Collect, track, and quantify problems and inquiries
- Educate consumers on their rights and responsibilities
- Help with enrollment in coverage by providing information, referral and assistance
- Resolve problems with obtaining premium tax credits

Requires such office or ombudsman to collect and report data to HHS on the types of problems and inquires they receive from consumers.

Directs HHS to use such data to identify areas where more enforcement action is needed and to share the data with state insurance regulators and the DOL and the Treasury for their enforcement activities.

A fund of $30 million was appropriated to fund these grants in fiscal year 2010, but the Secretary of HHS will have to request additional appropriations to fund the grant program in subsequent years.

Effective March 23, 2010

Responsibility and Data Exchange for Determining Eligibility

Each applicable state health subsidy program is required to establish, verify, and update eligibility for participation in any health subsidy program based on reliable third-party data.

Each state is required to develop for all applicable state health subsidy programs a secure electronic interface allowing for an exchange of data so that a determination of eligibility can be made for all such programs based on a single application.

Effective March 23, 2010

Affordable Coverage Portals

Requires HHS in consultation with states, to establish a mechanism (including a website) through which individuals and small employers can identify affordable coverage options.

Requires websites to provide information on at least the following coverage options (to the extent practicable):

- Private insurance coverage
- Medicaid and CHIP coverage

Rollout beginning July 1, 2010

Completed by October 1, 2010

- State high risk pool coverage
- Coverage under the new high risk pool program
- Coverage within the small group market, including reinsurance for early retirees and small business tax credits

Requires the format to require information on medical loss ratio, eligibility, availability, premium rates, and cost-sharing, and be consistent with the standards adopted for uniform coverage explanations under Public Health Service Act (PHSA) § 2715.

Directs HHS to develop a standardized format for presenting this information on or before May 22, 2010.

Permits HHS to contract out this requirement.

Medical Malpractice Tort Litigation Alternatives

Sense of Senate encouraging states to test alternatives to the current civil litigation system.

Funding begins fiscal year 2011 (October 1, 2011)

HHS will award planning grants to states for the development, implementation, and evaluation of alternatives to the existing civil litigation system for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

- Requires models to emphasize:
  - Patient safety
  - Disclosure of health care errors
  - The early resolution of disputes
- Permits patients to opt out of these alternatives at any time
- Requires multiple evaluations of the effectiveness of the alternatives being tested, including:
  - Annual evaluations by state programs
  - Annual assessments by HHS
  - An overall evaluation of the program, also conducted by HHS
  - Independent reviews by the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC)
- Requires these reports to evaluate effects of the demonstrations on:
  - Quality of care
  - Medical errors
  - Medical resources used
  - Time for dispute resolution

- Availability and price of liability insurance
- Assessment of the overall effectiveness of the alternatives being tested

The program is funded for five years (fiscal years 2011 through 2015) by a total allocation of $50 million. Individual states may receive up to $500,000 per year.

Group Size Market Definitions

Requires states to include the self-employed and employers with up to 100 employees in their small group markets; however, states have the option to keep the small group market at 1 to 50 employees in 2014 and 2015**.** All states are using 50 as the cut-off for 2014. States may use their existing definition of "employee" through 2015, except that all FF-SHOPs will use the "play or pay" definition of full-time and full-time equivalent employee beginning in 2014.

Effective January 1, 2014

Separate Insurance Pools

Requires separate pools for individual and small group, but permits states to merge the markets.

Requires these pools to include policies from both inside and outside the exchange (except for grandfathered coverage), including multi-state plans.

Specifies that state laws requiring grandfathered plans to be included in a pool shall not apply.

Effective January 1, 2014

Risk Corridors and Adjustments

Establishes a mandatory "risk corridor" program (for calendar years 2014 to 2016) and a permanent "risk adjustment" program for QHPs in the individual and small group markets offered through an exchange**,** excluding grandfathered coverage.

Requires HHS (in consultation with the states) to establish criteria and methods for carrying out such risk-adjustment activities. The intent is for HHS to utilize criteria and methods similar to those utilized to adjust payments to regional PPOs under the Medicare Part C and D Programs.

On March 11, 2013, HHS published a Final Rule on Benefit and Payment Parameters which:

- Includes an approval process for a state-run, permanent risk adjustment program (separate from the exchange approval process) if the state is running its own exchange. Only Massachusetts has filed to run its own risk adjustment program.
- Would impose a fee ($0.96/enrollee/year) if the federal government runs the program for the state
- Describes the method of measuring risk (age, sex, diagnosis/diagnoses, metal plan, and geographic region) and assigning each person a risk score. The individual risk scores would be averaged for each plan, factored with plan-specific cost factors, and sums would be transferred annually between plans with high and low scores.
- Infants, children, adults, catastrophic, and student health plans each would have their own transfer program
- If state has merged small and individual risk pools, these segments would also be combined for this program

Effective January 1, 2014

(Excludes grandfathered plans)

- Only applies to non-grandfathered plans
- Applies to plans both inside and outside of the exchange
- Insurers with high-risk populations would receive transfer payments from insurers with lower risk populations

The temporary risk corridor program would give insurers *inside the exchanges* more certainty by limiting losses and gains.

- If a participating plan's "allowable costs" (claims and quality improvement expenses) are greater than 103% but not greater than 108% of a "target amount" (premiums less administrative costs and taxes), the plan would be paid 50% of the amount in excess of 103% of the "target amount."
- If the "allowable costs" are less than 97%, the plan would pay 50% of the difference. Administrative costs, including profit, may not exceed 20% of premiums.

QHPs outside the exchanges also are included in the risk corridor program if they are substantially the same as an exchange plan. "Substantially the same" means the service area, benefits, cost-sharing structure, premiums, and provider networks are the same; differences required because of differences in state and federal law are immaterial.

States could choose to change the details of reinsurance or risk adjustment from those set out by the federal standards. Any state that decides to make changes would need to publish a notice at least one year before the benefit year begins, and by March in the calendar year before the effective date.

The administrative cost ceiling for the risk corridor program has been increased from 20% to 22% and the profit margin floor has been increased from 3% to 5% for 2015 to account for renewal of 2013 policies, extension of the high risk pools and extra costs due to Marketplace issues. Insurers will be able to claim up to 0.3% of their earned premium for ICD-10 conversion costs.

On February 27, 2015, HHS published a final rule on Benefit and Payment Parameters for 2016. Beginning in 2016, administrative costs for the program will increase to $1.75 per-enrollee-per-year for participating plans, up from $0.96.

Temporary Individual Market Reinsurance (Transitional Reinsurance Program)

On March 11, 2013, a final rule was published confirming that administration of the transitional reinsurance program (TRP) would largely be a federal function: Benefit and Payment Parameters - Final Rule

- HHS would administer in most states (only Connecticut has elected to operate their own programs)
  - State could have a self-administered supplemental program; could assess insured plans only for reporting
- Each insurer or plan sponsor of a self-funded major medical plan must report the average number of lives covered by major medical during calendar year
  - Major medical coverage is defined as insurance that covers a wide range of medical services and meets the 60% minimum value test
    - Includes short-term, limited duration coverage that meets this description, student health plans and transitional, non-ACA compliant renewed 2013 plans
    - Excludes covered lives residing in a U.S. territory

The temporary reinsurance program will be in effect from January 1, 2014 through December 31, 2016

- To avoid duplicate counting, only the plan that provides primary coverage reports
- Also to avoid duplicate counting if multiple vendors provide coverage, the carrier or plan sponsor that provides major medical coverage is responsible for the fee. If several carriers together provide the equivalent of major medical coverage, the carrier that provides the majority of inpatient hospital coverage is responsible for the fee.
- Counting methods are similar to those used for the Patient Centered Outcomes Research Institute (PCORI) program; however, could use different methods when counting for TRP and PCORI. Proposals include:
  - Requiring insured plans (but not self-funded) to use the same counting methods for PCORI and TRF in the same year
  - Requiring plans that use snapshot or snapshot factor to use representative dates if plan is added, terminated or changes funding method during a quarter
- Data must be reported by November **15** (reporting date for 2014 was extended to December 5, 2014) based upon covered lives during the first nine months of the calendar year. The amount to be available for this program is set out in the law ($10 billion in 2014, $6 billion in 2015, and $4 billion in 2016 for reinsurance in addition to collecting other funds from insurers for the general treasury, which is $2 billion in 2014 through 2015 and $1 billion in 2016).
- HHS will divide that amount by anticipated covered lives to create a national contribution rate. For 2014 the rate will be $5.25 per covered life per month. The rate multiplied by average covered lives would determine each entity's liability. The HHS Notice of Benefit and Payment Parameters for 2015 established that the reinsurance portion of the fee be collected early in the year and the treasury portion of the fee be collected late in the year; i.e. in $52.50 of the 2014 fee would be due January 15, 2015 and the remaining $10.50 will be due November 15, 2015. The 2015 annual fee will be $44 per covered person ($3.67 per month). $33 will be due January 15, 2016 and $11 will be due November 15, 2016. The HHS Notice of Benefit and Payment Parameters for 2016 finalized the 2016 fee at $27 per covered life (with $21.60 due January 15, 2017 and $5.40 due November 15, 2016). Note that the second payment of the year is to cover the treasury assessment, which is about the same amount for 2014 and 2015.
- The TRF fee will be reported and paid through www.pay.gov. The form became available October 24, 2014.
- Amounts would then be disbursed to insurers with non-grandfathered individual plans to cover:
  - 80% of claims costs in excess of a $45,000 deductible, to a maximum reimbursement of $250,000 per person for 2014
  - 50% of claims costs in excess of a $45,000 deductible to a maximum reimbursement of $250,000 for 2015. This reflects the proposed reduction of the deductible from $70,000 to $45,000.
  - 50% of claims in excess of a $90,000 deductible to a maximum reimbursement of $250,000 for 2016.
  - Reimbursements would be reduced pro rata if reinsurance dollars available were less than claims. Excess dollars will be used to increase the coinsurance rate for the current payment year.
  - Reimbursements will be based on national, not individual state, experience
- Insurers will be required to submit payment requests quarterly
- Includes an administrative fee

- Records must be maintained for 10 years
- Self-funded, self-administered plans will be exempt from the fee in 2015 and 2016 (which would benefit self-administered multiemployer plans, for instance). To be self-administered the plan may not use a third-party administrator for key administrative functions, including claims processing, claims adjudication, and enrollment. A plan can be self-administered even though it leases a network, uses a third-party administrator for pharmacy benefits or excepted benefits, or uses a third-party administrator for de minimis administrative services

For more information on deductibility of these fees see the ACA Section 1341 Transitional Reinsurance Program FAQs from the IRS.

Mandatory **national** reinsurance program (2014 to 2016) for the individual market (except for grandfathered coverage); original proposal was that states would run the program.

Non-Medicaid Program for Certain Low Income Individuals ("Basic Health Plan")

States and "regional compacts" of states may seek HHS approval to establish one or more federally-funded, non-Medicaid programs to cover persons who:

- Are not eligible for Medicaid
- Whose household incomes exceed 133% of the federal poverty level (FPL) but do not exceed 200% of FPL
- Are offered employer-sponsored coverage that does not meet the "affordable" coverage criteria
- Are under age 65 at the beginning of the plan year
- Would otherwise be eligible for subsidized coverage through a state-based exchange

The program would be in lieu of enrolling eligible individuals in exchanges. It specifically precludes eligible individuals from enrolling in an exchange plan (and therefore not able to receive exchange subsidies). Eligibility determinations generally will be for 12 months.

HHS must certify that the state basic health program:

- Premium costs do not exceed those of an exchange-based Silver Plan, after the reduction for any premium tax credits and cost-sharing reductions available
- Cost-sharing does not exceed that of an exchange-based Platinum Plan in the case of someone with household income not in excess of 150% of FPL
- The plan must at least cover "essential health benefits"

Required to contract with "managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market," and to make multiple plans available, if possible.

Federal funds for the state basic health program are equal to 95% of the subsidies and cost-sharing reduction that would have been provided over a fiscal year through an exchange for enrollees in the state basic plan option.

Participating plans would have to maintain a medical loss ratio (MLR) of 85%.

Effective January 1, 2014

Delayed to 2015

The state program is required to have a competitive process for entering into contracts with "standard health plans," including negotiation of:

- Premiums
- Cost-sharing
- Benefits in addition to the essential benefit requirements
- Inclusion of innovative features such as care coordination and care management for enrollees, especially for those with chronic health conditions
- Incentives for use of preventive services
- Managed care
- Establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan
- Suitable allowances for differences in health care needs of enrollees and differences in local availability of, and access to, health care providers
- Establishing specific measures and standards that focus on quality of care and improved health outcomes

A state may negotiate a regional compact with other states to include coverage of eligible individuals in all such states in agreements with contracted entities offering the coverage.

On September 25, 2013, HHS published proposed regulations for implementing the Basic Health Program (BHP). The Final Rule was published March 12, 2014. For states that are interested, the program will be first available in 2015. In many respects, the program will operate like a state-run exchange – states will need to submit a "blueprint" to HHS for approval, use the streamlined Medicaid/exchange eligibility applications, and offer at least two standard plans with the 10 EHBs.

Wellness Plans for the Individual Market

Effective no later than July 1, 2014

Applies the HIPAA bona fide wellness program rules to the individual market via a ten-state pilot program in 2014 through 2017, with the potential for expansion to more or all states after July 1, 2017.

Participating states:

- May permit premium discounts or rebates/reductions in applicable cost-sharing components for program participation or compliance
- Must insure consumer protection requirements are met
- Must require insurers to verify that such premium discounts:
  - Don't create undue burdens for insureds in the individual market
  - Do not lead to cost-shifting
  - Are not a subterfuge for discrimination

- Must insure that consumer data is protected
- Must ensure and demonstrate the program discounts and rewards are appropriate relative to anticipated participation levels and anticipated utilization and claim cost reductions.

State Waiver

States can apply for waivers to opt out of the following requirements if they implement programs that ensure their residents have coverage that is at least as comprehensive as the coverage required under exchange plans.

Effective for plan years beginning on or after January 1, 2017

- HHS will determine the scope of the waiver based on a state's application
- HHS will make the determination on waiver applications within 180 days of receipt
- No waivers can extend longer than five years unless such an extension is granted by HHS

Requirements that can be waived:

- Establishment of qualified health plans
- Health insurance exchanges
- Reduced cost-sharing for individuals
- Individual tax credit
- Employer responsibility requirements
- Individual responsibility requirement

For state waivers under which individuals and small employers would not qualify for the bill's tax credit or subsidy provisions, the Treasury Department is required to pay to the state the funds that would have been paid on behalf of exchange participants in the absence of a waiver, to help implement the state plan under the waiver.

State applications must contain:

- A comprehensive description of state plan that will meet the requirements for a waiver
- A 10-year budget plan that is budget neutral for the federal government
- An assurance that the state has enacted a law providing for state action under a waiver, including implementation of the state plan

Permits HHS to grant waiver requests if HHS determines that the state plan will:

- Provide coverage that is at least as comprehensive as the essential health benefits coverage
- Provide coverage that has cost-sharing protections against excessive out of pocket (OOP) expenditures that are at least as affordable as under this bill
- Extend coverage to at least a comparable number of residents as under this bill
- Not increase the federal deficit

Requires HHS and Treasury to issue regulations on or before September 23, 2010, that provide for:

- The process for public notice and comment at the state level as relates to state waivers, including hearings
- The process for submitting applications
- The process for providing public notice and comment after receipt of the application by HHS
- The process for the submission of periodic reports by the state to HHS
- The process for periodic evaluation of the programs under the waiver

Directs HHS to develop a coordinated process permitting states to submit a single application for a waiver under Medicare, Medicaid, and CHIP.

Federal Government Programs

Health Insurance Premium Rate Review

Effective March 23, 2010

Establishes federal review of health insurance premium rates (although the federal government cannot block increases).

The Secretary of HHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases beginning in 2010 to prevent unreasonable increases and publicly disclose such information.

All rate increases (regardless of size) must be submitted to HHS using a “unified rate review” template. This is in addition to any state filing requirement. This information will be posted on the state insurance department and HHS websites. Carriers that have a pattern of unreasonable increases may be barred from participating in an exchange.

Early Retiree Reinsurance Program – Eligibility

Effective on March 23, 2010

Directs HHS to establish a temporary reinsurance program to assist "employment-based plans" (including self-funded plans) with the costs of providing health benefits to early retirees, eligible spouses, surviving spouses, and dependents of such retirees.

“Employment-based plans” means a group benefits plan (including self-funded plans) providing health benefits that is:

- Maintained by:
  - One or more current or former employers (including state or local governments; but not the federal government)
  - Non-profits and religious entities
  - Employee organizations
  - Voluntary employee beneficiary associations (VEBAs)
  - A committee or board of individuals appointed to administer such plan
  - A multiemployer plan (as defined in Section 3(37) of ERISA)

To participate in the program, employment-based health plan sponsors must:

- Implement programs and procedures to generate cost savings for individuals with chronic and high-cost conditions (condition for which $15,000 or more in health benefit claims – including prescription drugs – are likely to be incurred during a plan year by one participant)
- Provide documentation of the actual cost of medical claims involved, *including PHI via the insurer or administrator*
- Submit an application and be certified by HHS

HHS has established a website at www.ERRP.gov to facilitate application to the program and to submit funding requests. Detailed instructions are at: www.errp.gov/how_to_apply.shtml.

Eligible retirees must be:

- Age 55 or older

- Not Medicare-eligible
- Not active employees of an employer maintaining, or currently contributing to, the employment-based plan, or of any employer that has made substantial contributions to fund such plan

Requires HHS to:

- Establish an appeals process to permit employment-based plans to appeal claims submitted
- Establish procedures to protect against fraud, waste and abuse
- Conduct annual audits of claims data

Sunsets the program on January 1, 2014 (or earlier if the funding is exhausted).

Note: HHS has issued guidance regarding how plan sponsors participating in the Early Retiree Reinsurance Program (ERRP) would submit a request for appeal of an adverse reimbursement determination, and how the appeals process works.

Definition of adverse reimbursement determination

- An adverse reimbursement determination is a determination constituting a complete or partial denial of a reimbursement request.
- This includes a determination regarding whether a given individual whom the sponsor has submitted to the Centers for Medicare and Medicaid Services (CMS) as an early retiree in advance of a reimbursement request satisfies the substantive criteria for being an early retiree for the entire time period claimed by the sponsor or whether a claim submitted in advance of a reimbursement request is for a health benefit, as defined by the ERRP statute, regulation, and other ERRP guidance.

Appealable determinations are ones that CMS makes based on the plan sponsor's submissions to CMS. A plan sponsor may not appeal a reimbursement determination on the ground that:

- It neglected to include a given item or service in its reimbursement request
- It misstated data with respect to a given item or service
- CMS could not process an Early Retiree List, Summary Claim Data, a Claim List, or a reimbursement request due to the fact that it was not submitted in the correct manner or format

The ERRP statute and regulations do not permit plan sponsors to:

- Appeal CMS determinations to deny an ERRP application
- Refuse to accept an application for processing
- Terminate approval of an application

The denial of an application, the refusal to accept an application, or the termination of an application approval are related to whether a plan sponsor may participate in the program, not a determination about reimbursement for participating plan sponsors.

Request for appeal

The ERRP regulations state that a sponsor has 15 calendar days from the date of receipt of an adverse reimbursement determination to submit an appeal. The 15-calendar day period does not begin to run until the sponsor receives the relevant email that notifies the plan sponsor about the adverse reimbursement determination. That email will describe the 15 calendar-day time limit for submitting an appeal.

Documentation to submit

A request for appeal must specify the findings or conclusions with which the plan sponsor disagrees and the reasons for the disagreements. In submitting a request for appeal, a plan sponsor should include all information and data necessary for the HHS Departmental Appeals Board to evaluate the request and CMS to respond to the appeal, including:

- A copy of the email notifying the plan sponsor about the adverse reimbursement determination
- The amount of reimbursement at issue
- The application ID number
- The plan year
- Information about the items and services at issue including dates of service
- Information about the individuals to whom the items or services were provided

Since the Appeals Board is independent of CMS:

- The plan sponsor should not assume that the Appeals Board would have information that the plan sponsor submitted to CMS, such as the plan sponsor‘s Claim List
- The plan sponsor also may submit supporting documentation not previously submitted to CMS
- The plan sponsor should not submit any documentation that is related to individuals, items or services not previously included in the Early Retiree List or Claim List, to the extent the adverse reimbursement determination being appealed is directly related to the response files sent with respect to those lists

How and where to submit documentation

If a plan sponsor wishes to submit its request for appeal and supporting documentation electronically, the plan sponsor should call the Departmental Appeals Board (DAB) at (202) 565-0208 as soon as possible before the applicable deadline to ascertain whether the Board is able to accept the submission electronically and to obtain any instructions for submission. Any electronic submissions must be made using the DAB web portal. Requests for appeal and supporting documentation must be mailed to the Department of Health and Human Services Departmental Appeals Board, MS 6127 Appellate Division, 330 Independence Ave., S.W. Cohen Building - Room G-644, Washington, D.C. 20201.

For more information, visit http://www.errp.gov.

Early Retiree Reinsurance Program – Exclusions and Exceptions

Effective on March 23, 2010

The services noted below, which are not covered by Medicare, will *not* be credited toward the $15,000 threshold nor reimbursed under the Program.

- Custodial care, such as personal care by individuals who are not medically trained
- Routine foot care, such as orthopedic shoes
- Personal comfort items, such as a television in a hospital room
- Routine services and appliances for vision (e.g., glasses, contact lenses)
- Hearing aids and auditory implants
- Cosmetic surgery, except when required to quickly repair of an accidental injury or improve function of a malformed body part
- Routine dental service
- Assisted suicide
- In-vitro fertilization and artificial insemination
- Abortion services, except if the pregnancy resulted from rape or incest or endangers the woman's life
- Drugs that are not covered by a standard Medicare Part D plan (unless covered under Medicare Parts A or B)
- Items or services not furnished in the United States

Some of Medicare's specific limits do not apply in ERRP:

- Medicare imposes amount, duration, and scope limits on certain items and services such as home health services and skilled nursing facility care. HHS will not impose the Medicare frequency or maximum limits because they intend to recognize limits set under the employment-based health plan.
- HHS will not apply Medicare medical necessity determinations to ERRP claims. HHS will defer to the medical necessity determinations made by the applicable sponsor's plan.
- HHS will not impose Medicare benefit restrictions that would require sponsors and HHS to develop a claims history, such as the requirement that an individual have been in a hospital before being admitted to a skilled nursing facility.
- Generally, Medicare's restrictions on the site or circumstances of care would not apply to ERRP. For example, HHS will count toward the program's cost threshold or reimburse otherwise valid ERRP claims for items and services of providers not participating in Medicare.

Early Retiree Reinsurance Program – Payments

Payments and claims:

- Reimburses 80% of claims of $15,000 or more, but below $90,000, subject to annual increases based on the medical care component of the consumer price index (CPI) rounded to the nearest $1,000
- Plans must submit claims charges (including both plan share and enrollee cost-share)
- Requires claims to be based on the actual amount expended by the plan, taking into account negotiated price concessions (e.g., discounts, rebates, direct or indirect subsidies or remunerations, etc.)
- Costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent (e.g., deductibles, copayments, or coinsurance) are to be included in the amounts paid by the participating employment-based plan in determining claim amounts

Method for determining claims and payments for plan years *starting before but ending after* June 1, 2010:

- For claims incurred before June 1, 2010, claims up to $15,000 count toward the cost threshold and cost limit
- For claims incurred before June 1, 2010, claims over $15,000 are not eligible for reimbursement and do not count toward the cost limit
- The reinsurance amount to be paid is based solely on claims incurred on or after June 1, 2010

Starting in October 2010, sponsors with approved applications who submit funding requests will begin to receive reimbursement for eligible claims.

Requires reinsurance payments to be used to lower costs for the plan, including premium costs for an employer and costs borne directly by participants and beneficiaries (such as premiums, deductibles, co-payments, and other out-of-pocket costs).

- Payments cannot be used as general revenues for plan sponsors.
- Reimbursements must be used as soon as possible, and no later than December 31, 2014.

Plans that receive ERRP reimbursements must maintain the plan sponsor contribution level in effect prior to ERRP. See the CMS guidance on complying with the maintenance of contribution requirement for more information.

Directs HHS to monitor the use of such payments by employers:

- Payments are retroactive for a plan year.
- Payments received under this reinsurance program are excluded from the gross income of a qualified health plan sponsor.

Appropriates $5 billion for this fund. Allows HHS to stop taking applications for participation in the program to comply with this funding limit.

Update: ERRP will cease accepting applications May 5, 2011.

Effective on March 23, 2010.

On October 3, 2011, CMS began providing specific, claim line-level feedback to sponsors who submit Claim Lists through a new, fully automated review system.

- Given this expedited feedback, all Claim Lists submitted on or after October 3 must be error-free (it must pass the automated review) in order for the plan sponsor to be able to submit a reimbursement request, and then be approved for payment.
- If a Claim List is determined to be invalid as a result of the automated review and cancelled from the system, the sponsor may resubmit a corrected Claim List.
- Similarly, before the automated processing system becomes effective in October 2011, Claim Lists and reimbursement requests that have errors will be cancelled from the system, and plan sponsors may resubmit them.

To provide plan sponsors with sufficient time to prepare for this level of review, the deadline for plan sponsors to submit error-free Claim Lists in support of reimbursements received based on a summary of aggregated claims has been extended from December 31, 2011, to March 30, 2012.

Finally, CMS is granting sponsors additional flexibility in submitting detailed claims information, offering options on some elements while maintaining fiscal integrity. Plan sponsors should refer to the updated Claim List layouts provided on the ERRP website for guidance on how to supply required data, and to the questions and answers provided on the website.

The program will sunset January 1, 2014. The last day to submit a claim is July 31, 2013. The last day to file a reopening request is December 31, 2013. The ERRP Secure Website was disabled January 10, 2014. After December 31, 2013, Plan Sponsors will no longer be required to update contact information, unless they are the subject of an active audit. Plan records should be kept for six years after the end of the year in which reimbursed costs were incurred.

Read the full text of the Notice outlining termination dates.

National Prevention, Health Promotion, and Public Health Council

Effective March 23, 2010

Requires the President of the United States to establish within HHS a National Prevention, Health Promotion, and Public Health Council, to be composed of representatives from designated federal agencies, to:

- Provide coordination and leadership with respect to prevention, wellness, health promotion practices and the public health system
- Develop a strategy to improve health status and reduce preventable illness
- Make recommendations to the President and Congress concerning the country's most pressing health challenges
- Consider and propose evidence-based and innovative approaches to promote new models of prevention, integrative health and public health on individual and community levels

The President shall establish an Advisory Group to the Council, composed of 25 non-federal members (including a diverse group of licensed health professionals).

Within one year of enactment, requires the council to recommend a national prevention, health promotion, and public health strategy that:

- Sets specific goals for improving health in the United States

- Establishes specific and measureable actions and timelines to carry out the strategy
- Makes recommendations to improve federal efforts

Requires the Council, by July 1, 2010, (and annually thereafter through January 1, 2015), to report on the Council's prevention and health promotion efforts and national progress in meeting specific goals (smoking reduction, improved nutrition, adequate exercise), with lists of national priorities, and including specific plans for meeting goals.

No less than every five years, requires joint reviews and evaluations by HHS and the Government Accounting Office (GAO) of every federal disease prevention and health promotion initiative, program and agency.

Prevention and Public Health Fund

Establishes a new Prevention and Public Health Investment Fund for prevention and public health programs, to be administered through HHS. Appropriates:

Effective March 23, 2010

- $500 million for fiscal year 2010
- $750 million for fiscal year 2011
- $1 billion for fiscal year 2012
- $1.25 billion for fiscal year 2013
- $1.5 billion for fiscal year 2014
- $2 billion for each of fiscal years 2015 and beyond

Funds are to be used for activities such as:

- Prevention research
- Health screenings
- The Community Transformation grant program (state and municipal wellness programs to create walking paths, nutritional awareness programs, etc.)
- Education and Outreach Campaign for Preventive Benefits (public-private partnership to raise awareness on preventive care)
- Immunization programs

Health Reform Implementation Fund

Establishes a $1 billion Health Insurance Reform Implementation Fund within HHS to implement health reform policies.

Effective March 23, 2010

National Health Education and Outreach Campaign

Effective March 23, 2010

HHS is required to establish a national public-private partnership to conduct a national prevention and health promotion outreach campaign, which will include:

- Raising awareness of activities to prevent chronic disease and to promote health via a national multi-media campaign
- Maintaining a website to provide science-based health promotion and disease prevention information for health care providers and the public
- Maintaining a website-personalized prevention plan tool for individuals to assess their disease risks and establish a personalized prevention plan
- Providing guidance to the states and health care providers on preventive and obesity-related services available to Medicaid enrollees
- Establishing an Internet portal for accessing risk-assessment tools

Appropriates $500 million and additional amounts as necessary.

Maternal and Child Health Services Grants

Effective March 23, 2010

Home Visiting Program. States and other eligible entities will be provided with grants to develop and implement evidence-based maternal, infant, and early childhood visitation models designed to promote improvements in maternal and pre-natal health, infant health, early childhood health and development, etc. Program funding is $1.5 billion total over five years (2010 to 2014).

Postpartum Depression Program. Program funding is $10 million total over three years (2010 to 2012).

Personal Responsibility Education. Designed to reduce pregnancy rates and prepare adolescents for adulthood. Program funding is $375 million total over five years (2010 to 2014)

Abstinence Education. Program funding is $250 million total over five years (2010 to 2014).

Pregnancy Assistance Fund. Designed to assist and provide support to pregnant and parenting teens and young women through programs such as:

- Those that help pregnant or parenting teens stay in or complete high school
- Intervention services and outreach so that pregnant and parenting teens and women are aware of services available to them

Program funding is $250 million total over ten years (2010 to 2019).

Oral Healthcare and Prevention Programs

HHS is required to establish a five-year national campaign that focuses on oral healthcare prevention and education, including:

- Ensuring that activities are targeted toward specific populations (children, pregnant women, parents, the elderly, the disabled, and ethnic and racial minority populations)
- Including community water fluoridation and dental sealant messaging
- Awarding demonstration grants to demonstrate the effectiveness of research-based dental caries disease management activities
- Awarding a grant to each state, territory, Indian tribe or organization to provide for the development of school-based dental sealant programs

Effective March 23, 2010

Other Prevention and Wellness Program Grants

HHS is required to establish and award grants for the following prevention and wellness initiatives:

- Community Transformation Grants: Funding as needed for fiscal years 2010 through 2014
- Healthy Aging (55 - 64) Program Grants: Funding as needed for fiscal years 2010 through 2014
- Individualized Wellness Plan Pilot Program Grants (for 10 Community Health Centers): Funding as needed
- Young Women's Breast Health Awareness Grants: Funding of $9 million per year for fiscal years 2010 through 2014

Effective March 23, 2010

Other Health Program Grants

HHS is required to establish and award grants for the following initiatives:

- Epidemiology-Laboratory Capacity Grants: Funding of $190 million per year for fiscal years 2010 through 2013
- Cures Acceleration Network Grants: Funding of $500 million for fiscal year 2010
- Centers of Excellence for Depression Grants: Funding of $100 million per year fiscal years 2011 through 2015, and $150 million per year for fiscal years 2016 through 2020

Effective March 23, 2010

Indian Health Care Improvement Act

The existing Indian Health Care Improvement Act has been permanently reauthorized. Funding mechanisms are revised and support is expanded for specific programs in the areas of:

- Behavioral
- Mental health
- Youth

Effective March 23, 2010

- Hospice
- Long-term care
- Cancer screening
- Assisted living
- Community-based services
- Suicide prevention

Native Hawaiian health laws are reauthorized and extended until 2019.

Pre-existing Condition Coverage for Individual Market via Temporary High Risk Pool

Directs HHS to establish a temporary, national high risk pool program: the Pre-Existing Condition Insurance Plan (PCIP).

Effective on or before June 21, 2010

Allows states (under defined circumstances) or non-profit entities to be given responsibility to administer the program. (Twenty-three states and the District of Columbia have elected to have HHS run their programs.)

Requires qualified high risk pools to:

- Provide coverage to all eligible individuals without any pre-existing condition restrictions
- Provide coverage for at least 65% of plan costs
- Limit out-of-pocket (OOP) costs to those for high-deductible health plans (HDHPs) ($5,950 for single; $11,900 for family)
- The interim final rule requires that **premium rates** for the Pre-existing Condition Insurance Plan (PCIP) must be at the standard premium rate offered for the standard population (not the high-risk population) in the individual market in the state where the PCIP operates
- Allow premiums to vary only according to the adjusted community rating rules under this bill, except that rates can vary by age in a range of 4:1
- Meets ant other requirements imposed by HHS

Defines eligible individuals as those who:

- Are a citizen or lawfully present in the United States,
- Have not had creditable coverage during the six-month period prior to applying for coverage through the PCIP, and
- Have a provable pre-existing condition as determined by HHS guidelines

PCIP may determine that an individual has a pre-existing condition if they satisfy any one of the following:

- The individual provides documented evidence that an insurer has refused, or has provided clear information that it would refuse, to issue individual coverage on grounds related to the individual's health
- The individual provides documented evidence that he or she has been offered individual coverage but only with a rider that excludes coverage of benefits associated with a pre-existing condition

- The individual provides documented evidence that he or she has a medical or health condition specified by the state and approved by the HHS

In an effort to boost plan enrollment, as of January 1, 2011, people enrolled in PCIP have a choice of three types of plans, each having different levels of premiums, calendar year deductibles, prescription copays and prescription deductibles:

- Standard Plan
- Extended Plan
- Health Savings Account Plan

Note: When the ACA was being developed, the Congressional Budget Office estimated that it could serve up to five million Americans between 2010 and 2014. As of April 30, 2011, actual enrollment totaled 21,500 (about 15,800 in the state-run PCIPs and about 5,700 in the federally run PCIP).

On September 1, 2011, HHS began paying a $100 fee to licensed brokers who enroll eligible people in the PCIP in the 23 states and the District of Columbia, where the federal government runs the program.

Requires HHS to establish criteria for determining whether insurers and group health plans have discouraged individuals from remaining enrolled in prior coverage based on health status.

- Requires issuers and employers who engage in such behavior to reimburse the program for the medical expenses of such individuals who subsequently enroll in the program.
- Determinations are to be based on criteria established by HHS and must include at least the following circumstances:
  - Offering of money or other financial considerations for dis-enrolling from prior coverage
  - In cases where the premium for prior private coverage exceeds the premium under the new HHS program:
    - the prior coverage is a policy no longer being actively marketed by the insurer, or
    - the prior coverage is one for which duration or health status can be considered in determining renewal premiums
- Requires HHS to establish an appeals process to enable individuals to appeal determinations under this provision as well as procedures to protect against fraud and abuse.

Appropriates $5 billion to pay claims and administrative costs of the high risk pool that are in excess of premiums collected.

- Allows HHS to stop taking applications for participation to comply with this funding limit.
- Provides for HHS to make “such adjustments as necessary” to eliminate any remaining deficit after such funds are spent.

Requires HHS to develop procedures to provide for the transition of program enrollees on January 1, 201,4 into plans offered through an exchange, including allowing for an extension of coverage after the risk pool provision is terminated, if HHS deems this necessary to avoid a lapse in coverage.

Supersedes existing state laws or regulations (other than state licensing laws or laws relating to plan solvency) with respect to qualified high risk pools established in accordance with this provision.

This national program can work with existing state high-risk pools and will end on January 1, 2014, once the exchanges become operational and the other pre-existing condition and guarantee issue provisions take effect. Program has been extended to April 30, 2014. Additionally, special enrollment in the exchanges is available May 1 to June 29, 2014, with coverage retroactive to May 1, 2014.

Participants will have personal and claims-related data mandatorily collected by the federal government in a national database. The data will be shared with other entities for law enforcement and other purposes.

Affordable Coverage Website

The portal must be available no later than July 1, 2010

The Secretary of HHS is required to establish a website through which residents of any state (the 50 states and the District of Columbia, but not U.S. territories) may identify affordable health insurance coverage options in that state. This site is www.HealthCare.gov for English, www. CuidadoDeSalud.gov for Spanish. A call center is now open at 1-800-318-2596, with TTY/TDD for the hearing impaired at 1-855-889-4325.

A website dedicated to business was launched August 1, 2013: http://business.usa.gov/healthcare.

At a minimum, the web portal is to provide information on the following coverage options:

- Health coverage offered by health issuers
- Medicaid coverage
- CHIP coverage
- State high risk health pool coverage
- Coverage under the ACA temporary high risk pool
- Coverage available in the small group market for small businesses

Information to be provided on the above coverage options:

- Percentage of total premiums expended on non-clinical costs
- Medical loss ratios
- Quality and performance information
- Financial ratings (Standard & Poor's, Moody's, A.M. Best, etc.)
- Eligibility
- Availability
- Premium rates
- Cost-sharing for each coverage option
- Geographic availability by ZIP code or county

- Links to provider networks
- Customer service telephone number

The website will also include information for small businesses about:

- Available coverage options
- Reinsurance for early retirees
- Small business tax credits
- Other information of interest to small businesses

The Secretary of HHS will create a standardized format for data presentation no later than June 21, 2010.

Elder Justice Act

Establishes an Elder Justice Coordinating Council and an Advisory Board on Elder Abuse, Neglect, and Exploitation.

Effective January 1, 2011

Establishes four grant programs with combined total funding of $600 million for fiscal years 2011 through 2014):

- Forensic Centers – research on forensic markers and optimal intervention procedures
- Long-term Care – worker training and working condition improvement grants
- Adult Protective Services Offices – best practice research and training
- Long-term Care Ombudsmen – improve complaint response and resolution

Additional grant programs:

- National Training Institute for Surveyors (of allegations): funded by a total of $48 million over four years (2011 to 2014)
- State Survey Agencies (complaint investigation systems): funded by a total of $20 million over four years (2011 - 2014).

Imposes monetary civil penalties (of up $300,000) for failing to report suspected crimes or for retaliation against someone who does.

Community Living Assistance Services and Support (CLASS) Act

CLASS Act – Description

Creates new, voluntary national insurance program (Community Living Assistance Services and Supports or "CLASS" program) financed through payroll deductions to provide a cash benefit to individuals who become functionally limited and require community living assistance services and support.

Program repealed January 1, 2013

Effective January 1, 2011

Federal Studies

Coverage and Enrollment Denial Study

The Government Accounting Office (GAO) study on denials of coverage and enrollment (and the reasons for such denials) by insured and self-funded group plans (including both qualified and non-qualified health plans).

Directs the GAO to include data on denials that were later approved by a plan.

Requires the report to be made available by HHS and DOL on a public website.

Report due on or before March 23, 2011

Federal Study of Charitable Care

Requires the Treasury Department, in consultation with HHS, to report annually to Congress:

- Levels of charitable care
- Bad debt expenses
- Unreimbursed costs of non-means tested government programs
- Unreimbursed costs of non-means tested government programs incurred by private tax-exempt, taxable, and government hospitals
- Costs of community benefit activities incurred by private tax-exempt hospitals

Report to Congress on March 23, 2015, the trends in these amounts studied.

Report due on or before March 23, 2011

Federal Study on Self-insured Plans

Mandates *annual* reports by the DOL to Congress on self-insured plans, using data collected from the Annual Return/Report of Employee Benefit Plans (DOL Form 5500).

The studies will include general information on self-insured group health plans, including:

- Plan type
- Number of participants
- Benefits offered
- Funding arrangements
- Benefit arrangements

The studies will also use data from the financial filings of self-insured employers, including information on:

- Assets
- Liabilities

Report due on or before March 23, 2011

- Contributions
- Investments
- Expenses

Federal Health Plan Market Study

Mandates an HHS study (and report to Congress) of the fully insured and self-insured group health plan market, including evaluation of extent to which the ACA insurance reforms may:

- Cause adverse selection in the large group market
- Encourage small and mid-size employers to self-insure

The study will compare:

- Employer characteristics (industry, size, etc.)
- Health plan benefits
- Financial solvency
- Capital reserve levels
- Insolvency risks

HHS, in coordination with DOL, will collect information and analyze:

- The extent to which self-insured health plans can offer less costly coverage, and if so, whether lower costs are due to:
  - Efficient administration
  - Lower overhead
  - The denial of claims
  - Very limited benefit packages
- Claim denial rates
- The extent to which plans scale back benefits during economic downturns
- The effect of the limited recourse options on consumers
- Any potential conflicts of interest between the health care needs of self-insured enrollees and self-insured employers' financial contribution and profit margin
- The effect of such conflict on the administration of the plan

Report issued March 31, 2011: Report to the Congress on a Study of the Large Group Market

Report due on or before March 23, 2011

Health Plan Value Study

HHS is to develop methodology, in consultation with relevant stakeholders (including insurers, consumers, employers and providers) to measure health plan value.

Requires such methodology to consider:

- Overall costs to enrollees
- Quality of care
- Efficiency of the plan in providing care
- Relative risk of plan enrollees
- Actuarial value (or other comparative measure of covered benefits)

Report due September 23, 2011

National Worksite Health Policies and Program Study

Requires the Centers for Disease Control (CDC) to conduct a national survey to assess employer-based wellness programs and make recommendations to Congress based on the findings.

Requires evaluations of all programs funded through the CDC before evaluations are conducted on privately funded programs, unless such a program requests an evaluation.

Survey to be conducted within two years of enactment, and at regular intervals thereafter.

Effective on or before March 23, 2012.

GAO Study on Rating System of Nursing Homes

The Government Accounting Office (GAO) will conduct a study on the Five-Star Quality Rating System of nursing homes paid for Medicare and Medicaid services, analyze the system's implementation, and suggest potential improvements to the system.

Report due March 23, 2012.

Employer Responsibility Study

HHS, in consultation with Treasury, must conduct a study of the procedures necessary to protect:

- Employees' right to keep their tax return information confidential
- Employees' right to enroll in a QHP through an exchange if their employers do not provide affordable coverage
- Employers' right to adequate due process
- Employers' right to access information to accurately determine payments assessed on them

Report due January 1, 2013

Study of Use of Geographic Variations in Determining Federal Poverty Level

Requires HHS to study the feasibility and implication of adjusting the federal poverty level (FPL) to reflect variations in cost of living among various geographic regions in the United States, its territories and possessions. The study must focus on the disparity in poverty level and cost of living, and the effect of such disparities on efforts to expand and ensure health care.	Report due January 1, 2013

Federal Study on Effectiveness of Wellness Programs

HHS, in consultation with the Departments of Labor and Treasury, must submit a report to Congress on: • The effectiveness of wellness programs in promoting health and preventing disease • The effect of wellness programs on access to care and affordability of coverage for both participants and non-participants • The effect of premium and cost-sharing incentives on participant behavior (and behavioral changes) • The effectiveness of different types of rewards as added by the ACA The Secretaries must gather relevant information employers, including state and federal agencies.	Report due not later than March 23, 2013

Study on Effect of Employer Mandate Penalty Tax on Workers' Wages

DOL will conduct a study to determine whether employee wages are adversely affected by the employer mandate penalties. No date was specified for delivery of the report.	Effective January 1, 2014

Health Insurance Competition and Market Concentration Study

Requires the GAO to conduct an ongoing study, beginning in 2014, on competition and market concentration in the health insurance market in the U.S. after implementation of reforms, including an analysis of new health insurance issuers. Requires such reports to be submitted to Congress by December 31 of each even-numbered year.	Initial report to be submitted by December 31, 2014

Study on Affordability of Health Insurance

The Comptroller General will conduct a study on the affordability of health insurance and report its findings to Congress. The study is to include: • Effect of premium assistance tax credits, cost-sharing reductions, and the small employer tax credits on expanding health insurance coverage for individuals • Availability of affordable health benefit plans, including whether the 9.5% (9.56% in 2015, 9.66% in 2016) of household income threshold for affordable employer coverage is appropriate	Effective on or before March 23, 2015

- Whether the 9.5% (9.56% in 2015, 9.66% in 2016) threshold may be lowered without significantly increasing the federal government's costs
- The ability of individuals to maintain "essential health benefits" coverage

GAO Study of Exchange Activities and Enrollees

Requires the GAO to conduct an ongoing study of exchange activities and enrollees, including a review of:

- Exchange operations and administration
- Exchange expenses
- Exchange progress in meeting goals
- Surveys and reports of QHPs
- Claims statistics and complaints data
- The number of doctors, by area and specialty, who are not accepting new patients in federal government health plans
- The adequacy of provider networks

Also requires the study to include:

- A survey of the cost of coverage provided to small employers inside and outside of exchanges
- Observations about the use and operation of the exchanges
- Recommendations for operational or policy improvements

Initial report due on or before January 1, 2019

HHS Quality and Information Initiatives

Tax Credit for Acute and Chronic Disease (Therapeutic Discovery) Research

Provides a 50% tax credit (as part of the investment credit) for a "qualified" investment (qualified by the Treasury Department in consultation with HHS) in qualifying acute and chronic disease research (certified by Treasury) during 2009 and 2010 for businesses with 250 or fewer employees.

Qualified investments are only those projects that show reasonable potential to:

- Result in new therapies to treat areas of unmet medical need or to prevent, detect, or treat chronic or acute diseases and conditions
- Reduce long-term health care costs in the United States
- Significantly advance the goal of curing cancer within the 30-year period following March 23, 2010

The total amount of credits under the program is limited to $1 billion. Grants in lieu of tax credits are also available.

Applicable to amounts paid or incurred on or after January 1, 2009

Health Care Delivery System Best Practices Research

The Agency for Healthcare Research and Quality (AHRQ) must identify and help implement best practices in the delivery of high quality, safe, and affordable health care services. Finding must be made available to the public through multiple media.

Funded at $20 million for fiscal years 2010 through 2014.

Effective March 23, 2010

Patient-Centered Outcomes Research

Establishes a non-governmental non-profit Patient-Centered Outcomes Research Institute (PCORI) to conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures.

Governed by a Board consisting of AHRQ and National Institutes of Health (NIH) Directors and 19 additional members (appointed by the Comptroller General) representing consumers (3), providers (7), private payers (3), drug/device makers (3), quality improvement researchers (1), and federal and state health programs (2).

Funding levels are:

- $10 million for fiscal year 2010
- $50 million for fiscal year 2011
- $150 million for fiscal year 2012
- For fiscal years 2013 through 2019, $150 million plus the net fees collected from a dedicated tax on insured and self-insured plans

Effective March 23, 2010

Funded by the Patient-Centered Outcomes Research Trust Fund that collects:

- $1 multiplied by the number of lives covered under each health insurance policy or self-insured health plan for plan/policy years ending prior to October 1, 2013, and
- $2 (growing at the rate of per capita growth in health expenditures) in 2014 to 2019

Places conditions on HHS uses of Comparative Effectiveness Research (CER), including:

- HHS may not deny coverage of items or services under Medicare solely on the basis of CER
- HHS may not use CER that values older, disabled, or terminally ill lives lower than younger, non-disabled or not terminally ill lives
- The PCORI may not establish cost-effectiveness based on dollars-per-quality adjusted life year or similar measures

The Office of Communication and Knowledge Transfer within AHRQ creates tools to broadly disseminate CER findings to providers, patients, payers and policy makers.

Medical Reimbursement Data Centers

Effective March 23, 2010

Establishes Medical Reimbursement Data Centers at academic or other nonprofit entities to:

- Collect medical reimbursement data voluntary provided by insurers
- Organize and analyze such information
- Make it available to insurers, providers, researchers, policymakers and the general public

Directs such Centers to:

- Develop (and update) fee schedules and other database tools that reflect market rates for medical services and geographic differences in those rates
- Make health care cost information available to the public through a website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services
- Regularly publish information on methodologies used to analyze health charge data and make such data available to researchers and policymakers

Specifically notes that insurers are **not** required to provide data to these Centers.

Provides $250 million in state grants during 2010 to 2014 to help states carry out this provision and to fund State Health Insurance Premium Reviews. Limits grants to individual states to no less than $1 million and no more than $5 million for a grant year. See the proposed rule on Rate Increase Disclosure and Review.

Quality Measure Development	
Quality measures conforming to the National Strategy will be developed, with facilitation by the Agency for Healthcare Research and Quality (AHRQ) and input from a contracted "consensus-based" entity. Funded at $95 million per year for fiscal years 2010 to 2014.	Effective March 23, 2010
Other Quality Initiative Grant Programs	
The following grant programs are established: • Community-Based Health Teams to Support Patient-Centered Medical Homes: Funding unspecified • Providers Serving Primarily Underserved Populations: Funding unspecified • Chronic Condition Medication Management via Licensed Pharmacists: Funding unspecified (effective May 1, 2010) • Regionalized Emergency Care Centers: Funded as needed for fiscal years 2010 to 2014 • Trauma Care Center Grants: Funded at $200 million for fiscal years 2010 to 2014 • Shared Decision-Making Resource Centers: Funding unspecified • Health Professional Clinical Education Improvement Demonstration Programs: Funding unspecified • Patient Navigator Program Grants: Funding unspecified (fiscal years 2010 to 2015) • Environmental Health Hazard Exposure Screening: Funding at $23 million for fiscal years 2010 to 2014, and $23 million per year thereafter • Public University Health Center Infrastructure Funding Grants: Funded at $100 million for fiscal year 2010	Effective March 23, 2010 unless otherwise noted
Hospital Charge Data Disclosure	
Requires all hospitals to disclose annually publically (in accordance with guidelines developed by HHS) a list of its standard charges for items and services, including for Medicare diagnosis-related groups (DRGs).	Effective September 23, 2010
Value-Based Purchasing Programs	
HHS shall develop a plan to implement value-based purchasing programs for Medicare payments to: • Skilled nursing facilities • Home health agencies • Ambulatory surgical centers	Effective January 1, 2011

National Strategy for Quality Improvement

Effective January 1, 2011

Directs HHS to establish a national strategy to improve the delivery of health services, patient outcomes, and population health and identify national priorities for such improvement.

Directs HHS to identify national priorities for such improvement and requires such priorities to:

- Have the greatest potential for improving outcomes, efficiency, and patient-centeredness of care for all populations
- Identify areas in the delivery of health services that have the potential for rapid improvements in quality and efficiency
- Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques
- Improve federal payment policy to emphasize quality and efficiency
- Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes
- Address health care provided to patients with high-cost chronic diseases
- Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions and health care-associated infections
- Reduce health disparities

Requires HHS to submit its initial recommended strategy to Congress on January 1, 2011, and to submit annual updates to that strategy thereafter. Requires each update to include:

- A review of the short- and long-term goals of the national strategy and any gaps in such
- An analysis of the progress in meeting such goals and any barriers to such progress
- Information reported under current child health quality measures for Medicaid and CHIP and, after January 1, 2014, the new adult health quality measures under Medicaid

Requires HHS to create a website by January 1, 2011, to make public information regarding the national priorities, the agency-specific strategic plans, and other information HHS determines to be appropriate.

Provider Quality Reporting Disclosure

Website to be established on or before January1, 2011

HHS will develop a website on Medicare physicians participating in the Physician Quality Reporting Initiative (PQRI), and by January 1, 2013, implement a plan to publicly report information on physician performance.

- To the extent practicable, HHS will include data reflecting care to all patients seen by physicians, and appropriately attribute care when multiple providers are involved in caring for a patient
- Report to Congress due January 1, 2015
- Financial incentive demonstration program for Medicare beneficiaries utilizing the quality data to begin January 1, 2019

Medicaid Quality Measures

HHS must develop and propose a set of quality measures for Medicaid beneficiaries:

- For adults between the ages of 21 and 65
- For maternity care provided to mothers receiving benefits under Medicaid or CHIP

Funding of $60 million is provided for each of fiscal years 2010 through 2014.

Measures must be published by January 1, 2012

Availability of Medicare Claims Data

HHS may sell standardized extracts of non-patient identifiable Medicare Parts A, B, and D claims data for specified geographic areas to "qualified" public and private entities to evaluate provider performance.

Effective January 1, 2012

Accountable Care Organizations

Implements physician payment reforms under Medicare Parts A and B that:

- Enhance payment for primary care services
- Encourage investment in physician practice infrastructure
- Encourage physicians to join together to form “accountable care organizations” to gain efficiencies and improve quality

On March 31, 2011, HHS released proposed new rules regarding accountable care organizations (ACOs).

Effective January 1, 2012

Acute Care Hospital Value-Based Purchasing Program

Establishes a value-based purchasing program for hospitals participating in Medicare to motivate enhanced quality outcomes for acute care hospitals.

Authorizes a value-based purchasing program demonstration project for Critical Access Hospitals to begin no later than March 23, 2012.

Requires the Secretary of HHS to submit a plan to Congress by fiscal year 2012 to move home health and nursing home providers into a value-based purchasing payment system.

Effective for hospital discharges occurring on or after October 1, 2012

Hospital Re-Admission Rates

Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions. Uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions.

Applies to hospital admissions on or after October 1, 2012

Quality Measure Reporting

Requires the Secretary of HHS to implement quality measure reporting programs for certain providers, including:

- Long-term care hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Cancer hospitals exempt from the Prospective Payment System (PPS)
- Hospice providers

Failure to report will result in a 2% reduction in the annual market basket update.

Effective fiscal year 2014 (October 1, 2013)

Reporting of Provider Quality Information

Requires HHS to make available to the public, through standardized websites, performance information summarizing data on quality measures.

- Such information shall include information on clinical conditions and, where appropriate, shall be provider-specific and disaggregated and specific enough to meet the needs of patients with different conditions.
- Requires information to be tailored to the different needs of providers, practitioners, patients, consumers, researchers, and other stakeholders

On August 5, 2011, CMS launched a new website, Quality Care Finder, that allows one-stop shopping for consumers looking for information on quality or the type of services provided by hospitals, physicians, nursing homes, home care or dialysis providers.

The site compares facilities based on several criteria, including how well hospitals guard against infection during outpatient surgical procedures and the satisfaction of previous patients.

On August 18, 2011, CMS announced the following:

- A Quality Care Finder for consumers to access online all of Medicare's compare tools (comparison information on hospitals, nursing homes and plans)
- An updated Hospital Compare website, which now includes data about how well hospitals protect outpatients from surgical infections and whether hospitals care for outpatients treated for suspected heart attacks with proven therapies that reduce death. Hospital Compare also includes 10 measures that capture patient experience with hospital care, and features information about the volume of certain hospital procedures performed and conditions treated for Medicare patients and what Medicare pays for those services. Both sets of inpatient measures are risk-adjusted, taking health conditions into account to level the playing field among hospitals and to help ensure accuracy in performance reporting.
- An enhanced Quality Improvement Organization (QIO) program that provides technical assistance and resources to health care providers across the country to assist them in changing how care is delivered in hospitals, nursing homes, physician offices, and across care settings.

Effective fiscal year 2014 (October 1, 2013)

Medicare Part A and Part B

Reduction of Medicare Claims Submission Period	
The time period for filing a written request for payment for services provided under Medicare Parts A and B is reduced from three calendar years to one calendar year.	Applies to services provided on or after January 1, 2010.
Medicare Part B Reimbursements For Native Americans	
Removes the sunset provision in the current law to allow Native American tribes, tribal organizations, and urban Native American organizations to continue to receive reimbursement for Medicare Part B services furnished by certain Native American hospitals and clinics.	Effective January 1, 2010
Medicare Eligibility for Individuals Exposed to Environmental Hazards	
A person may be deemed to be immediately eligible for Medicare, regardless of age, if the person: • Is diagnosed with one or more medical conditions • Has been present for an aggregate total of six months in a geographic area subject to an emergency declaration: – During a period of not less than 10 years prior to such diagnosis – During a period of 10 years prior to the implementation of all remedial and removal actions • Has filed an application for benefits	Effective March 23, 2010
Disabled TRICARE Beneficiary Special Enrollment Period	
A special (late enrollment penalty-free) 12-month Medicare Part B enrollment period is established for military retirees, their spouses (including widows and widowers), and dependent children: • Who are otherwise eligible for TRICARE, and • Entitled to Medicare Part A based on disability or end stage renal disease (ESRD), and • Who have declined Part B	Effective March 23, 2010
Nursing Home Transparency Provisions	
Nursing homes, skilled nursing facilities, and nursing facilities are required to comply with new provisions regarding: • Disclosure of ownership and organizational structure (to be made publicly available) • Substantially increased disclosures (including staffing and complaint information) to the publically-accessible Nursing Home Compare website	Effective March 23, 2010 except as noted

- Disclosure of facility and staffing expenditure
- Standardized complaint forms and resolution process (by March 23, 2011)
- Dementia management and abuse prevention training for employees prior to active employment (by March 23, 2011)
- Facility closure notifications within 60 days of the pending closure (by March 23, 2011)
- More detailed staffing information disclosure (by March 23, 2012)
- Submission of plans to HHS to comply with the Quality Assurance and Performance Improvement (QAPI) program requirements (by January1, 2013)
- Implementation of a compliance and ethics program for all employees and agents (by March 23, 2013)

HHS may impose per instance or per day civil monetary penalties for non-compliance with any requirement.

Center for Medicare & Medicaid Innovation

Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

Funded at $100 million per year.

Effective March 23, 2010

Physician-Owned Facilities and Self-referral Limitations

Extends the implementation of a ban on new physician-owned hospitals participating in Medicare to December 31, 2010.

Adds a limited exception to growth caps on existing physician-owned facilities for those hospitals that treat the largest number of Medicaid patients in their county.

Increases the requirements that must be met to allow for self-referral to such facilities.

Effective March 23, 2010

Physicians Ordering Durable Medical Equipment (DME) or Home Health Services

Physicians or other health professionals who certify or order home health services or durable medical equipment (DME) are required to be a Medicare-eligible practitioner and enrolled in the Medicare program.

Physicians ordering DME or home health services that are billable to Medicare must produce supporting documentation upon request of HHS or face disenrollment from Medicare for up to a year.

Medicare-enrolled physicians or eligible professionals must document that there has been a face-to-face (or tele-health) encounter with a Medicare eligible patient prior to ordering DME or home health services.

HHS may extend the requirement to other categories of items or services.

Effective July 1, 2010

Medicare Reimbursement Changes to Facilities and Providers

Reduces annual market basket updates for (effective date): • Inpatient hospitals (2010) • Skilled nursing facilities (2010) • Inpatient psychiatric facilities (2010) • Inpatient rehabilitation facilities (2010) • Home health providers (2011) • Ambulatory surgical services (2011) • Laboratory services (2011) • Durable medical equipment (2011) • Prosthetic devices (2011) • Orthotics (2011) • Miscellaneous services (2011) • Inpatient acute hospital services (2012) • Long-term care hospitals (2012) • End-stage renal disease providers (2012) • Hospital outpatient services (2012) • Ambulance services (2012) • Hospice providers (2013) Effective fiscal year 2014, reduces Medicare Disproportionate Share Hospital payments to reflect lower uncompensated care costs relative to increases in the number of insureds. Payments are reduced initially by 75%, and then subsequently increased based on the amount of uncompensated care.	Effective fiscal years 2010 through 2014 as noted

Preventive Services Coverage

Requires Medicare coverage of an annual wellness visit with no cost-sharing, including creation of a personalized prevention plan that includes a health risk assessment. Requires such risk assessments be completed prior to or as part of the annual wellness visit. Requires HHS to develop guidelines and a model for health risk assessments by September 23, 2011. Removes cost-sharing for specified preventive services and waives the deductible for colorectal cancer screening tests.	Effective January 1, 2011

Reimbursements for Nurse Midwife Services

The reimbursement for nurse midwife services provided to Medicare beneficiaries is increased from 65% to 100% of the payment amount for the same service provided by a physician.	Effective January 1, 2011

Medicare Physician Quality Reporting Initiative

Extends payments under the Physician Quality Reporting Initiative through 2014. • Increases payments 1.0% in 2011 • Increases payments 0.5% in 2012 through 2014 For physicians not submitting quality data: • Reduces payments 1.5% in 2015 • Reduces payments 2.0% in 2016 and thereafter	Effective January 1, 2011

Payment Bonus for Physicians

Primary care practitioners and general surgeons practicing in health professional shortage areas will be provided with a 10% Medicare payment bonus for five years.	Effective for services provided on or after January 1, 2011

Community-Based Care Transitions Program

Establishes the five-year Community-based Care Transitions Program to provide transition services to high-risk Medicare beneficiaries that are at risk for hospital re-admission.	Effective January 1, 2011.

Independent Payment Advisory Board (IPAB)

Establishes a 15-member Independent Payment Advisory Board (IPAB) to develop and submit recommendations to Congress to: • Implement Medicare payment changes • Keep Medicare spending below targeted levels • Improve health outcomes for patients • Promote quality and efficiency • Expand access to evidence-based care Annually, beginning in 2014, IPAB is to develop a proposal that includes recommendations to reduce the rate of Medicare spending growth to meet specific targets. • The Medicare per capita target growth rate is the five-year average percentage increase in:	Funding is effective beginning with fiscal year 2012 (October 1, 2011)

  - The Consumer Price Index for all urban consumers (CPI-U) and the medical care component of CPI-U, through 2017
  - The nominal gross domestic product (GDP) plus 1% per year, beginning in 2018

To bring down the overall rate of growth for the Medicare program, specifically directs that the Board may:

- Look at reductions in Medicare Advantage and Medicare Part D payments to account for administrative costs and profit
- Deny high bids
- Reduce or eliminate performance bonuses

Proposals may **not** include recommendations to:

- Ration health care
- Raise revenues or premiums
- Increase beneficiary cost-sharing
- Restrict benefits
- Modify eligibility requirements
- Reduce payment rates for items and services furnished prior to January 1, 2020, by providers and suppliers meeting specified criteria

Annual reports to Congress are required beginning January 15, 2014.

Board recommendations would be legally binding absent legislative action by Congress.

Directs the President to send the proposal to Congress within two days, which is directed to introduce it in both Senate and House with provisions for *automatic, expedited* consideration with *limited* debate.

If no proposal is sent in a required year, HHS is directed to develop a proposal based on the same criteria as required of the IAPB.

If no bill is enacted by August 15 in a year when a Board proposal is required and transmitted, HHS is directed to implement the Board's recommendations administratively.

Includes an annual public report, beginning July 2014, that allows for comparisons by region, types of services, types of providers, and both private payers and Medicare of the following:

- System-wide health care costs and quality of care at the most local level feasible
- Patient access to care and cost-sharing burden on beneficiaries
- Epidemiological and demographic changes
- Increase, effectiveness, and utilization of technology
- Any other areas deemed by the Board to affect spending and quality of care

Beginning 2015 and every two years thereafter, Board makes *non-binding* recommendations on ways to slow national health spending (*excluding* recommendations for Medicare and other federal health programs). The Board will be funded with $15 million in fiscal year 2012, with annual CPI-U increases thereafter. The Board may be discontinued in 2017 by 60% majority vote.	
Medicare Physician Resource Use Reporting	
HHS will give physicians confidential reports that measure each physician's resource use. • HHS will develop an "episode grouper" to aggregate claims for separate but clinically related items and services • Give reports to physicians that benchmark their patterns of resource use by episodes of care	Effective January 1, 2012
Independence At Home Demonstration Project	
Establishes a six-year Independence at Home demonstration program to test the use of home-based primary care teams for chronically ill Medicare beneficiaries to improve outcomes and lower costs. Funded at $5 million per year.	Effective January 1, 2012
Payment Bundling	
Establishes a five-year national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.	Effective January 1, 2013.
Physician Value-Based Payment	
Creates a value-based payment program for physicians providing services to Medicare beneficiaries, with the program phased in over two years.	Effective January 1, 2015.
New Standards for MediGap Plans C and F	
Directs the National Association of Insurance Commissioners (NAIC) to develop revised standard MediGap Plans C and F to include requirements for nominal cost-sharing to encourage the use of appropriate physician services under Medicare Part B.	Effective January 1, 2015

Medicare Part C – Medicare Advantage Plans

Medicare Advantage Coding Intensity Adjustment

Medicare Advantage risk scores are to be adjusted to reflect changing coding patterns and to meet lower Medicare fee-for-service rates.

The adjustment (reduction) factor:

- For 2010, will not be less than the 2010 adjustment factor plus 1.3%
- For 2015 through 2018, will not be less than the previous year adjustment factor plus 0.25%
- For 2019 and subsequent years, will not be less than 5.7%

Effective March 23, 2010

Medicare Advantage Payment Provisions

Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels.

Then restructures payments to Medicare Advantage plans (except plans under the Program of All-Inclusive Care for the Elderly) over a four- or six-year period, depending on the level of payment change:

- Higher payments for areas with low fee-for-service (FFS) rates (up to 107.5% of traditional Medicare spending)
- Lower payments for areas with high FFS rates (down to 97.5% of traditional Medicare spending)

Establishes a new mechanism to increase payments (ranging from an additional 0.75% to 2.5%) over a three-year period to "high-quality" Medicare Advantage plans, even though traditional Medicare does not base its payments on quality measures.

Reduces Medicare Advantage funding by a total of $206 billion over 10 years. Direct cuts account for $136 billion and interactions with other cuts in the FFS Medicare program account for an additional $70 billion.

Effective January 1, 2011

Medicare Advantage Plan Design Limitations

Prohibits Medicare Advantage plans from charging higher cost-sharing (greater than that in traditional fee-for-service Medicare) for:

- Chemotherapy administration services
- Renal dialysis services
- Skilled nursing care
- Such other services CMS deems appropriate

Effective for plan years beginning on or after January 1, 2011

Medicare Advantage Supplementary Beneficiary Premium Limitations

Medicare Advantage plans must use any supplementary beneficiary premiums to:

- Lower enrollees' cost-sharing for medical services
- Provide coverage for preventive and wellness benefits
- Provide coverage for additional services that are not part of the Medicare fee-for-service program

Effective for plan years beginning on or after January 1, 2012

Medicare Advantage Enrollment and Dis-enrollment Periods

The annual enrollment period will run from October 15 through December 7 of the year prior to the plan year. The January through March open enrollment period is eliminated.

Medicare Advantage annual coordinated election period will be from November 1 through December 15.

Medicare Advantage beneficiary may switch from Medicare Advantage to traditional fee-for-service Medicare between January 1 and March 15 each year. However, the ability from one Medicare Advantage plan to another is restricted.

Special needs individuals may enroll during annual or coordinated open enrollment periods or at the time of diagnosis.

Effective for enrollment periods applicable to plan years on or after January 1, 2012

Medicare Advantage Loss Ratio Requirements

Requires a minimum 85% medical loss ratio (MLR).

Plans failing the MLR test must remit to HHS “total revenue of the Medicare Advantage plan under this part” for the year multiplied by the amount under the 85% MLR requirement.

- After three consecutive years of failing the MLR requirement, plans are prohibited from new enrollment during the second successive contract year
- After five consecutive years, plans will be terminated

Effective for contract years beginning on or after January 1, 2014

Medicare Part D – Prescription Drugs

Medicare Part D Coverage Gap Rebate

There is a gap in Medicare prescription drug coverage (Medicare Part D) between $2,830 and $6,440 in total drug spending (the “donut hole”).

New provision provides a $250 government-issued rebate to all Medicare Part D beneficiaries that reach the coverage gap in 2010, if such beneficiaries:

- Are not in a qualified retiree Medicare prescription drug plan (PDP)
- Are not entitled to a low-income subsidy

The rebate will be provided by the 15th day of the third month following the end of the quarter during which the beneficiary enters the "donut hole."

Rebates are effective on or after January 1, 2010.

Medicare Part D Low-Income Subsidy Provisions

The Medicare Part D low income premium subsidy (LIS) benchmarks are calculated to exclude any beneficiary rebate in Medicare Advantage prescription drug programs (MA-PDs) that bid below the benchmark or Medicare Advantage performance quality bonus payments.

Directs HHS to develop a *de minimis* policy to permit a Part D plan to waive any minimal monthly premium for a LIS-eligible individual.

Extends for one year the LIS determination period for individuals whose spouse dies.

The policy of auto-enrolling LIS-eligible beneficiaries shall include MA-PD and PDPs that have waived the monthly premium for LIS individuals.

For LIS-eligible individuals that are reassigned to another plan (because their previous plan no longer qualifies for LIS enrollments), within 30 days HHS is required to provide the beneficiary with:

- Information on formulary differences between plans
- A description of the individual’s right to request a coverage determination, exception or reconsideration

Effective January 1, 2011

Medicare Part D Coverage Gap Discount Program

Beginning with drugs dispensed after January 1, 2011, pharmacy manufacturers are required to provide discounts of 50% for brand-name drugs for Part D enrollees in the Part D “donut hole.”

Discounts paid by the manufacturer are counted as incurred drug expenses toward the catastrophic limit.

Effective January 1, 2011

Medicare Part D Coverage Gap Coinsurance Reductions

In conjunction with increasing discounts required of drug manufacturers for Medicare Part D prescriptions, the beneficiary's co-insurance requirement (currently 100%) for the "donut hole" with be reduced as follows **for costs incurred in the "donut hole" only**:

- For generic and non-formulary drugs:
  - Implements a 93% coinsurance rate in 2011
  - Phases it down 7% per year for years 2012 through 2019 (when it will be 37%)
  - Coinsurance will be 25% in years 2020 and thereafter
- For formulary brand drugs, implements coinsurance rates of:
  - 50% in 2011 and 2012
  - 47.5% in 2013 and 2014
  - 45% in 2015 and 2016
  - 40% in 2017
  - 35% in 2018
  - 30% in 2019
  - 25% in 2020 and thereafter

Note: in 2020, the manufacturer discounts of 50% noted above account for 50% of the coinsurance reduction and Medicare Part D pays for 25% of the reduction.

Effective January 1, 2011

Drug Costs Count toward Part D Out-of-Pocket Cap

The following drug costs count toward the Medicare Part D annual out-of-pocket cap:

- Incurred by AIDS drug assistance programs
- Incurred by Indian Health Service, a Native American tribe or organization on behalf of Part D enrollees

Effective January 1, 2011

Medicare Part D Cost-Sharing Elimination for Certain Individuals

Cost-sharing is eliminated under Medicare Part D for individuals and couples who:

- Are full benefit dual eligible (Medicare and Medicaid)
- Receive care under a home and community-based waiver
- Would otherwise require institutional care in an enumerated facility

Effective January 1, 2012

Medicaid and Children's Health Insurance Program (CHIP) – Coverage Provisions

Freestanding Birth Center Services	
States may reimburse providers (including midwives or a licensed birth attendant) at licensed or approved freestanding birth centers for Medicaid covered childbirth and ambulatory services provided to Medicaid eligible individuals. Operation or supervision by a physician is **not** required for Medicaid coverage.	Effective March 23, 2010 (unless state legislative action is necessary)
Family Planning Option	
Allows states to provide Medicaid CHIP family planning services and supplies to non-pregnant women and other individuals without a waiver. • Benefits can be provided solely based on income, removing requirement that individuals be of child-bearing age. • The state has the option of only considering the income of the applicant or beneficiary, and disregarding the income of others in the household. • Benefits include medical diagnosis and treatment services in a family planning setting. • States may allow applicants to be deemed "presumptively eligible" (providing thereby a two-month period for services). Requires benchmark or benchmark-equivalent benefit packages for expansion population to include family planning services.	Effective March 23, 2010
Hospice Care for Children	
A terminally ill child may have payment made both for hospice and for curative services received concurrently.	Effective March 23, 2010
Tobacco Cessation	
Requires state coverage of tobacco cessation services for pregnant women, with no cost-sharing.	Effective October 1, 2010
Home Health Option for Chronically Ill	
Permits states to provide home health care under Medicaid (via a provider or a health team designated by the beneficiary that provides health home services) for individuals with chronic conditions. Requires community health teams to support primary care practices that serve as patient-centered medical homes for Medicaid patients with chronic conditions.	Effective January 1, 2011

Planning grants totaling $25 million will be available.	
Access to Preventive Services	
States must provide, with no cost-sharing: • Coverage for all U.S. Preventive Services Task Force (USPSTF) services graded A or B • Certain vaccines to Medicaid adults Increases state matching rate by 1% for prevention services provided to eligible Medicaid adults.	Effective January 1, 2013
Foster Care Children	
Requires individuals below the age of 26 who were formerly in foster care under the responsibility of the state when they reached the age of 18 to be eligible for Medicaid. • They are entitled to full Medicaid benefits and are not limited to benchmark or benchmark-equivalent coverage. • Creates a state option to provide presumptive eligibility for this population.	Effective January 1, 2014
Medicaid Benefit Changes	
Expansion population required to receive benchmark-equivalent benefit packages under Social Security Act § 1937, modified as follows: • Benchmark benefit requirements are modified, requiring such packages to be at least the essential health benefits offered through exchanges. • Modified upon enactment to include coverage of prescription drugs and mental health services, family planning services and parity with mental health services ***if*** offered by an entity that is not a Medicaid managed care organization (MCO) and such entity provides both medical and surgical benefits and mental health and substance use disorder benefits. • Note the Mental Health Parity and Equality Act requirements already apply to Medicaid only insofar as a state's Medicaid agency contracts with one or more MCOs or Prepaid Inpatient Health Plans (PIHPs), to provide medical or surgical benefits as well as mental health or substance use disorder benefits.	Effective January 1, 2014

Medicaid and Children's Health Insurance Program (CHIP) – Other Provisions

CHIP Extension

Reauthorizes the Children's Health Insurance Program (CHIP) through September 30, 2015, but then must be reauthorized.

Increases state funding via federal allotment as follows:

- $17.4 billion in fiscal year 2013
- $19.4 billion in fiscal year 2014
- $21.1 billion in fiscal year 2015 (fiscal year 2015 includes two semiannual allotments of $2.85 billion and a one-time allotment of $15.4 billion)

Increases state matching rates between October 1, 2015, and September 30, 2019, by 23 percentage points up to 100%, excluding children in families with incomes at or above 300% of the federal poverty level (FPL).

Requires states to maintain CHIP eligibility through September 30, 2019.

In fiscal year 2010, the enhanced federal matching rate is provided (instead of the regular federal match) to any state that has an approved state plan amendment effective January 1, 2006, to provide child health assistance through Medicaid for children up to age 5 whose family income does not exceed 200% FPL.

Makes other technical changes related to the Children's Health Insurance Program Reauthorization Act (CHIPRA) enrollment and citizenship verification process, altering funds available for state performance payments by removing certain unexpended grants for coverage of childless adults from the available bonus pool, and other minor technical changes.

Effective March 23, 2010

Must be reauthorized on or before October 1, 2015.

Home and Community-Based Services (HCBS)

States are given the option to provide more types of HCBS to individuals (whose income is equal to or less than 300% of the Supplemental Security Income (SSI) benefit rate) with higher levels of need through a state plan amendment, rather than through a waiver.

States may also extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.

The state no longer has the authority to:

- Limit the number of individuals who are eligible for HCBS
- Establish a waiting list for receipt of such services
- Waive the state-wideness requirement with regard to HCBS

States are required to apply spousal impoverishment rules to beneficiaries who receive HCBS the period January 1, 2014, through December 31, 2018.

Effective March 23, 2010

Medicaid Prescription Drug Rebates

Rebates paid by drug manufacturers to state Medicaid programs are increased. Total rebate liability is limited to 100% of the average manufacturer price.	Effective March 23, 2010

Medicaid Maintenance of Effort Requirements

Maintenance of effort requirement precludes a state from lowering Medicaid eligibility levels for: • Individuals under age 19 (or any higher limit the state has set) until October 1, 2019 • Adults until HHS has determined a state exchange is fully operational Exempts states over the period January 1, 2011. through December 31, 2013, if the state has or is projected to have budget deficits during that period, allowing such states to alter eligibility for non-pregnant, non-disabled adults whose income exceeds 133% of the federal poverty level.	Effective March 23, 2010

Outreach and Assistance Funding

Provides funds for: • State health insurance programs: – $7.5 million for fiscal year 2009 – $15 million for fiscal years 2010 through 2012 • Area Agencies on Aging: – $7.5 million for fiscal year 2009 – $15 million for fiscal years 2010 through 2012 • Aging and Disability resource centers: – $5 million for fiscal year 2009 – $10 million for fiscal years 2010 through 2012 • The National Center for Benefits and Outreach and Enrollment: – $5 million for fiscal year 2009 – $5 million for fiscal years 2010 through 2012	Effective March 23, 2010

Provisions Related to Native Americans

Prohibits cost-sharing for Native Americans with income at or below 300% of FPL who are enrolled in coverage through an exchange. Establishes that health programs operated by the Indian Health Service, Native American tribes, tribal organizations, and Urban Indian organizations shall be the payer of last resort for services, notwithstanding other provisions to the contrary. Facilitates enrollment of Native Americans under the Medicaid Express Lane enrollment option.	Effective March 23, 2010

Early Medicaid Expansion Option

States have a new option to provide Medicaid coverage to the expansion population through December 31, 2013, and can phase in coverage by making lower income individuals eligible first. States that provide presumptive eligibility to pregnant women or children may also do so for individuals meeting expansion eligibility requirements. The presumptive eligibility period is not to exceed two months. Individuals newly eligible between April 1, 2010, and January 1, 2014 (for states that elect the option to expand early), who are parents of children under the age 19 (or such higher age a state may have elected) must not be enrolled in Medicaid unless the child is enrolled in Medicaid or other coverage.	Effective April 1, 2010

Community-Based Collaborative Care Networks

HHS provides grants (through the Health Resources and Services Administration (HRSA)) to consortia of providers with a joint governance structure that provide comprehensive and integrated health care services for low-income populations. Grantees may: • Help low-income individuals access services and health coverage programs • Help low-income individuals obtain a regular primary care provider • Provide case and care management • Perform health outreach and provide transportation Funding to be provided as needed for fiscal years 2011 through 2015.	Effective fiscal year 2011 (October 1, 2010)

State-Specific Provisions

U.S. Territories: Medicaid payments will be increased 30%, Federal Medical Assistance Percentage will be increased 5%, and effective January 1, 2014, payments made to territories to reimburse medical assistance expenses to newly eligible individuals will not count against the spending caps. **Louisiana:** Prevents reductions in federal matching rate. **Tennessee:** Allots $100 million in disproportionate share hospital (DSH) funds over fiscal year 2012 and fiscal year 2013.	Effective January 1, 2011, except as otherwise noted

Hawaii: Provides a DSH allotment to Hawaii for the second, third, and fourth quarters of 2012 of $7.5 million. Specifies that Hawaii will be treated as a low DSH state for purposes of calculating the annual DSH allotment for fiscal year 2013 and succeeding years.

Nebraska, expansion states, and disaster recovery states: Increased Federal Medical Assistance Percentage (based on detailed rules).

Community First Choice Option

The Community First Choice Option gives state Medicaid programs the option to provide home and community-based support services to individuals:

- Whose incomes do not exceed 150% of the federal poverty level (FPL) (or with higher incomes if the individual requires a nursing home level of care)
- Who otherwise require the level of care offered in a hospital, nursing care facility, etc.

Increases state federal matching rate by 6% for services provided under such option.

Effective October 1, 2011

Reduced Medicaid DSH Allotments

Once the rate of uninsureds in a state decreases by 45%, Medicaid disproportionate share hospital (DSH) payments will be reduced by 50% (low DSH states' allotments are reduced by 25%). Thereafter, allotments will be reduced by an amount corresponding to further declines in the uninsured rates.

Establishes a payment methodology whereby the largest DSH reductions would be imposed on the states with the largest reduction in the number of uninsured individuals.

Directs the Secretary of HHS to develop a methodology for reducing federal DHS allotments to all states in order to achieve the mandated reductions.

Caps the aggregate reductions for fiscal years 2014 through 2020 (annual amounts vary between $0.5 billion and $5.6 billion).

Reductions begin in fiscal year 2014 (October 1, 2013)

Medicaid Expansion

Requires states to provide Medicaid benefits to “newly eligible individuals” with modified gross household incomes at or below 133% of the federal poverty level (FPL) ($29,327 for a family of four in 2010; $34,381 in 2014; $32,252.50 in 2015) who are:

- Over age 19 and under age 65
- Not pregnant
- Not eligible for Medicaid under any other category
- Not eligible for or enrolled for Medicare benefits

Effective January 1, 2014

These “newly eligible individuals” must **not**, as of December 1, 2009:

- Have been eligible for Medicaid under any other category covered by the state plan or Medicaid waiver program on March 23, 2010
- Have been eligible for benchmark or benchmark equivalent benefits under SSA Sec.1937(b)
- Have been eligible for benchmark-equivalent benefits but were not enrolled, or were on a waiting list for, a program with capped or limited enrollment that was full

Medicaid benefits for "newly eligible individuals" will be benchmark or benchmark-equivalent coverage, rather than full Medicaid benefits.

Individuals newly eligible as of January 1, 2014 who are parents of children under the age 19 (or such higher age a state may have elected) may not be enrolled in Medicaid unless the child is enrolled in Medicaid or other coverage.

States that provide presumptive eligibility to pregnant women or children may also do so for individuals meeting expansion eligibility requirements The presumptive eligibility period is not to exceed two months.

States also have a new option to expand Medicaid to non-elderly *above* 133% FPL (no upper income limits are specified).

On August 15, 2011, HHS released proposed rules addressing the Medicaid eligibility increase and the proposed enrollment system.

On June 28, 2012, the U.S. Supreme Court ruled that Congress did not have the authority to withhold all Medicaid payments to states if they fail to comply with the expanded eligibility requirements of the ACA. It is currently unclear how many states will choose not to expand Medicaid eligibility.

Medicaid Expansion Funding

Effective January 1, 2014

Additional federal funding is provided to states for the newly eligible population.

- States that already expanded ("expansion states") also receive enhanced federal funding for individuals who are not newly eligible but otherwise fit the definition of the expansion population.
- In later years, generally no state would receive less than 93% in 2019 and 90% in 2020 and beyond.

“Expansion states” are states that before March 23, 2010, offered statewide coverage to parents and non-pregnant, childless adults up to 100% of the federal poverty level (FPL) that is not:

- Dependent on access to employer coverage or employment
- Limited to premium assistance, hospital-only benefits, a high-deductible health plan purchased through an HSA or a health opportunity account demonstration program.

A state which offers coverage to only parents or non-pregnant childless adults will not be considered an expansion state.

Specific matching rates for the newly eligible population are as follows for all states **except** expansion states:

- From January 1, 2014, through December 31, 2016, states receive 100% federal funding
- In 2017, the federal government pays 95% of the cost

- In 2018, the federal government pays 94%
- In 2019, the federal government pays 93%
- In 2020 and beyond, the federal government pays 90%

For expansion states:

- Federal match increases by 2.2 percentage points in calendar year 2014 for all populations:
  - Who are not newly eligible in any state that is an "expansion state," and
  - HHS determines will not receive any additional federal payments for newly eligible individuals, and
  - Have not been approved by HHS to divert a portion of disproportionate share hospital (DSH) allotments to the cost of providing Medicaid coverage under a waiver that is in effect on July, 2009
- In addition, the matching rates for expansion states for non-pregnant childless adults are increased by an amount that consists of a transition percentage of the amount by which the federal matching rate for the state is less than the matching rate provided for newly eligible individuals. The transition percentages are:
  - 50% for 2014
  - 60% for 2015
  - 70% for 2016
  - 80% for 2017
  - 90% for 2018
  - 100% for 2019 and thereafter
- For example, in 2017, a state that has a 50% Federal Medical Assistance Percentage (FMAP) would get an additional 80% of the difference between 95% and 50%, (0.8 x 45 = 36) for a total matching rate of 86% (state share 14%).

See the Final Rule – Increased FMAP Changes under the ACA

Medicaid / CHIP and Exchanges – Enrollment Simplification and Coordination

States are required to develop an Internet site and procedures for individuals to enroll through the Internet in Medicaid or CHIP. The website must:

- Allow individuals to enroll or reenroll in Medicaid with an electronic signature.
- Must also allow for enrollment in Medicaid or CHIP without any further determination by a state if an exchange identifies the individual as eligible for Medicaid or CHIP.
- Be linked to any website of an exchange established by the state and allow an individual to compare the Medicaid and CHIP benefits, premiums and cost-sharing with those of an exchange plan.

Effective January 1, 2014

States are required to ensure individuals determined ineligible for Medicaid or CHIP are screened for eligibility in an exchange plan and subsidies.

- States must also coordinate coverage for individuals enrolled in Medicaid or CHIP and an exchange plan.
- States can use Medicaid and CHIP agencies to determine exchange subsidy eligibility if such agencies enter into an agreement with an exchange and the agreement complies with Treasury's conditions for reducing administrative costs.

Exchanges are required to inform individuals of eligibility requirements for Medicaid and CHIP. If an exchange determines that such individuals are eligible for any such program, exchanges are required to enroll such individuals in such program.

HHS is required to develop a single form that will allow individuals to apply for enrollment in Medicaid, CHIP, or exchange subsidies and receive a determination of eligibility.

Effective October 1, 2015, states can enroll CHIP-eligible children in exchange plans.

- States must certify with HHS that such coverage is comparable in benefit and cost-sharing levels to CHIP coverage in the state.
- CHIP-eligible children who cannot enroll in CHIP because of federal allotment caps are deemed ineligible for CHIP and eligible for federal tax credits in exchanges.

Final rules for Medicaid and CHIP essential health benefits were issued July 15, 2013.

Medicaid / CHIP Premium Assistance

Requires states to offer premium assistance and Medicaid wrap-around benefits (as a voluntary alternative to traditional Medicaid) to Medicaid beneficiaries (including children) who are offered employer-sponsored coverage, if cost-effective to do so, under terms outlined already in current law.

Repeals the Children's Health Insurance Program Reauthorization Act (CHIPRA) provision deeming qualified employer coverage as meeting the cost-effectiveness requirement. Premium assistance must now meet the cost-effectiveness standards in all instances.

Precludes states from requiring individuals to apply for employer coverage as a condition of Medicaid eligibility.

Effective January 1, 2014

(The cost-effectiveness requirement is retroactive to February 4, 2009)

Medicaid / CHIP Income Determinations

Requires states to use modified adjusted gross income (MAGI) and household income (if applicable) to determine eligibility for CHIP and Medicaid non-elderly individuals.

- Generally removes state ability to disregard income and expenses, and removes asset and resource tests, except that in determining eligibility using MAGI, states are to disregard income equal to 5% of the upper income limit that applies to the individual.

Effective January 1, 2014

- The definition of MAGI is the same as the income measure used to determine eligibility for exchange subsidies. MAGI is adjusted gross income increased by any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax and foreign earned income excluded from gross income.
- HHS must ensure that the changes will not result in children who would have been eligible no longer being eligible.

Exceptions to the new income determination rules:

- Any individual enrolled in Medicaid on January 1, 2014, who would have been ineligible under the new rules will remain eligible until the later of March 31, 2014, or his or her next Medicaid eligibility re-determination date.
- Five distinct categories of possible beneficiaries are exempted from the new income determination rules:
  - Individuals who are eligible for Medicaid through another federal or state assistance program (e.g., foster care children and individuals receiving SSI)
  - The elderly
  - Certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled, without regard to whether the individual is eligible for SSI
  - The medically needy
  - Enrollees in a Medicare Savings Program (e.g. Qualified Medicare Beneficiaries for whom Medicaid pays the Medicare premiums or coinsurance and deductibles)

Children no longer eligible for Medicaid as a result of the elimination of disregards are eligible for CHIP.

Health Care Delivery Provisions

Community Health Centers

Qualified Community Health Centers are funded the following levels: • $3.0 billion for fiscal year 2010 • $3.9 billion for fiscal year 2011 • $5.0 billion for fiscal year 2012 • $6.4 billion for fiscal year 2013 • $7.3 billion for fiscal year 2014 • $8.3 billion for fiscal year 2015 • Funding increased by formula for fiscal year 2016 and later	Effective for fiscal year 2010

School-Based Health Center Grants

School campus-based primary health centers will receive $50 million per year in grants for fiscal years 2010 through 2013. Grant recipients must provide a 20% match (either in cash or kind) from non-federal sources (subject to waiver for hardship via HHS). Grant monies are to be used for: • Acquiring and leasing equipment • Providing health services training • Management and operations of health center programs • Salaries Funds may **not** be used for abortions, and any services provided to minors requires parental consent.	Effective March 23, 2010

Emergency Medical Services For Children

Additional funding of $138 million is provided for the Emergency Medical Services Program For Children for fiscal years 2010 through 2014.	Effective March 23, 2010

Programs For Medically Underserved

HHS is required to create a grant program to fund programs focused on underserved communities: • Recruitment and training programs • Preventive medicine and public health training programs • Health care providers who treat a high percentage of medically underserved or other special populations	Effective March 23, 2010

Integrated Primary and Specialty Care Grants

To benefit adults with mental illnesses who have other medical needs, grants and co-operative agreements will be provided to entities who co-locate primary and specialty care services in community-based behavioral health settings. The appropriation for fiscal year 2010 was $50 million.	Effective March 23, 2010

Extending Payment Protections for Rural Hospitals

Extends Medicare payment protections for small rural hospitals, including: • Hospital outpatient services • Lab services • Facilities that have a low volume of Medicare patients but play an important role in their communities • Medicare-dependent hospitals' inpatient operating costs • Low-volume hospitals' inpatient costs • Critical-access hospitals' outpatient services and ambulance services	Effective March 23, 2010

Payments to Federally Qualified Health Centers

Requires payments by Qualified Health Benefits Plans to Federally Qualified Health Centers (FQHCs) to be at least as high as payments to FQHCs under Medicare or Medicaid.	Effective January 1, 2014

Health Care Workforce Provisions

Tax Relief for Health Professionals

Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.	Applies to amounts received on or after January 1, 2009

Medical Provider Loan Programs

The federal student loan program for primary care is modified to: • Limit the service obligation to a maximum of 10 years (including residency) • Lower the penalty for non-compliance with loan repayment • Lift the requirement for parental financial information for independent students Creates a pediatric specialty loan repayment program to increase the supply of pediatric providers. Establishes a Public Health Workforce Loan Repayment Program and recruitment and retention programs for allied health professionals to ensure an adequate supply of public health professionals to eliminate critical shortages in federal, state, local, and tribal public health agencies. Expands the existing loan repayment and scholarship programs for nursing students. • Amends loan agreements under the Nursing Student Loan Program. • Provides for repayment of education loans to increase the number of qualified nursing faculty. Provides funding to reauthorize loan repayments and fellowships for faculty positions and to reauthorize educational assistance in the health professions for individuals from disadvantaged backgrounds. Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.	Effective March 23, 2010

Health Care Workforce Programs

Expands and improves low interest student loan programs, scholarships, and loan repayments for health students (including nurses) and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.	Effective March 23, 2010

National Health Care Workforce Commission

Establishes an independent National Commission to provide comprehensive, non-biased information and recommendations to Congress and the President for aligning federal health care workforce resources with national needs.	Effective March 23, 2010

National Health Service Corps

Expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas. Improves the National Health Service Corps program by increasing loan prepayment amounts, allowing for half-time service and allowing for teaching to count for up to 20% of the corps service commitment. Authorizes funding of: • $320 million in fiscal year 2010 • $414 million in fiscal year 2011 • $535 million in fiscal year 2012 • $692 million in fiscal year 2013 • $893 million in fiscal year 2014 • $1,155 million fiscal year 2015 • Funding increases by formula for fiscal year 2016 and later	Effective March 23, 2010

United States Public Health Sciences Track

The United States Public Health Sciences Track provides advanced degrees to physicians and other medical and public health professionals. Students receive scholarship funds in exchange for committing to work in underserved communities; a two-year commitment for each year of school covered. The scholarship is for a maximum of four years with training taking place at institutions located in areas of health professional shortage. The work commitment can be reduced by 25% if the student participates in a high-needs specialty or practices in a federal medical facility located in a health professional shortage area.	Effective March 23, 2010

Healthcare Workforce Grant Programs

Grants programs are established for: • State and local mid-career public health official training: Funded at $30 million per year for fiscal years 2011 through 2015	Effective for fiscal years as noted

- State and local mid-career allied health official training: Funded at $30 million per year for fiscal years 2011 through 2015
- Nurse-Managed Health Clinics: Funded at $50 million for fiscal year 2010 and amounts as needed for fiscal years 2011 through 2014
- Alternative Dental Providers Demonstration Project Grants: 15 projects funded at a minimum of $4 million each for the period 2011 through 2015
- Nurse Education, Practice and Retention Grants: Funded at $338 million for fiscal year 2010 and amounts as needed for fiscal years 2011 through 2016
- Community Health Workforce Grants: Funded by amounts as needed for fiscal years 2010 through 2014
- Family Nurse Practitioner Training Program Demonstration Grants: Funded at $1.8 million for each three-year program (fiscal years 2011 through 2014)
- Programs of Excellence for Minorities: Funded at $50 million each year for fiscal years 2010 through 2015
- Area Health Education Center Grants: Funded at $125 million each year for fiscal years 2010 through 2014
- Workforce Diversity Nursing Grants: Funded as needed
- Primary Care Extension Program Grants: Funded at $120 million each year for fiscal years 2011 through 2014
- Expanded Primary Care Residency Grants: Funded at $125 million for fiscal years 2010 through 2012 and amounts as needed thereafter
- Graduate Nurse Education Demonstration Grants: Funded at $200 million for fiscal years 2012 through 2015

Education and Training Programs

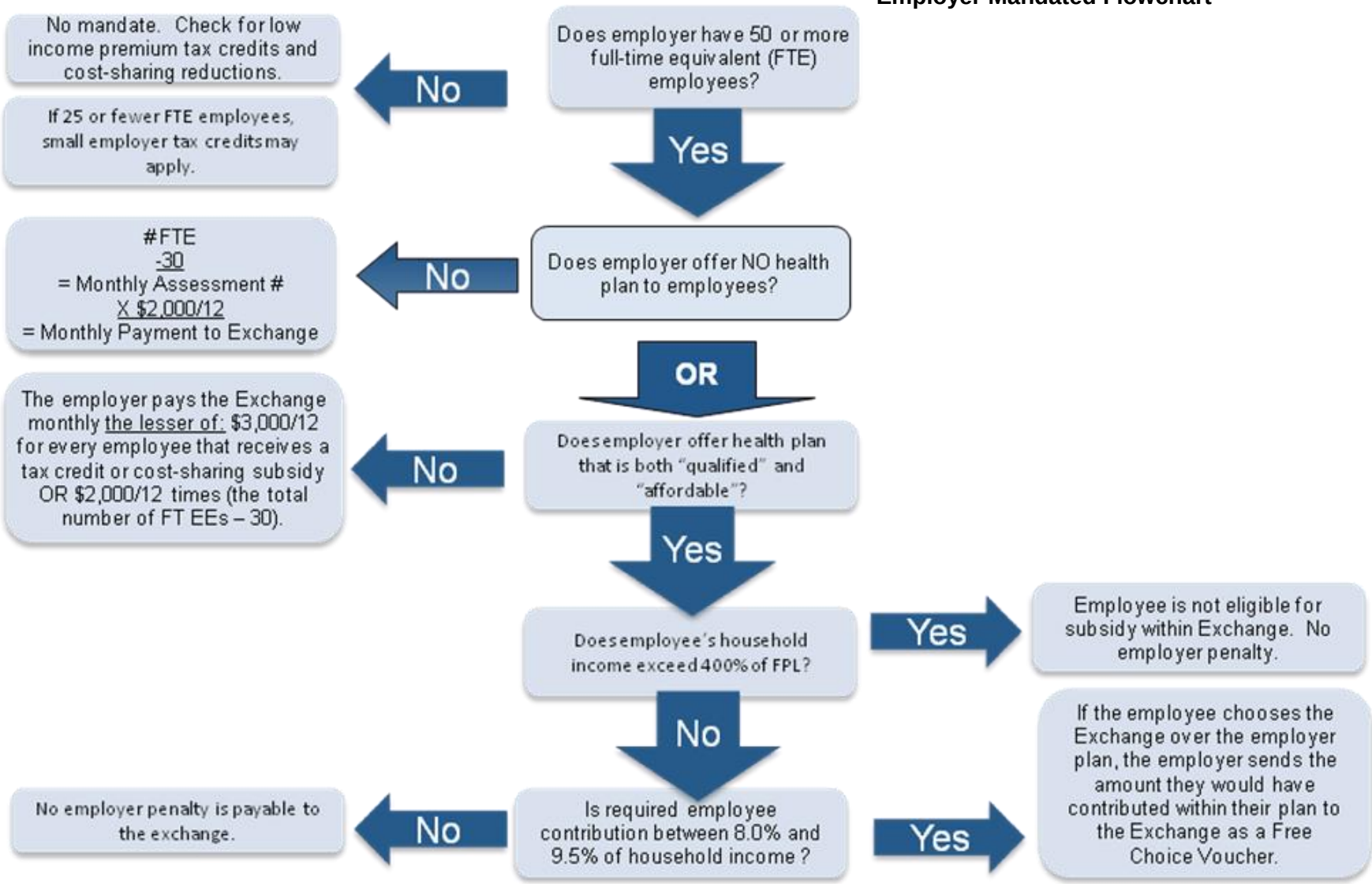
Education and training programs are established for:

Effective for fiscal years as noted

- Primary Care Training (including physician assistants): Funded at $125 million for fiscal years 2010 and amounts as needed for fiscal years 2011 through 2014
- Long-term Care Direct Worker Training: Funded at $10 million total for fiscal years 2011 through 2013
- Oral Health Professionals Training: Funded at $30 million for fiscal year 2010 and amounts as needed for fiscal years 2011 through 2015
- Geriatric Education and Training Centers: Funded at $21 million for fiscal years 2010 through 2014
- Mental and Behavioral Health Training and Education: Funded at $35 million for fiscal years 2010 through 2013
- State and Local Fellowship Training in Public Health: Funded at $39.5 million each year for fiscal years 2010 through 2013

Appendix 1 – Employer Mandate Flow Chart

Employer Mandated Flowchart



Appendix 2 – ACA Cost Analysis: Employee Information Needed

Number of full-time employees

Number of full-time equivalent employees

Number of seasonal workers

Number of full-time equivalent employees working less than 120 days in preceding year

Number of employees in a waiting period of 90 days or less

Number of employees receiving Premium Assistance Tax Credit

Number of employees whose plan contribution exceeds 9.5% (9.56% in 2015, 9.66% in 2016) of household income

Number of employees in classes ineligible for Employer Tax Credit

Number of employees in classes exempted from individual mandate

Average annual wages

Each employee's household income

Aggregate value of benefits (single / family)

Does health plan have a minimum actuarial value of 60%?

Number of employees whose household income is less than 400% of federal poverty level (FPL) ($45,960 for one person, $94,200 for a family of four in 2013)

Number of above employees whose plan contribution is between 8.0% and 9.8% of household income (number single and number family)

Number of employees whose household income is between 100% of FPL ($11,670 for one person, $23,850 for a family of four in 2014) and 400% of FPL ($46,680 for one person, $95,400 for a family of four in 2013)

Number of above employees whose plan contribution exceeds 9.5% (9.56% in 2015, 9.66% in 2016) of household income

Appendix 3 – Small Business Tax Credit Tables

Small Business Tax Credit as a percent (maximum of 35%) of employer contribution to premiums – For-profit firms in 2010-2013 and non-profit firms in 2014+

	Average Wage					
Firm size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Small-Business Tax Credit as a percent (maximum of 50%) of employer contribution to premiums – For-profit firms in 2014+

	Average Wage					
Firm size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Up to 10	50%	40%	30%	20%	10%	0%
11	47%	37%	27%	17%	7%	0%
12	43%	33%	23%	13%	3%	0%
13	40%	30%	20%	10%	0%	0%
14	37%	27%	17%	7%	0%	0%
15	33%	23%	13%	3%	0%	0%
16	30%	20%	10%	0%	0%	0%
17	27%	17%	7%	0%	0%	0%
18	23%	13%	3%	0%	0%	0%
19	20%	10%	0%	0%	0%	0%
20	17%	7%	0%	0%	0%	0%
21	13%	3%	0%	0%	0%	0%
22	10%	0%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Small-Business Tax Credit as a percent (maximum of 25%) of employer contribution to premiums – Non-profit firms in 2010-2013

	Average Wage					
Firm size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Up to 10	25%	20%	15%	10%	5%	0%
11	23%	18%	13%	8%	3%	0%
12	22%	17%	12%	7%	2%	0%
13	20%	15%	10%	5%	0%	0%
14	18%	13%	8%	3%	0%	0%
15	17%	12%	7%	2%	0%	0%
16	15%	10%	5%	0%	0%	0%
17	13%	8%	3%	0%	0%	0%
18	12%	7%	2%	0%	0%	0%
19	10%	5%	0%	0%	0%	0%
20	8%	3%	0%	0%	0%	0%
21	7%	2%	0%	0%	0%	0%
22	5%	0%	0%	0%	0%	0%
23	3%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: Congressional Research Service “Summary of Small Business Health Insurance Tax Credit Under PPACA” (P.L. 111-148), April 5, 2010.

Appendix 4 – Small Group Market Average Premiums by State

2012 Tax Year

State	Employee Only	Family
Alabama	$5,084	$12,727
Alaska	7,321	15,774
Arkansas	4,864	11,864
Arizona	4,460	10,244
California	4,999	12,161
Colorado	5,308	13,014
Connecticut	5,955	15,273
Delaware	6,272	14,354
District of Columbia	6,017	15,140
Florida	5,462	13,013
Georgia	5,481	12,206
Hawaii	4,938	12,270
Idaho	4,690	10,427
Illinois	5,760	14,125
Indiana	5,414	12,386
Iowa	4,818	11,531
Kansas	4,959	12,163
Kentucky	4,660	11,387
Louisiana	5,300	12,446
Maine	5,413	12,837
Maryland	5,289	13,188
Massachusetts	6,110	16,269
Michigan	5,334	12,936
Minnesota	5,360	13,589
Mississippi	4,997	11,667
Missouri	5,089	11,975

State	Employee Only	Family
Montana	$5,148	$11,197
Nebraska	5,325	12,511
Nevada	5,028	11,793
New Hampshire	6,030	15,026
New Jersey	6,063	14,470
New Mexico	5,527	12,909
New York	5,849	14,688
North Carolina	5,352	12,251
North Dakota	4,806	11,939
Ohio	4,987	12,143
Oklahoma	5,042	11,836
Oregon	5,130	12,197
Pennsylvania	5,400	13,357
Rhode Island	6,151	14,959
South Carolina	5,244	12,243
South Dakota	5,037	12,136
Tennessee	5,113	11,520
Texas	5,222	12,803
Utah	4,744	12,072
Vermont	5,678	13,099
Virginia	5,263	12,884
Washington	4,904	11,703
West Virginia	5,679	13,112
Wisconsin	5,575	14,387
Wyoming	5,657	13,688

Source: IRS Form 8941

2010 Tax Year

State	Employee Only	Family
Alabama	$ 4,441	$ 11,275
Alaska	6,204	13,723
Arkansas	4,329	9,677
Arizona	4,495	10,239
California	4,628	10,957
Colorado	4,972	11,437
Connecticut	5,419	13,484
Delaware	5,602	12,513
District of Columbia	5,355	12,823
Florida	5,161	12,453
Georgia	4,612	10,598
Hawaii	4,228	10,508
Idaho	4,215	9,365
Illinois	5,198	12,309
Indiana	4,775	11,222
Iowa	4,652	10,503
Kansas	4,603	11,462
Kentucky	4,287	10,434
Louisiana	4,829	11,074
Maine	5,215	11,887
Maryland	4,837	11,939
Massachusetts	5,700	14,138
Michigan	5,098	12,364
Minnesota	4,704	11,938
Mississippi	4,533	10,501
Missouri	4,663	10,681

State	Employee Only	Family
Montana	$ 4,772	$ 10,212
North Carolina	4,920	11,583
North Dakota	4,469	10,506
Nebraska	4,715	11,169
New Hampshire	5,519	13,624
New Jersey	5,607	13,521
New Mexico	4,754	11,404
New York	5,442	12,867
Nevada	4,553	10,297
Ohio	4,667	11,293
Oklahoma	4,838	11,002
Oregon	4,681	10,890
Pennsylvania	5,039	12,471
Rhode Island	5,887	13,786
South Carolina	4,899	11,780
South Dakota	4,497	11,483
Tennessee	4,611	10,369
Texas	5,140	11,972
Utah	4,238	10,935
Vermont	5,244	11,748
Virginia	4,890	11,338
Washington	4,543	10,725
West Virginia	4,986	11,611
Wisconsin	5,222	12,819
Wyoming	5,266	12,163

Source: Department of Health and Human Services

Appendix 5 – Small Business Tax Credit Amount Reduction Tables

Credit Amount Reduction for Employers with More Than 10 Full-Time Equivalent Employees

Number of FTE Employees	Credit Amount Reduction
1 - 10	0.000%
11	6.667%
12	13.334%
13	20.000%
14	26.668%
15	33.335%
16	40.002%
17	46.669%
18	53.336%
19	60.003%
20	66.670%
21	73.337%
22	80.004%
23	86.671%
24	93.338%
25 or more	100.000%

Credit Amount Reduction for Employers With Average Annual FT Employee Compensation > $25,000

Average Annual Compensation *	Credit Amount Reduction
$25,000 or less	0%
$26,000	4%
$27,000	8%
$28,000	12%
$29,000	16%
$30,000	20%
$31,000	24%
$32,000	28%
$33,000	32%
$34,000	36%
$35,000	40%
$36,000	44%
$37,000	48%
$38,000	52%
$39,000	56%
$40,000	60%
$41,000	64%
$42,000	68%
$43,000	72%
$44,000	76%
$45,000	80%
$46,000	84%
$47,000	88%
$48,000	92%
$49,000	96%
$50,000 or more	100%

* If an employer's average annual wages are not a multiple of $1,000, average annual wages are rounded down to the next lowest multiple of $1,000.

Appendix 6 – Out-of-Network Emergency Services Payment Methodology

A plan or issuer satisfies the copayment and coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of three possible amounts:

- The amount negotiated with in-network providers for the emergency service furnished
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions
- The amount that would be paid under Medicare for the emergency service

Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

For plans and health insurance coverage under which there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the first amount above is disregarded, meaning that the greatest amount is going to be either the out-of-network amount or the Medicare amount.

Additionally, with respect to determining the first amount, if a plan or issuer has more than one negotiated amount with in-network providers for a particular emergency service, the amount is the median of these amounts, treating the amount negotiated with each provider as a separate amount in determining the median.

- For example, if for a given emergency service a plan negotiated a rate of $100 with three providers, a rate of $125 with one provider, and a rate of $150 with one provider; the amounts taken into account to determine the median would be $100, $100, $100, $125, and $150; and the median would be $100.
- Following the commonly accepted definition of median, if there is an even number of amounts, the median is the average of the middle two.
- Cost sharing imposed with respect to the participant, beneficiary, or enrollee would be deducted from this amount before determining the greatest of the three amounts above.

The second amount above is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services.

- For example, if a plan generally pays 70% of the usual, customary, and reasonable amount for out-of-network services, the second amount above for an emergency service is the total (that is, 100%) of the usual, customary, and reasonable amount for the service,
  - not reduced by the 30% coinsurance that would generally apply to out-of-network services
  - but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network.

The DOL issued its 31st FAQ on the implementation of the ACA, and included provisions on the “reasonable” amount.

Non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage cannot impose cost sharing on out-of-network emergency services in a greater amount than what is imposed for in-network emergency services. Balance billing is not included in the statutory definition of cost sharing, which is the practice of providers billing patients for the difference between the provider's billed charges and the amount collected from the plan or issuer, plus the amount collected from the patient in the form of a copayment or coinsurance amount. Agencies have determined that a reasonable amount be paid by a plan or issuer before a patient becomes responsible for a balance billing amount.

A plan or issuer satisfies the out-of-network emergency care copayment or coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount at least equal to the greatest of the following three amounts (adjusted for in-network cost sharing):

- The median amount negotiated with in-network providers for the emergency service.
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount).
- The amount that would be paid under Medicare for the emergency service (collectively, minimum payment standards).

The latest FAQ states that plans or issuers must disclose how they calculate these minimum payment standards and the "usual, customary, and reasonable amount." Documentation of this must be included in plan documents, and provided to participants within 30 days of request.

Appendix 7 – Model Notice: Designation of a Primary Care Physician

The following model language can be used to satisfy the notice requirement.

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

> For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

> You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Appendix 8 – Section 105(h) Nondiscrimination Rules

New Nondiscrimination Requirements for Fully Insured Group Health Plans under the ACA (these have been delayed indefinitely)

The Patient Protection and Affordable Care Act (ACA) extends the nondiscrimination requirements of Section 105(h) of the Internal Revenue Code of 1986 (the "Code"), to most insured group health plans (including HRAs and Mini-Med plans). These rules, which previously applied only to self-funded group health plans, prohibit employers from discriminating in favor of highly compensated individuals relative to rank-and-file employees with respect to eligibility to participate in, and benefits provided under, a group health plan.

The new nondiscrimination requirements are effective for plan years beginning on or after September 23, 2010. However, Section 1251 of the ACA exempts "grandfathered health plans" from the new nondiscrimination rule for as long as the plan maintains grandfathered status. **Note: the effective date has been postponed subject to issuance of future guidance.**

Background on Section 105(h), Current Status and Future Guidance

Section 105 defines the conditions under which benefits may be received tax-free. Therefore, if premiums are paid with after-tax dollars, the benefits are automatically received tax-free and are not subject to Section 105 regulations.

The ACA does not literally extend Section 105(h) of the Code to fully insured group health plans. It adds Section 2716 to the Public Health Services Act (PHSA), which provides that insured plans must satisfy the substantive requirements of Sections 105(h) (2), (3), (4), (5) and (8). For the most part, however, it would appear that the rules applicable under PHSA section will track the Section 105(h) rules previously applied to self-funded plans.

Even though Section 105(h) was added to the Internal Revenue Code in 1978, there is very little interpretive authority. The Treasury Department and IRS issued final regulations in 1981 as well as a handful of private letter rulings in the early 1980s. The IRS has not issued any precedential guidance interpreting Section 105(h) since 1989 and has listed Section 105(h) as a "no rule" area, which means that the IRS will not issue private letter rulings in the area. Moreover, the IRS has attempted to enforce Section 105(h) on only rare occasions.

The extension of Section 105(h) to fully insured plans as part of the ACA could ultimately cause the government to reconsider whether further guidance is required. Any guidance that is published will likely come jointly from the three agencies responsible for much of the other ACA guidance that has been released to date (Treasury, Labor, and HHS).

Scope

Because the new nondiscrimination rules were added as part of the PHSA, rather than directly to Section 105(h) of the Code, certain plans will be automatically exempted from its scope, even though those plans might have been subject to the Section 105(h) rules if the plans were self-insured.

Grandfathered Plans are Exempted
Perhaps the broadest exception to the new nondiscrimination applies to plans that constitute "grandfathered plans" within the meaning of ACA Section 1251 and related tri-agency regulations.

HIPAA-Excepted Benefits are Not Covered
Unlike Section 105(h), which applies broadly to all self-insured plans that reimburse medical expenses, the ACA version of Section 105(h) does **not** apply to HIPAA excepted benefits (see Appendix A, below), including limited scope dental or vision benefits. Similarly, long-term care benefits that qualify as excepted benefits are **not** subject to the new nondiscrimination requirements.

Treatment of Former Employees
Although not perfectly clear, it appears that the nondiscrimination rules may **not** be applicable to group health plans that provide benefits only to former employees. In this regard, notwithstanding the absence of an exemption in the PHSA, the relevant agencies have taken the position that the group market reforms in the PHSA, including Section 2716, do **not** apply to a group health plan that covers fewer than two participants who are employees. Note, however, given that Section 105(h) clearly applies to former employees, it seems somewhat anomalous that Section 2716 would be inapplicable to group health plans covering former employees.

Governmental Plans
For the same reason that PHSA Section 2716 appears to be inapplicable to plans governing former employees, it appears that the ACA's nondiscrimination rules (unlike Section 105(h)) will **not** be interpreted as applying to governmental plans. Whether this is in fact the case, however, is not entirely clear.

Self-Funded Plans
Stop loss insurance is generally not considered "health insurance coverage" unless regulated by the state as such.

Section 105(h) Nondiscrimination Tests

When applicable, Section 105(h) involves two separate and complex tests, **both of which must be passed** – somewhat mislabeled as an eligibility test (it's functionally a participation test) and a benefits test (functionally an availability test). Both tests depend on whether the plan disproportionately favors "highly compensated individuals" relative to other employees.

Highly Compensated Individuals Defined
For purposes of the Section 105(h) tests, highly compensated individuals are defined to include the all of following.

- The five highest paid officers during the current year
- A shareholder who owns more than 10% of the value of the employer's stock (after attribution of stock held by the spouse, etc.) at the time a benefit is provided during the year
- An individual who is among the highest paid 25% of all employees (other than excludable employees discussed below)

These requirements are not mutually exclusive. For example: If one of the five highest paid officers is not among the 25% of highest paid employees, that officer still needs to be included in the highly compensated individual category.

Whether an individual is an officer should be determined upon the basis of all the facts including, for example, the source of his or her authority, the term for which the employee is elected or appointed, and the nature and extent of his or her duties.

- The term "officer" implies continuity of service, exclusive of those employed for a special or single transaction.
- An employee who has the title of an officer but not the authority of an officer is not an officer for these testing purposes.
- Likewise, an employee who does not have the title of an officer but the authority of an officer is an officer for testing purposes.
- Typically the term "officer" would include the president, vice presidents, general manager, treasurer, secretary and comptroller of a corporation, and any other person who performs duties corresponding to those normally performed by persons occupying such positions.

In determining employees in the top 25% of pay, one interpretation is that only the current year's compensation should be used for Code Section 105(h) purposes. On the other hand, the legislative history to Code Section 105(h) indicates that a "look back" determination (as used in the definition of highly compensated individual (HCI) for other Code sections, such as Code Section 414(q)) is required.

Under Code Section 415(c)(3), compensation includes any amounts included as gross income on the participant's Form W-2, as well as the following amounts not included in gross income:

- Pre-tax salary reduction amounts under the Code Section 125 cafeteria plan. “Salary reduction amounts” mean not only the employee contributions that are withheld from pay, but also any cashable employer credits up to the amount of credits that can be cashed out. For example, assume an employer gives each employee $800 to spend on benefits. The employee may either use the amount to purchase benefits or may waive benefits and receive $400 in cash. The potential cash out amount, $400, should be treated as compensation whether received in cash or not.
- Pre-tax salary reduction amounts under the Code Section 132 transportation fringe benefit plan.
- Pre-tax salary reduction amounts under the employer’s 401(k) plan.

Note that this definition is much broader than the class that is taken into account under other nondiscrimination testing regimes, including the cafeteria plan rules and the tax-qualified plan rules. Any employee in the top quarter of the employee population will be considered a highly compensated individual. There is no minimum dollar threshold, such as the current $110,000 for highly compensated employee status under the cafeteria and retirement plan rules.

Excludable Employees
Certain employees are not taken into account in the denominator in performing the eligibility test, including:

- Employees who have not completed three years of service prior to the beginning of the plan year
- Part-time employees (less than 25 hours per week, or up to 35 hours where full-time employees doing similar work in the same industry and location work substantially more hours)
- Seasonal employees (less than seven months per year, or nine months per year where similar employees work substantially more months)
- Employees subject to a collective bargaining agreement (may be excluded whether eligible to participate or not)
- Employees who have not attained age 25 prior to the beginning of the plan year
- Non-resident aliens who receive no U.S. source income (Note: foreign nationals at a foreign location of a U.S. company who are not otherwise benefitting under the plan are not considered to be receiving U.S. source income.)

At times, the IRS has informally suggested that an otherwise excludable employee may not be excluded if the employer benefits some otherwise excludable employees. Thus, for example, if the employer provides group health plan coverage to some part-time employees but not all part-time employees, it is possible that all part-time employees must be taken into account in testing.

The Eligibility Test
A plan satisfies the eligibility test if it satisfies any one of the following three tests:

- The plan benefits at least 70% or more of all non-excludable employees (including those ineligible for the plan)
- Seventy percent of all non-excludable employees (including those ineligible for the plan) are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit
- Each classification of employees eligible for the plan is a nondiscriminatory class of employees (the “nondiscriminatory classification test”)

Although there is at least some ambiguity, the eligibility tests appear to apply based on who is actually benefitting under the plan, not on mere eligibility to participate. As a result, if a group health plan provides that employees must pay a portion of premiums, it appears that only employees who elect to pay their share of the premiums and, therefore, benefit under the program are taken into account in the numerator.

Thus, to the extent that an employer designs a group health plan that results in a substantial portion of its population opting out, the plan may have an eligibility problem. This may become an even greater issue if, for example, a substantial number of employees opt out to obtain coverage through a health insurance exchange or decide to obtain coverage from a spouse's employer.

Also, the eligibility test (but not the benefits test) depends on numeric testing of the employer's workforce. The data gathering aspect of the tests alone could represent a substantial new burden for some employers.

Moreover, the eligibility test applies on a controlled group basis. That is, all employers who share a common parent (generally based on 80% ownership) are treated as a single employer. There is no provision for separate testing of different entities, divisions, or lines of business. The controlled group rules will have a significant impact on the eligibility test results because employees of another employer in the same controlled group must be considered in your calculations even though they are not eligible for the plan being tested. (See Appendix B, below, for an overview of control group rules.)

The 70% test and the 70/80 test are both very difficult to pass, especially where the sponsor has more than one plan. This puts a great deal of emphasis on the nondiscriminatory classification test.

The nondiscriminatory classification test is by far the most flexible test. It is, however, also by far the most complicated to apply. The Section 105(h) regulations incorporate the nondiscriminatory classification test under Section 410(b) for tax-preferred retirement plans. There is also an argument that the old law test – referred to as the fair classification test – is applicable.

The nondiscriminatory classification test (410(b) test) requires that the eligibility class satisfy **both**:

- A subjective standard that the classification is reasonable and established under objective business criteria that identify the category of employees who benefit under the plan; for example:
  - Nature of compensation (salaried, hourly, etc.)
  - Full-time vs. part-time
  - Specified job categories
  - Geographic location
  - "Similar bona fide business criteria"
- An objective standard that it is a nondiscriminatory classification under a numeric "safe harbor" test that is based on "benefiting" a specified percentage of non-highly compensated individuals

There is much debate over the definition of "benefiting" for purposes of the nondiscriminatory classification test:

- One interpretation is that "benefiting" means "participating" in the plan. This is based on the two subtests that precede the nondiscriminatory classification test, both of which define benefiting to mean participating.
- On the other hand, this test is based on a similar pension discrimination test established in Code Section 410(b). Under Section 410, benefiting means merely eligible.

The following is a summary of how to conduct the safe harbor portion of the nondiscriminatory classification test:

- Determine the ***benefiting percentages*** for each group of employees. The eligibility percentage for each group is determined by dividing the number of employees in the group that are benefiting by the total number of employees in that group.
  - Highly compensated employees (HCIs) = HCIs benefiting ÷ Total non-excludable HCIs
  - Non-highly compensated employees (NHCIs) = NHCIs benefiting ÷ Total non-excludable NHCIs
- Determine the plan's "**ratio percentage**": NHCI benefiting percentage ÷ HCI benefiting percentage
- Determine the plan's "**non-highly compensated employee concentration percentage**" (non-excludable NHCIs) : Total non-excludable NHCIs ÷ Total non-excludable employees

- Once the plan's NHCI concentration percentage has been determined, the safe harbor and unsafe harbor percentage is identified using the **nondiscriminatory classification chart** (see Appendix C, below). The safe and unsafe harbor percentages correspond to the plan's NHCI concentration percentage.
  - If the plan's ratio percentage is equal to or greater than the safe harbor percentage, then the plan's employee classification is deemed non-discriminatory.
  - If the ratio percentage is less than the safe harbor percentage but more than the unsafe harbor percentage, then the plan may still pass if it passes the "facts and circumstances" test. Some "facts and circumstances" to be considered are:
    - The underlying business reasons for the classification. The greater the business reason, the more likely the eligibility classification is non-discriminatory.
    - The percentage of the employer's employees eligible for the plan. The higher the percentage, the more likely the classification is non-discriminatory.
    - Whether the number of employees benefiting under the plan in each salary range is representative of the number of employees in each salary range of the employer's workforce.
    - The difference between the plan's ratio percentage and the safe harbor percentage. The smaller the difference, the more likely the classification is non-discriminatory.

See Appendix C, below, for the Safe Harbor Table. See Appendix D, below, for an eligibility test case example.

The Benefits Test
In contrast to the eligibility test, the benefits test is on its face quite simple, albeit strict. The benefits test consists of two subsets – discrimination on the face of the plan, and discrimination in operations – both of which must be passed.

Conditions for passing the face of the plan subset:

- All benefits provided for participants who are highly compensated individuals must be provided for all other participants. In essence, all employees (both highly compensated and non-highly compensated) who participate in the plan must receive the same benefits **on the same terms and conditions**.
- The maximum benefit attributable to employer contributions must be uniform for all participants and may not be based on a participant's age, years of service, or compensation.

Plan discrimination in operation is a facts and circumstances determination. Examples of possible discrimination in operations:

- The duration of a particular benefit under the plan (prior to amendment or termination) coincides with the period during which an HCI utilizes the benefit.
- The plan administrator or insurer approves certain claims for medical expenses for HCIs while denying them for NHCIs.

The benefits test applies based on benefits subject to reimbursement, not to actual payments of claims. The benefits test, for example, precludes a lower deductible or co-pay for highly compensated individuals. It is not, however, affected by whether the actual utilization rate is higher for highly compensated individuals.

The regulations under Section 105(h) provide an exception from the nondiscrimination requirements for "medical diagnostic procedures." Thus, for example, an employer with a self-insured plan may provide executives with an annual physical exam and it would not be considered discriminatory. **Note**: **It is too early to know whether this exception will apply to insured plans.**

The following facts and circumstances are indicators that a plan may violate the benefits test:

- Management employees can elect a higher annual reimbursement amount.
- Employer credits are higher for management, salaried, or full-time employees.

- The annual reimbursement amount is higher for individuals who have more years of service (discounting any carryover amounts under an HRA to the extent that the employer contributions each year were the same for each similarly situated participant).
- One group of employees is not subject to a waiting period (or a short waiting period) while another group is subject to a waiting period (or a longer waiting period).

There is no option for actuarial equivalence in the regulations, making testing two arrangements under one "plan" nearly impossible.

Treasury regulations do, however, provide a special rule for a plan that provides optional benefits that potentially softens the strict general benefits test. Under the special rule, an optional benefit will not run afoul of the rule requiring that all non-highly compensated individuals get the same benefits as highly compensated individuals **if** all eligible participants may elect the benefit and the required employee contributions are the same amount.

This rule is very helpful for testing plans with multiple insured options. For example, a plan may offer an indemnity option and an HMO option under the same plan without running afoul of the nondiscrimination rules, provided that both options are universally available and the employee's share of the premium is the same for all employees.

In contrast to retirement plans which generally permit benefits to vary relative to the compensation earned by a participant, Treasury regulations interpreting Section 105(h) expressly provide that a plan discriminates if the benefits subject to reimbursement under the plan vary in proportion to compensation.

Interaction between the Eligibility Test and the Benefits Test
The line between the eligibility test and the benefits test may blur in certain circumstances. In a private letter ruling issued in the early 1980s, the IRS took the position that a plan which made certain highly compensated individuals immediately eligible for participation but imposed a 90-day waiting period for other employees ran afoul of the benefits test. That is, even though a waiting period is arguably an eligibility feature, the IRS tested it under the inflexible benefits test. As a result, the plan could not satisfy Section 105(h) even if it passed the numeric coverage requirements during the waiting period.

This notion that eligibility features may be tested under the stringent benefits test of Section 105(h) raises the specter that different employees may not be required to pay different shares of the premium obligation. It suggests, for example, that an employer may not fully subsidize premiums for highly compensated individuals while requiring that rank-and-file employees pay a portion of the premiums.

Operational Compliance
The benefits tests must be satisfied in both form and in operation. It is not enough for a plan document to merely include provisions that satisfy section 105(h). The arrangement must be operated in a manner that is nondiscriminatory.

A closely related issue has to do with the timing of amendments or plan changes. Treasury regulations provide that a plan change may cause the arrangement to run afoul of Section 105(h) if the timing of the change, for example, a plan termination (or the elimination of a benefit under the plan) has the effect of discriminating in favor of highly compensated individuals.

Aggregation and Disaggregation
An employer is largely free to define the "plan" subject to nondiscrimination testing. That is, the employer may aggregate and disaggregate arrangements into component plans.

An employer may, for example, treat two different populations covered by a single written plan document as two separate plans for nondiscrimination testing purposes. This is sometimes done because differences in benefits would otherwise cause an arrangement to fail to satisfy section 105(h) but the plan is able to satisfy the eligibility requirements if each benefit structure is tested separately. **Disaggregated plans may be tested separately for the benefits test if each disaggregated plan can pass the eligibility test on a control group basis.**

Similarly, two or more plans may be aggregated for testing purposes, although this is done less frequently simply because differences in benefit structures may make aggregation impracticable. To the extent that an employer chooses to aggregate two plans together for testing purposes, it must do so for **both** the eligibility and benefits test. (See Appendix E, below, for an aggregation and disaggregation case example.)

Former Employees
As mentioned above, it appears that the ACA's nondiscrimination rules do not apply to a retiree-only plan. However, to the extent that a fully insured group health plan covers both current and former employees, the rules will apply.

There is, however, very little guidance on how Section 105(h) applies to former employees. The regulations absolve a plan from performing numeric coverage testing with respect to a "retired employee" but provide that all benefits provided to a retired highly compensated individual must be provided to all retired employees. There is, however, no definition of retired employee.

This could, for example, raise a question about whether an employer may pay COBRA premiums for former highly compensated individuals but not for other individuals. More generally, it is not clear how COBRA elections will be taken into account, although presumably a plan will not fail the nondiscrimination rules solely because former highly compensated individuals elect COBRA coverage at a higher rate.

Some Implications for Insured Plans

In general, fully insured benefits provided solely to highly compensated individuals will now run afoul of the new nondiscrimination requirements to the extent they apply (e.g., the plan is not grandfathered). As a result, fully insured executive medical plans will generally be prohibited. There is, however, an exception from the requirements of Section 105(h) for "reimbursements paid under a plan for medical diagnostic procedures" for an employee, but not a dependent. This carve-out generally allows for executive physicals and related transportation expenses.

Treatment of After-Tax Premiums
One approach to Section 105(h) problems affecting self-insured plans is to provide that premiums paid on behalf of highly compensated individuals are paid with after-tax dollars. This generally has the effect of making the arrangement one that is taxed under Code Section 104(a)(3), which has no nondiscrimination requirements.

It appears, however, that this approach will not be effective under the ACA for insured plans. That is, it appears that employee after-tax payments to a fully insured group health plan, and related benefits, will be subject to nondiscrimination testing. In this regard, there is nothing analogous to Section 104(a)(3) under the Section 105(h) rules as incorporated in the PHSA, ERISA, and the Code by the ACA.

Interaction with Cafeteria Plan Nondiscrimination Rules
There is substantial overlap between the nondiscrimination requirements under Code Section 125 for cafeteria plans and Section 105(h). In this regard, for example, both sections impose an eligibility test that may be satisfied using the nondiscriminatory classification test. There are, however, substantial differences. For example, the two sections define highly compensated individuals differently, and the cafeteria rules include a key employee concentration test, which is often problematic.

Penalties for Failure to Satisfy Nondiscrimination Rules
The consequences associated with a failure to satisfy Section 2716 of the Public Health Service Act (PHSA) are **not** the same as those associated with a failure to satisfy Section 105(h).

"Excess reimbursements" paid to a highly compensated individual under a discriminatory **self-insured** medical reimbursement plan are taxable to the individual. Two situations produce an excess reimbursement:

- For a benefit available to a highly compensated individual but not to other participants, the total amount reimbursed under the plan is taxable.
- In the case of benefits available to all participants, and not otherwise discriminatory, where the plan discriminates as to participation, excess reimbursement is determined by multiplying the total amount reimbursed to the highly compensated individual for the plan year by a fraction:
  - The numerator is the total amount reimbursed to all highly compensated individuals under the plan
  - The denominator is the total amount reimbursed to employees under the plan for the plan year

The employer sponsoring a **fully insured** group health plan that fails to satisfy Section 105(h) is subject to an excise tax under Section 4980D of the Code. The excise tax under Code Section 4980D is $100 per day during the noncompliance period with respect to "each individual to whom the failure relates," not to exceed the lesser of 10% of the group health plan costs or $500,000.

The tax does not apply if the taxpayer did not know of the violation and would not have discovered the violation by exercising reasonable diligence, or with respect to an unintentional failure that is corrected within 30 days. Also, the IRS has the discretion to waive the tax in whole or in part to the extent the failure was due to reasonable cause and not to willful neglect.

The minimum excise tax after notice of examination is:

- $2,500 for *de minimis* failures and
- $15,000 if the violations are more than *de minimis*.

In terms of identifying the individuals "to whom the failure relates," it seems quite likely that the sponsor and issuer may need to look to different classes of persons depending on the nature of the failure.

Example: a failure related to excluding individuals from coverage generally. In this case, it would seem to be that appropriate individual to look to is *not* with respect to an enrollee, but rather to those participants who are being excluded from coverage.

On the other hand, take, for example, a failure with respect benefits provided under the plan. In this instance, the correct approach would appear to be to look to the participants in the plan who subject to reduced benefits.

Significantly, there is an exception from the excise tax for a group health plan maintained by a small employer, which is generally defined as an employer employing an average of at least two but not more than 50 employees on business days during the preceding calendar year. However, it is our understanding from speaking with Treasury Department representatives that the Department is likely to read the exception to only apply where the prohibited discrimination results from the underlying insurance policy itself versus employer plan design or related employer activity (such as discriminatory plan eligibility rules or employer premium subsidies).

In addition, the ACA nondiscrimination requirements are included in ERISA and also the PHSA. With respect ERISA, it appears likely that a participant (or the Department of Labor) is permitted to bring a lawsuit utilizing ERISA's remedial provisions to compel compliance with the nondiscrimination standards. These remedies would be available with respect to both large and small group health plans.

With respect to the PHSA, there is some lack of clarity regarding whether issuers may be subject to penalty under the PHSA with respect to a discriminatory fully insured plan. In general the PHSA applies only to issuers and non-federal governmental plans. The basis for the lack of clarity is that new PHSA Section 2716 states only that a fully insured "group health plan" shall not discriminate; there is no express reference to issuer (as included in various other ACA insurance reforms).

The absence of any reference to "issuer" leaves unclear whether issuers may be subject to penalty under the PHSA. Given that issuers are unlikely to know whether a plan is in fact discriminatory, this would seem to counsel against subjecting issuers to liability.

To the extent the nondiscrimination rules contained in PHSA Section 2716 apply to issuers, the penalty regime is fairly similar to that provided under the Code (as set forth above), with several notable differences. As under the Code, the maximum amount of the penalty is $100 per day per individual to whom the failure relates. However, unlike the excise tax under the Code, *no* maximum penalty applies for the tax year at issue; thus the penalty could exceed the $500,000 threshold that applies for purposes of the Code.

In determining the amount of the penalty, the statute provides that the HHS Secretary will consider the previous record of compliance of the entity and the gravity of the violation. The statute also provides that the penalty shall not apply where:

- The failure was not discovered despite the exercise of reasonable diligence, and

- The failure was due to reasonable cause (and not willful neglect) and is corrected during the 30-day period beginning on the first day that any of the entities against which the penalty is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

Potential Adjustments if the Tests are Failed
All plans should test during the plan year so that adjustments can be made. The following is a brief overview of the possible adjustments that can be made to reverse the results of a failed test.

- **Eligibility test.** There are very few adjustments that can resolve an eligibility test failure. Essentially, the employer must increase the number of NHCIs that *benefit* or decrease the number of HCIs that *benefit*. In some cases the employer may have to do both. Also, the manner in which the plan sponsor interprets the term *benefiting* (i.e., actually participating or merely eligible) will dramatically affect the results and the options available if the employer fails.
- **Benefits test.** If the agencies issue guidance or regulations consistent with Code Section 105(h) rules and regulations, then the employer should be able to separate the different classifications of employees into separate "plans" for purposes of testing. For example, if hourly employees are required to contribute less than salaried employees, the employer can segregate hourly and salaried employees into separate plans for purposes of testing. Then, if each plan passes the eligibility test, then the plan as a whole passes the tests.

Implications for Self-Insured Plans

Although the ACA's nondiscrimination requirements are applicable only to certain fully insured group health plans, it is possible that the new requirements could ultimately have a material impact on self-insured plans. As mentioned above, Treasury and IRS have for many years avoided issues related to the interpretation of Section 105(h). At some point, we anticipate that the responsible agencies could publish more substantive guidance interpreting the PHSA provisions and that guidance could (and most likely would) also have implications for the application of the currently vague rules of Section 105(h).

This summary is not intended to be, nor should it be construed as, legal or tax advice. UBA is not authorized nor does it purport to provide tax or legal advice and this guide should not be viewed as a substitute thereof. It is intended merely as an educational resource. We strongly recommend that each plan sponsor consult with qualified legal advisors regarding compliance with this rule.

Appendix A. Nondiscrimination Rules: HIPAA-Excepted Benefits

There are essentially four subcategories of excepted benefits excluded from HIPAA's portability rules. Those categories are:

- Benefits that are excluded under all circumstances:
  - Accident or disability income insurance
  - Liability insurance, including general liability and auto liability insurance
  - Workers' compensation
  - Automobile medical payment insurance
  - Credit only insurance
  - Coverage for on-site medical clinics
- The following benefits are exempt when offered through a separate policy or, alternatively, if they do not otherwise constitute an integral part of the plan. For this purpose, a benefit is not an integral part of the plan if the participant has the right to elect the coverage separately from medical:
  - "Limited-scope" dental or vision benefits. Limited-scope dental coverage is defined as coverage substantially all of which consists of treatment of the mouth. Likewise, limited-scope vision coverage is defined as coverage substantially all of which is treatment for the eyes. Dental or vision benefits offered under the same plan as medical benefits may still be "limited-scope" as long as the coverage is voluntary, and the dental or vision benefits can be elected separately and a separate contribution is required.
  - Long-term care
  - Nursing home care
  - Home health care
  - Community-based care
- Limited-scope specified disease and hospital (or other fixed) indemnity coverage, provided that:
  - Such coverage is provided under a separate policy, certificate or contract of insurance
  - No coordination exists between the provision of such benefits and any exclusion under any plan maintained by that employer
  - Benefits are paid for an event regardless of whether benefits are provided under any group health plan maintained by the same plan sponsor

  The regulations clarify that hospital indemnity insurance will qualify as an excepted benefit only if it provides a fixed amount of benefits per day (or other period) for each day the individual is in the hospital, regardless of the amount of expenses. If the policy provides benefits other than a fixed amount per day for hospitalization, the plan fails to qualify as an excepted benefit. For example, if the plan provides benefits only for a fixed percentage of hospital expenses up to a fixed maximum (e.g., 75% up to $100 per day), the plan is not an excepted hospital indemnity plan.
- The following types of benefits if offered under a separate policy or contract:
  - Medicare supplemental policy
  - TRICARE supplemental policy
  - Coverage providing "similar supplemental coverage" to a group health plan. The final regulations clarify that the exception for "similar supplemental coverage" is limited to coverage that is specifically designed to fill gaps in the primary health coverage such as coinsurance or deductibles (e.g., such as

a Medi-Gap or CHAMPUS/TRICARE supplement plan). Coverage that is supplemental only because of the plan's coordination provisions is not "similar supplemental coverage."

Appendix B. Nondiscrimination Rules: Overview of Controlled Group Rules

A parent/subsidiary controlled group consists of a parent corporation and one or more subsidiary corporations.

- A parent/subsidiary controlled group exists if the members of the group (other than the common parent) are at least 80% owned by other members of the group, and if the common parent owns at least 80% of at least one of the member corporations.
- Brother/sister controlled groups of employers will be deemed to be a controlled group of employers where five or fewer shareholders *control* the corporations. For this purpose, control is defined as:
  - Ownership of at least 80% of the entity **and**
  - Ownership of more than 50% of the entity, taking into account the stock ownership of each such person only to the extent that such stock ownership is identical with respect to each such corporation.
- An "affiliated service group" is defined generally as a service organization that regularly performs services in certain professional fields, such as health, law, engineering, for the "first service organization" and is a shareholder or partner in the first service organization.

Appendix C. Nondiscrimination Rules: Safe Harbor Table

Comparative Coverage Ratios

NHCE Concentration Percentage	Safe Harbor Percentage	Unsafe Harbor Percentage
0 - 60	50.00	40.00
61	49.25	39.25
62	48.50	38.50
63	47.75	37.75
64	47.00	37.00
65	46.25	36.25
66	45.50	35.50
67	44.75	34.75
68	44.00	34.00
69	43.25	33.25
70	42.50	32.50
71	41.75	31.75
72	41.00	31.00
73	40.25	30.25
74	39.50	29.50
75	38.75	28.75
76	38.00	28.00
77	37.25	27.25
78	36.50	26.50
79	35.75	25.75

NHCE Concentration Percentage	Safe Harbor Percentage	Unsafe Harbor Percentage
80	35.00	25.00
81	34.25	24.25
82	33.50	23.50
83	32.75	22.75
84	32.00	22.00
85	31.25	21.25
86	30.50	20.50
87	29.75	20.00
88	29.00	20.00
89	28.25	20.00
90	27.50	20.00
91	26.65	20.00
92	26.00	20.00
93	25.25	20.00
94	24.50	20.00
95	23.75	20.00
96	23.00	20.00
97	22.25	20.00
98	21.50	20.00
99	20.75	20.00

Appendix D. Nondiscrimination Rules: Eligibility Test Case Example

Case Specifics:

- Employer has 75 non-HCEs and 25 HCEs (assume none are excludable employees)
- Employer sponsors group medical coverage for all its employees working in its home state
- All 25 HCEs and 45 of the non-HCEs are eligible (work in its home state)
- 22 HCEs and 30 non-HCEs actually participate

Calculations:

- Participation (measured across controlled group) = 52 ÷100 = 52%
- Eligibility (measured across controlled group) = 70 ÷ 100 = 70%
- Participation of those eligible = 52 ÷70 = 74%
- Plan's ratio percentage = 40% of non-HCEs participating ÷ 88% of HCEs participating = 45.45%
- Non-HCE concentration (measured across controlled group) = 75 ÷ 100 = 75%
- Safe harbor percentage change amount (0.75% for each whole percent that the non-HCE concentration exceeds 60%) = 15% x 0.75% = 11.25%
- Plan safe harbor percentage = 50% - 11.25% (the safe harbor percentage change amount) = 38.75%

Results:

- **70% test: Fails test.** Only 52% (measured across controlled group) participate.
- **70/80 test: Fails test.** Part 1: 70% are eligible to participate (pass); Part 2: 74% of those eligible actually participate (fail)
- **Nondiscriminatory classification test: Passes test**. Part 1: Classification (home state) is based on objective business criteria (pass); Part 2: Plan's ratio percentage of 45.45% exceeds the employer's safe harbor percentage of 38.75%

Appendix E. Nondiscrimination Rules: Aggregation and Disaggregation Case Example

Case Specifics:

- Employer has employees in 13 states
- Employer sponsors self-funded plan available to all employees
- Employer sponsors two insured plans: one for New York employees only and one for California employees only

Analysis:

- Employer likely cannot satisfy the benefits test if all three arrangements are treated as a single aggregated plan
- Employer will need to disaggregate the insured plans from each other and from the self-funded plan
- In order to pass the eligibility test (using the nondiscriminatory classification test), will likely need to carve out the self-funded component for employees in New York and then aggregate that group with the insured plan for New York employees only to form a single plan for testing purposes
- Repeat the step immediately above for the California employees

Resulting Aggregation/Disaggregation Strategy to Pass Nondiscrimination Testing:

Create three separate plans for testing by disaggregating and re-aggregating as follows:

1. Aggregate Insured and self-funded plans for California
2. Aggregate insured and self-funded plans for New York
3. Retain self-funded plan for employees in all states except California and New York

Appendix 9 – Interim Guidance on External Review Procedures

Interim Guidelines for Insured Plans

An insured plan must comply with either a state's external review procedures (if any) or with federal standards that will be posted on the HHS website in the near future. In the case of an insured plan, the insurance carrier has the primary responsibility for complying with these external review standards.

Interim Procedures for Self-Funded Plans

During an interim period (commencing with the first plan year beginning on or after September 23, 2010, and ending when future guidance is issued), non-grandfathered, self-funded ERISA plans have two options for complying with this new external review requirement:

- They may voluntarily comply with a state's external review procedures (assuming a state makes those procedures available to self-funded plans), or
- They may implement procedures outlined by the Department of Labor (DOL) in its Technical Release 2010-01, which are based on the NAIC's "Uniform Health Carrier External Review Model Act."
  - They allow a claimant to request an external review after the denial of an internal appeal.
  - If the requirements for an *expedited* external review are satisfied, such a review may be available after the denial of a *claim*.
  - Although plans must *offer* this external review option, a claimant need not take advantage of the option before seeking judicial review.

In general, an expedited external review is available if a claimant's medical condition is such that the timeframes for either an internal appeal of a denied claim or a standard external review would seriously jeopardize the claimant's life, health, or ability to regain maximum function.

Standard External Review Procedures

- A claimant must be given up to four months to request an external review of the denial of an internal appeal.
- Once a plan receives such a request, it has only five days in which to determine whether an external review is available to the claimant and, if so, whether the claimant's request for such a review is complete.
- After making that determination, the plan has only *one* day in which to notify the claimant if an external review is not available or if the request is incomplete.
- If a request for an external review is complete (and the claimant is entitled to exercise that option), the plan must promptly assign the request to an accredited independent review organization (IRO).
  - To avoid bias and assure independence of the IRO, a plan must contract with at least three different IROs. Note: Self-funded plans do not need to contract directly with IROs, but may access those services through the plan's TPA.
  - Requests for external reviews must then be assigned to these IROs either randomly or on a rotating basis.
- Within five days after assigning a request to an IRO, the plan must provide the IRO with all of the documents and information the plan considered in denying the claim or appeal.
  - If a plan fails to meet this deadline, the IRO may terminate the external review and simply reverse the plan's decision.
- The IRO must then act in accordance with the terms of its agreement with the plan.

  - The Technical Release spells out a number of provisions that must be incorporated into such an agreement.
    - An IRO must notify the claimant within ten business days of receiving a request for review,
    - Must promptly forward to the plan any additional information submitted by the claimant, and
    - Must notify both the claimant and the plan of the IRO's final decision within 45 days of receiving the request for review.
- If an IRO reverses a plan's decision, the plan must *immediately* provide the requested coverage or pay the claims at issue.

Expedited External Review Procedures

Should the circumstances entitle a claimant to an "expedited" external review, that review may take place contemporaneously with any internal appeal.

- Upon receiving a request for an expedited external review, a plan must "immediately" determine whether the request meets the standards for such a review, and
- "Immediately" notify the claimant of its determination on this point.
- If the request is eligible for expedited review, the plan must transmit all of the necessary documents and information to the IRO "electronically or by telephone or facsimile or any other available expeditious method."
- The IRO must then make its determination "as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two hours after the IRO receives the request for an expedited external review."

Appendix 10 – Refusal to Purchase Health Coverage Sample Annual Penalty Table

Household Income	2014 Penalty	2015 Penalty	2016 Penalty
$ 10,830	$ 108.30	$ 325.00	$ 695.00
$ 21,660	$ 216.60	$ 433.20	$ 695.00
$ 32,490	$ 324.90	$ 649.80	$ 812.25
$ 43,320	$ 433.20	$ 866.40	$ 1,083.00
$ 55,125	$ 551.25	$ 1,102.50	$ 1,378.13
$ 66,150	$ 661.50	$ 1,323.00	$ 1,653.75
$ 77,175	$ 771.75	$ 1,543.50	$ 1,929.38
$ 88,200	$ 882.00	$ 1,764.00	$ 2,205.00

Appendix 11 – Income Levels for Various Federal Poverty Levels and Number of People

2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
For families/households with more than 8 persons, add $4,160 for each additional person.	

2016 Poverty Guidelines for Alaska	
Persons in family/household	**Poverty guideline**
1	$14,840
2	20,020
3	25,200
4	30,380
5	35,560
6	40,740
7	45,920
8	51,120
For families/households with more than 8 persons, add $5,200 for each additional person.	

2016 Poverty Guidelines for Hawaii	
Persons in family/household	**Poverty guideline**
1	$13,670
2	18,430
3	23,190
4	27,950
5	32,710
6	37,470
7	42,230
8	47,010
For families/households with more than 8 persons, add $4,780 for each additional person.	

2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890
For families/households with more than 8 persons, add $4,160 for each additional person.	

2015 Poverty Guidelines for Alaska	
Persons in family/household	**Poverty guideline**
1	$14,720
2	19,920
3	25,120
4	30,320
5	35,520
6	40,720
7	45,920
8	51,120
For families/households with more than 8 persons, add $5,200 for each additional person.	

2015 Poverty Guidelines for Hawaii	
Persons in family/household	**Poverty guideline**
1	$13,550
2	18,330
3	23,110
4	27,890
5	32,670
6	37,450
7	42,230
8	47,010
For families/households with more than 8 persons, add $4,780 for each additional person.	

2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090
For families/households with more than 8 persons, add $4,060 for each additional person.	

2014 Poverty Guidelines for Alaska	
Persons in family/household	**Poverty guideline**
1	$14,580
2	19,660
3	24,740
4	29,820
5	34,900
6	39,980
7	45,060
8	50,140
For families/households with more than 8 persons, add $5,080 for each additional person.	

2014 Poverty Guidelines for Hawaii	
Persons in family/household	**Poverty guideline**
1	$13,420
2	18,090
3	22,760
4	27,430
5	32,100
6	36,770
7	41,440
8	46,110
For families/households with more than 8 persons, add $4,670 for each additional person.	

2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630
For families/households with more than 8 persons, add $4,020 for each additional person.	

2013 Poverty Guidelines for Alaska	
Persons in family/household	**Poverty guideline**
1	$14,350
2	19,380
3	24,410
4	29,440
5	34,470
6	39,500
7	44,530
8	49,560
For families/households with more than 8 persons, add $5,030 for each additional person.	

2013 Poverty Guidelines for Hawaii	
Persons in family/household	**Poverty guideline**
1	$13,230
2	17,850
3	22,470
4	27,090
5	31,710
6	36,330
7	40,950
8	45,570
For families/households with more than 8 persons, add $4,620 for each additional person.	

Appendix 12 – Premium Tax Credit Table

Illustrative Examples of Required Premium Contributions and Monthly Credit Amounts, if Premium Credits were Available in 2013, by Coverage Tier

For the 48 contiguous states and the District of Columbia

Coverage Tier	Income Level (based on FPL)	Federal Poverty Level (FPL)	Maximum Premium Contribution as a % of Income	Age of youngest adult [a]	Monthly Premium [b]	Required Monthly Contribution from Enrollee(s)	Monthly Credit Amount
Self-Only	$17,235	150%	4.0%	20	$183	$57	$126
	$17,235	150%	4.0%	60	$782	$57	$725
	$40,215	350%	9.5%	20	$183	$183 [c]	$0
	$40,215	350%	9.5%	60	$782	$318	$464
Family of Three [d]	$29,295	150%	4.0%	20	$549	$98	$451
	$29,295	150%	4.0%	60	$1,747	$98	$1,649
	$68,355	350%	9.5%	20	$549	$541	$8
	$68,355	350%	9.5%	60	$1,747	$541	$1,206

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013; and "National Health Care Calculator," U.C. Berkeley Labor Center

Notes: Under ACA, premium credits will not be available until 2014; the data in this table are for illustrative purposes only. The monthly premium and contribution estimates reflect 2013 dollars. With respect to the poverty guidelines, different income levels apply in Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The poverty guidelines are updated annually for inflation.

a. Premiums for exchange plans will be age-adjusted to allow for a maximum 3:1 variation based on age for adults. Exchange premiums also will be allowed to vary based on tobacco use (1.5:1 variation), family size, and geography. For additional information about these rating restrictions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

b. The actual premiums for exchange plans are not known at this time. The premium estimates are based on the Congressional Budget Office's national estimates for silver-tier plans, as incorporated in the National Health Care Calculator. Given these are national estimates, they do not reflect variation due to geographic cost differences; differences which are allowed to be incorporated into premiums for exchange plans.

c. The required premium contribution for an individual whose income is $40,215 in 2013 would be $318 per month, which is 9.5% (9.56% in 2015, 9.66% in 2016) of $40,215 divided by 12. However, the monthly premium for a 20-year-old is lower ($183), so that person would pay the lower amount for exchange coverage.

d. Premiums for exchange plans are allowed to vary based on family size. In this table, the hypothetical family comprises two adults and one child under age 21.

Appendix 13 – Illustrative Silver Plan Premiums and Maximum Out-of-Pocket Payments

Maximum Out-of-Pocket Premium Payments under the ACA for Individual Silver Plan, If Currently Implemented

For the 48 contiguous states and the District of Columbia

Federal Poverty Level	Max. Premium as Percent of Income (2014)	Maximum Annual Premium (Current) by Family Size			
		1	2	3	4
100%	2.0%	$217	$291	$366	$441
133.00%	2.0%	$288	$388	$487	$587
133.01%	3.0%	$487	$656	$824	$992
150%	4.0%	$650	$874	$1,099	$1,323
200%	6.3%	$1,365	$1,836	$2,307	$2,778
250%	8.05%	$2,180	$2,932	$3,685	$4,438
300%	9.5%	$3,087	$4,152	$5,218	$6,284
350%	9.5%	$3,601	$4,845	$6,088	$7,332
400%	9.5%)	$4,115	$5,537	$6,958	$8,379

Source: Based on "Annual Update of the HHS Poverty Guidelines," 74 Federal Register 4200, January 23, 2009, and ACA.

ACA: Illustrative 2009 Silver Plan Premiums, Adjusted by Enrollee Age and Geographic Cost

	Single premium			Single+1 premium			Family of four premium		
Age	Low	Med	High	Low	Med	High	Low	Med	High
20	$2,110	$2,637	$3,165	$4,220	$5,274	$6,330	$5,687	$7,108	$8,530
30	$2,141	$2,676	$3,211	$4,282	$5,352	$6,422	$6,290	$7,862	$9,435
40	$2,800	$3,500	$4,200	$5,600	$7,000	$8,400	$7,548	$9,435	$11,321
50	$4,342	$5,428	$6,513	$8,684	$10,856	$13,026	$10,489	$13,112	$15,734
60	$6,329	$7,911	$9,494	$12,658	$15,822	$18,988	$14,960	$18,700	$22,440

Source: Based on Kaiser Family Foundation illustrative health insurance premiums. Illustrated premiums for low-cost and high-cost areas vary by 20% above and below the level for medium-cost areas, and reflect 3:1 age banding.

ACA: Illustrative 2009 Silver Plan Premiums, As a Percentage of Income at 400% of FPL Adjusted by Enrollee Age and Geographic Cost

	Single premium			Single+1 premium			Family of four premium		
Age	**Low**	**Med**	**High**	**Low**	**Med**	**High**	**Low**	**Med**	**High**
20	4.9%	6.1%	7.3%	7.2%	9.0%	10.9%	6.4%	8.1%	9.7%
30	4.9%	6.2%	7.4%	7.3%	9.2%	11.0%	7.1%	8.9%	10.7%
40	6.5%	8.1%	9.7%	9.6%	12.0%	14.4%	8.6%	10.7%	12.8%
50	10.0%	12.5%	15.0%	14.9%	18.6%	22.4%	11.9%	14.9%	17.8%
60	14.6%	18.3%	21.9%	21.7%	27.1%	32.6%	17.0%	21.2%	25.4%

Source: Based on Kaiser Family Foundation illustrative health insurance premiums.
Available online at http://healthreform.kff.org/SubsidyCalculator.aspx , accessed on March 23, 2010.

Appendix 14 – Calculating Increases in Fixed Amount Cost-Sharing For Purposes of Retaining Grandfather Status

Maximum Fixed Amount Cost-Sharing Other Than a Co-Payment (deductible, co-insurance)

Total percentage increase in cost-sharing requirement (measured from March 23, 2010) cannot exceed the maximum percentage increase (defined below).

Maximum Fixed Amount Cost-Sharing For a Co-Payment

Total increase in the co-payment (measured from March 23, 2010) exceeds the greater of:

- ($5 x medical inflation as defined below) + $5
- The maximum percentage increase (defined below) (with the increase in co-payment calculated as a percentage increase)

Medical Inflation Defined

The term “medical inflation” means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI–U) (unadjusted) published by the Department of Labor using the 1982–1984 base of 100.

Consumer Price Index Detailed Reports can be found on the Bureau of Labor Statistics website.

The increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI–U (unadjusted) published by the Department of Labor for March 2010, using the 1982–1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect, and then dividing that amount by 387.142.

Maximum Percentage Increase Defined

The term “maximum percentage” increase means medical inflation (as defined above) expressed as a percentage, plus 15 percentage points.

Medical Care Component of CPI-U (unadjusted)

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2009	369.830	372.405	373.189	374.170	375.026	375.093	375.739	376.537	377.727	378.552	379.575	379.516
2010	382.688	385.907	387.142	387.703	387.762	388.199	387.898	388.467	390.616	391.240	391.902	392.323
2011	393.858	397.065	397.726	398.813	399.375	399.552	400.305	400.874	401.605	403.430	404.858	405.629
2012	408.096	410.466	411.498	412.480	413.655	415.345	416.759	417.123	418.039	418.359	418.653	418.654
2013	420.687	423.221	424.154	423.815	422.834	424.264	424.836	426.866	428.026	428.082	427.740	427.809
2014	429.621	432.769	433.369	434.054	434.874	435.352	435.924	435.777	436.575	437.027	438.445	439.720
2015	440.969	442.783	444.020	446.663	447.213	446.271	446.773	446.536	447.289	450.065	451.371	451.072
2016	454.175	458.295	458.620	459.994								

Examples Provided in Interim Rule

Example 1:

- On March 23, 2010, a grandfathered health plan has a copayment of $30. The plan is subsequently amended to increase the copayment requirement to $40.
- Within the 12-month period before the $40 copayment takes effect, the greatest value of the overall medical care component of CPI-U is 475.

Conclusion:

- The increase in the copayment from $30 to $40, expressed as a percentage, is 33.33% (40 - 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%).
- Medical inflation from March 2010 is 0.2269 (475 - 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269 = 22.69%).
- The maximum percentage increase permitted is 37.69% (22.69% + 15% = 37.69%).
- Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 2:

- Same facts as Example 1, except the grandfathered health plan subsequently increases the $40 copayment requirement to $45 for a later plan year.
- Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of CPI-U is 485.

Conclusion:

- The increase in the copayment from $30 (the copayment that was in effect on March 23, 2010) to $45, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%).
- Medical inflation from March 2010 is 0.2527 (485 - 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527 = 25.27%).
- The increase that would cause a plan to cease to be a grandfathered health plan is the greater of the maximum percentage increase of 40.27% (25.27% + 15% = 40.27%), or $6.26 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26).

- Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 3:

- On March 23, 2010, a grandfathered health plan has a copayment of $10. The plan is subsequently amended to increase the copayment requirement to $15.
- Within the 12-month period before the $15 copayment takes effect, the greatest value of the overall medical care component of CPI-U is 415.

Conclusion:

- The increase in the copayment, expressed as a percentage, is 50% (15 - 10 = 5; 5 ÷ 10 = 0.5; 0.5 = 50%).
- Medical inflation from March 2010 is 0.0720 (415.0 - 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720 = 7.20%).
- The increase that would cause a plan to cease to be a grandfathered health plan is the greater of the maximum percentage increase of 22.20% (7.20% + 15% = 22.20), or $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36).
- The $5 increase in copayment would not cause the plan to cease to be a grandfathered health plan since it is less than the maximum allowed increase of $5.36.

Example 4:

- The same facts as Example 3, except on March 23, 2010, the grandfathered health plan has no copayment ($0). The plan is subsequently amended to increase the copayment requirement to $5.
- Within the 12-month period before the $5 copayment takes effect, the greatest value of the overall medical care component of CPI-U is 415.

Conclusion:

- Medical inflation from March 2010 is 0.0720 (415.0 - 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720).
- The increase that would cause a plan to cease to be a grandfathered health plan is $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36).
- The $5 increase in copayment is less than $5.36. Thus, the $5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Appendix 15 – NAHU Overview of Exchange Provisions

National Association of Health Underwriters

Overview of Provisions in the Proposed Federal Rule on the Establishment of Exchanges and Qualified Health Plans (Released on July 11, 2011) of Specific Interest to Health Insurance Agents and Brokers

Subject	HHS Commentary From Preamble	Regulatory Provision
Agent-Specific Provisions		
Definition of Agent/Broker		"Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer." P. 177
Governing Boards—Conflicts of Interest	"Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests. We propose in paragraph (c)(3) that the voting members of an Exchange governing board represent consumer interests by ensuring that membership may not consist of a majority of representatives of health insurance issuers, agents, or brokers, or any other individual licensed to sell health insurance. We invite comment on the extent to which these categories of representatives with potential conflicts of interest should be further specified and on the types of representatives who have potential conflicts of interest. We propose these categories as a minimum Federal standard. A State may wish to adopt more stringent or specialized conflict of interest requirements than those used in connection with regular governmental operations." P27	"c) Governing board structure. If the Exchange is an independent State agency or a nonprofit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that: (1) Is administered under a formal, publicly-adopted operating charter or by-laws; (2) Holds regular public governing board meetings that are announced in advance; (3) Represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and (4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured." P. 185

Subject	HHS Commentary From Preamble	Regulatory Provision
Governing Boards – Experience	"We propose that the Exchange governing body ensure that a majority of members have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. We invite comment on the types of representatives that should be on Exchange governing boards to ensure that consumer interests are well-represented and that the Exchange board as a whole has the necessary technical expertise to ensure successful operations." P 28	"c) Governing board structure. If the Exchange is an independent State agency or a nonprofit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that: Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, healthcare delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured." P. 185
Disclosure	"We propose that each Exchange publish a set of guiding governance principles that includes ethical and conflict of interest standards and disclosure of financial interests that are posted for public consumption…We propose to require that an Exchange have in place procedures for disclosure of financial interest by members of the governing body or governance structure of the Exchange. We invite comment on this proposal and whether additional detail should be proposed." P 28	" (d) Governance principles. (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest. (2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure." P. 185
Stakeholder Consultation	The law requires Exchange consultation with key stakeholders including "individuals and entities with experience in facilitating enrollment in health coverage." HHS has proposed expanding the mandatory stakeholder list to specifically require the consultation of agents and brokers. P30-31	"The Exchange must regularly consult on an ongoing basis with the following stakeholders: (a) Educated health care consumers who are enrollees in QHPs; (b) Individuals and entities with experience in facilitating enrollment in health coverage; (c) Advocates for enrolling hard to reach populations, which include individuals with a mental health or substance abuse disorder; (d) Small businesses and self-employed individuals; (e) State Medicaid and CHIP agencies; (f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 USC §479a, that are located within such Exchange's geographic area; (g) Public health experts; (h) Health care providers; (i) Large employers; (j) Health insurance issuers; and (k) Agents and brokers." P. 186-187
Ability To Access Consumer account Information Through the Exchange IT System	"We would encourage Exchanges to develop a feature whereby eligibility and enrollment experts, caseworkers, Navigators, agents and brokers, and other application assisters are able to maintain records of individuals they have assisted with the application process. We request comment on this proposal." P 44	

Subject	HHS Commentary From Preamble	Regulatory Provision
Use of Agents and Brokers that ARE NOT Navigators	"Section 1312(e) of the Affordable Care Act gives States the option to permit agents or brokers to assist individuals enrolling in QHPs through the Exchange. This includes allowing agents and brokers to enroll qualified individuals, qualified employers, or qualified employees in QHPs and to assist individuals with applications for advance payments of the premium tax credit and cost-sharing reductions. We propose to codify this option under paragraph (a) of §155.220. We note that the standards described in this section would not apply to agents and brokers acting as Navigators. Any entity serving as a Navigator, including an agent or broker, may not receive any financial compensation from an issuer for helping an individual or small group select a specific QHP, consistent with §155.210. We also clarify that the statute permits agents and brokers to assist with applications for advance payments of the premium tax credit and cost-sharing reductions." P49	**"§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.** (a) General rule. A State may choose to permit agents and brokers to – (1) Enroll qualified individuals, qualified employers or qualified employees in any QHPs in the individual or small group market as soon as the QHP is offered through an Exchange in the State; and (2) Assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs." P. 193-194
Agent Referrals	"To ensure that individuals and small groups have access to information about agents and brokers should they wish to use one, in paragraph (b) we propose to permit an Exchange to display information about agents and brokers on its website or in other publicly available materials." P 49	"Website disclosure. The Exchange may elect to provide information regarding licensed agents and brokers on its website for the convenience of consumers seeking insurance through that Exchange." P. 194
Premium Must be the Same Regardless of How Policy Was Purchased	"Each QHP issuer must offer a QHP at the same premium rate without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent. We interpret this provision to mean that an issuer must charge a premium that uses underlying rating assumptions that account for all expected enrollees of a QHP, including individuals that enroll in the QHP outside of an Exchange, and for all methods of enrollment, including through an Exchange, an agent or broker, or the issuer itself. Thus, the resulting premium for a QHP would vary only by the rating factors listed in 2701(a) of the PHS Act." P. 134	"Same premium rates. A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent." P. 229

Subject	HHS Commentary From Preamble	Regulatory Provision
Impact on Small Businesses (including Agents)	"The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Using the Small Business Administration (SBA) definitions of small entities for agents and brokers, providers, and employers, ***HHS tentatively concludes that a significant number of firms affected by this proposed rule are not small businesses."*** P. 160 "As discussed above, this proposed rule is necessary to implement standards related to the Establishment of Exchanges and Qualified Health Plans as authorized by the Affordable Care Act. For purpose of the Regulatory Flexibility Analysis, we expect the following types of entities to be affected by this proposed rule: (1) QHP issuers; (2) agents and brokers; and (3) employers. We believe that health insurers and agents and brokers would be classified under the North American Industry Classification System (NAICS) Codes 524114 (Direct Health and CMS–9989. According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities for both of these NAICS codes." P. 165 "We anticipate that the agent and broker industry, which is comprised of large brokerage organizations, small groups, and independent agents, will play a critical role in enrolling qualified individuals in QHPs. We are proposing to codify Section 1312(e) of the Affordable Care Act, which gives States the option to permit agents or brokers to assist individuals enrolling in QHPs through the Exchange. Agents and brokers must meet any condition imposed by the State and, as a result, could incur costs. In addition, agents and brokers who become Navigators will also agree to comply with associated requirements and are likely to incur some costs. Because the States and the Exchanges will make these determinations, we cannot provide an estimate of the potential number of small entities that will be affected or the costs associated with these decisions." P. 168	
Navigator Provisions		
Definition of a Navigator		"Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the requirements described in §155.210." P. 180
Requirement to Have a Navigator Program		**"§155.210 Navigator program standards.** (a) General Requirements. The Exchange must establish a Navigator program consistent with this section through which it awards grants to eligible public or private entities described in paragraph (b) of this section." P. 191

Subject	HHS Commentary From Preamble	Regulatory Provision
Experience of Navigators	"A Navigator must demonstrate to the Exchange, as required by section 1311(i)(2)(A) of the Affordable Care Act, that the entity has existing relationships, or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a QHP through the Exchange. We note that an entity need not have the ability to form relationships with all relevant groups in order to be eligible for Navigator funding; for example, an entity that can effectively conduct outreach to rural areas may not be as effective in urban areas." P 45	(b) Entities eligible to be a Navigator. (1) To receive a Navigator grant, an entity must – (i) Be capable of carrying out at least those duties described in paragraph (d) of this section; (ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP" P. 191-192
Navigator Licensure/ Certification	"A Navigator must meet any licensing, certification or other standards prescribed by the State or Exchange, as appropriate, consistent with section 1311(i)(4)(A) of the Affordable Care Act. This will allow the State or Exchange to enforce existing licensure standards (such as verifying that agents who seek to be Navigators are licensed), certification standards, or regulations for selling or assisting with enrollment in health plans and to establish new standards or licensing requirements tailored to Navigators (such as participating in periodic trainings), as appropriate." P. 45-46	"(b) Entities eligible to be a Navigator. (1) To receive a Navigator grant, an entity must – (iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable" P. 192
Navigator Conflicts of Interest	"Any entity that serves as a Navigator may not have conflict of interest during the term as Navigator. We specify "during the term as a Navigator" because we want to ensure that an entity that might have formerly had a conflict would not be excluded from consideration if that conflict no longer exists. We clarify that these standards would not exclude, for example, a non-profit community organization that previously received grant funding from a health insurance issuer from serving as a Navigator. We seek comment on whether we should propose additional requirements on Exchanges to make determinations regarding conflicts of interest." P. 46	"(b) Entities eligible to be a Navigator. (1) To receive a Navigator grant, an entity must – (iv) Not have a conflict of interest during the term as Navigator." P. 192
Exchange Inclusion of Multiple Types of Navigators	"We seek comment as to whether we should require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization, or whether we should require that Navigator grantees reflect a cross section of stakeholders." P. 46	"The Exchange must include entities from at least two of the following categories for receipt of a Navigator grant: (i) Community and consumer-focused nonprofit groups; (ii) Trade, industry, and professional associations; (iii) Commercial fishing industry organizations, ranching and farming organizations; (iv) Chambers of commerce; (v) Unions; (vi) Resource partners of the Small Business Administration; (vii) Licensed agents and brokers; and (viii) Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies." P. 192

Subject	HHS Commentary From Preamble	Regulatory Provision
Navigator Compensation	"Consistent with 1311(i)(4) of the Affordable Care Act, health insurance issuers are prohibited from serving as Navigators and a Navigator must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. Such consideration includes, without limitation, any monetary or non-monetary commission, kick-back, salary, hourly-wage or payment made directly or indirectly to the entity or individual from the QHP issuer. These provisions would not preclude a Navigator from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in non-QHPs. We seek comment on this issue and whether there are ways to manage any potential conflict of interest that might arise." P. 46-47	The Exchange must ensure that a Navigator must not – (1) Be a health insurance issuer; or (2) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP.
Accountability of Navigators	"As part of its obligation to establish the Navigator program and oversee the grants, the Exchange must ensure that Navigators are performing their duties as required." P. 47 "The Exchange may require that a Navigator meet additional standards and carry out duties so long as such standards are consistent with requirements set forth herein." P. 47	The regulation itself does not fully address this obligation on the part of the exchange, other than say that the state must have a navigator program and that it must ensure that navigators are not health insurance issuers or those who receive direct or indirect compensation from them.
Fair/Impartial Information Presented by Navigators	"We also propose that the information and services provided by the Navigator be fair, accurate, and impartial and acknowledge other health programs. The Affordable Care Act requires the Secretary to collaborate with the States to develop standards related to this requirement. We are considering standards related to content of information shared, referral strategies, and training requirements to include in grant award conditions. We welcome comment on potential standards to ensure that information made available by Navigators is fair, accurate, and impartial." P. 47	"(d) Duties of a Navigator. An entity that serves as a Navigator must carry out at least the following duties: (2) Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs; P. 192
Duties of a Navigator	"The Navigator must also facilitate enrollment in a QHP through the Exchange and provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate State agency or agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage. Further the Navigator must provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. We seek comment regarding any specific standards we might issue through future rulemaking or additional guidance on these proposed requirements that we might further develop." P 48	"(d) Duties of a Navigator. An entity that serves as a Navigator must carry out at least the following duties: (1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange; (2) Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs; (3) Facilitate enrollment in QHPs; (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being

Subject	HHS Commentary From Preamble	Regulatory Provision
		served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act." P. 192
Navigator Program Funding	"The Exchange is prohibited from supporting the Navigator program with Federal funds received by the State for the establishment of Exchanges. Thus, the Exchange must use operational funds generated through non-Federal sources (pursuant to section 1311(d)(5)) including general operating funds, to fund the Navigator program. If the State chooses to permit or require Navigator activities to address Medicaid and CHIP administrative functions, and such functions are performed under a contract or agreement that specifies a method for identifying costs or expenditures attributable to Medicaid and CHIP activities, the Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities at the administrative Federal financial participation rate described in 42 CFR 433.15 for Medicaid and 42 CFR 457.618 for CHIP." P 48	"Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange." P. 193
Date Navigator Program Must Operational	"We are considering a requirement that the Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. Since consumers will likely require significant assistance to understand options and make informed choices when selecting health coverage, we believe it is important that Exchanges begin the process of establishing the Navigator program by awarding grants and training grantees in time to ensure that Navigators can assist consumers in obtaining coverage throughout the initial open enrollment period. We seek comment on this timeframe under consideration." P. 48-49	

Subject	HHS Commentary From Preamble	Regulatory Provision
Other Provisions Directly Relevant to Agents/Brokers/Navigators		
Use of Other Organizations To Assist With Enrollment (Beyond Agents and Navigators)	We recognize that there are web-based entities and other entities with experience in health plan enrollment that are seeking to assist in QHP enrollment in several ways, including: by contracting with an Exchange to carry out outreach and enrollment functions, or by acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange. To the extent that an Exchange contracts with such an entity, the Exchange would need to adhere to the requirements proposed for eligible contracting entities at §155.110(a). In the event that the Exchange contracts with such web-based entities, the Exchange would remain responsible for ensuring that the statutory and regulatory requirements pertinent to the relevant contracted functions are met. We understand that such entities may provide an additional avenue for the public to become aware of and access QHPs, but we also note that advance payments of the premium tax credit and cost-sharing reductions may only be accessed through an Exchange. We seek comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange. We also seek comment on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any security-or privacy-related implications of such an arrangement. P 50	
Customer Service Referenced in All Exchange Notices	"We propose that any notice sent by an Exchange pursuant to this part must be in writing and include (1) contact information for customer service resources, which might include web-based information, call center, Navigators, or consumer assistance programs; (2) an explanation of rights to appeal, if applicable; and (3) a citation to the specific regulation serving as the cause for notice." P. 50	(a) General requirement. Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees must be in writing and include: (1) Contact information for available customer service resources; (2) An explanation of appeal rights, if applicable; and (3) A citation to or identification of the specific regulation supporting the action. (b) Accessibility and readability requirements. All applications, forms, and notices must be written in plain language and provided in a manner that: (1) Provides meaningful access to limited English proficient individuals; and (2) Ensures effective communication for people with disabilities. (c) Re-evaluation of appropriateness and usability. The Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices on an annual basis and in consultation with HHS in instances when changes are made. P. 194

Subject	HHS Commentary From Preamble	Regulatory Provision
Marketing Practices	"The regulation codifies the section that "prohibits QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs. We seek comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs. We seek comment on also applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents and representatives. Such a requirement would protect consumers from deceptive and misleading marketing practices and allow an Exchange to take action to address such practices if the State's department of insurance or applicable State agency did not have the authority or capacity to do so under applicable law. We considered setting detailed and uniform Federal standards prohibiting specific marketing practices across all QHP issuers, but were concerned about the interaction with current State marketing rules or unintentionally creating "safe harbors" that might allow issuers to technically comply with specific requirements without meeting the spirit of the broader marketing protections. We permit States and Exchanges to adopt additional requirements for the marketing of health plans that are most appropriate to the unique market dynamics in that State, both inside and outside the Exchange. Any Exchange that chooses to apply additional marketing requirements to QHP issuers should consider working closely with State insurance departments to ensure that all health insurance issuers in the State are subject to the same minimum marketing requirements in order to create a level playing field with equal consumer protections inside and outside the Exchange. One particular area of concern in regulating marketing practices of health insurance issuers is ensuring that individuals understand the coverage options made available under the Affordable Care Act. For those individuals already covered by Medicare or other third-party coverage, enrollment in a QHP could be duplicative and/or unnecessary. We are particularly concerned that QHPs may be marketed towards certain vulnerable populations, such as Medicare beneficiaries, for whom coverage from a QHP would not be necessary. We seek comment on a standard that QHP issuers do not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP. " P. 122-124	"A QHP issuer and its officials, employees, agents and representatives must – (a) State law applies. Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and (b) Non-discrimination. Not employ marketing practices that discourage the enrollment of individuals with significant health needs in QHPs." P. 277

Subject	HHS Commentary From Preamble	Regulatory Provision
Website	We propose to codify section 1311(d)(4)(C) of the Affordable Care Act, which requires an Exchange to maintain an Internet website. The Affordable Care Act provides two key provisions related to the establishment of an Exchange website. First, section 1103(b) of the Affordable Care Act requires the Secretary to establish a standardized format for presenting coverage option information, which is utilized to present comparative health plan information on the current HealthCare.gov website. Second, section 1311(c)(5) requires the Secretary to make available to all Exchanges a model Exchange website template developed by the Secretary. We are currently evaluating the extent to which the Exchange website may satisfy the need to provide plan comparison functionality using HealthCare.gov, and invite comments on this issue. Generally, we envision the Exchange website to be an easy-to-use access point that serves as a primary source of information about available QHPs, Exchange activities, and other sources of health coverage. We believe that the Exchange website is an appropriate venue to post QHP information as required by other sections of the Affordable Care Act that require disclosure of information that would be helpful for consumers in comparing QHPs, including the medical loss ratio (section 2718 of the PHS Act), transparency in coverage data (section 1311(e)(3) of the Affordable Care Act), summary of benefits and coverage (section 2715 of the PHS Act)2 and levels of coverage (section 1302(d) of the Affordable Care Act). We specifically propose in §155.205(b)(1) through (6) that an Exchange must maintain an up-to-date Internet website that: 1. Presents standardized comparative information on each available QHP. Such information must include: i. Premium and cost-sharing information; ii. The summary of benefits and coverage required by section 2715 of the PHS Act. Exchanges may consider making this information available through a link from their website to each QHP's website or Exchanges could require QHPs to submit this information in a manner that supports a searchable format; iii. The level of coverage of a QHP (that is, bronze, silver, gold, platinum, or catastrophic coverage consistent with section 1302(d) and 1302(e) of the Affordable Care Act); iv. The results of enrollee satisfaction surveys described in section 1311(c)(4) of the Affordable Care Act; v. Quality ratings assigned to QHPs described in section 1311(c)(3) of the Affordable Care Act; vi. The medical loss ratio as reported in accordance with interim final rule 75 FR 74921, December 1, 2010, amended 75 FR 82278, December 30, 2010; vii. Transparency of coverage measures reported to the Exchange as required under §155.1040;	"b) Internet website. The Exchange must maintain an up-todate Internet website that: (1) Provides standardized comparative information on each available QHP, including at a minimum: (i) Premium and cost-sharing information; (ii) The summary of benefits and coverage established under section 2715 of the PHS Act; (iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act; (iv) The results of enrollee satisfaction survey, described in section 1311(c)(4) of the Affordable Care Act; (v) Quality ratings assigned pursuant to section 1311(c)(3) of the Affordable Care Act; (vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR 158; (vii) Transparency of coverage measures reported to the Exchange during certification in §155.1040; and (viii) The provider directory made available to the Exchange pursuant to §156.230. (2) Is accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons with limited English proficiency. (3) Publishes the following financial information: (i) The average costs of licensing required by the Exchange; (ii) Any regulatory fees required by the Exchange; (iii) Any payments required by the Exchange in addition to fees under (i) and (ii) of this paragraph; (iv) Administrative costs of such Exchange; and (v) Monies lost to waste, fraud, and abuse. (4) Provides applicants with information about Navigators as described in §155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section. (5) Allows for an eligibility determination to be made pursuant to §155.200(c) of this subpart (6) Allows for enrollment in coverage in accordance with subpart E of this part." P. 189-191

Subject	HHS Commentary From Preamble	Regulatory Provision
	and viii. The provider directory reported to the Exchange during certification pursuant to §156.230; 2. Provides meaningful access to information for individuals with limited English proficiency. Such accessibility needs may be met by providing language assistance services, which may include translated information and "tag lines" directing individuals to translated materials and/or telephone numbers to call to reach interpreters for assistance. Websites must also be accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. HHS has issued guidance regarding the requirements of section 504 with respect to website accessibility. The guidance states that at this time, the Department will consider a recipient's websites, interactive kiosks, and other information systems addressed by section 508 standards as being in compliance with section 504 if such technologies meet those standards. We encourage States to follow either the 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities. States may wish to consult the latest section 508 guidelines issued by the US Access Board or W3C's Web Content Accessibility Guidelines (WCAG) 3. Publishes the following financial information: the average cost of licensing required by the Exchange, any regulatory fees required by the Exchange, any other payments required by the Exchange, administrative costs of the Exchange, and monies lost to fraud, waste, and abuse in accordance with section 1311(d)(7) of the Affordable Care Act. 4. Provides contact information for Navigators and other consumer assistance services, including the telephone number of the Exchange call center; 5. Allows for an eligibility determination pursuant to the standards established in accordance with §155.200(c) of this subpart; and 6. Allows for enrollment in coverage pursuant to subpart E of this part. We are considering a website requirement that would allow applicants and enrollees to store and access their personal account information and make changes, provided that the website complied with the standards developed by the Secretary pursuant to section 3021(b)(3) of the PHS Act, as added by section 1561 of the Affordable Care Act. The standards address electronic enrollment systems for Federal and State health and human services, provide for the submission and storage of electronic documents, and permit reuse of stored information.	

Subject	HHS Commentary From Preamble	Regulatory Provision
Exchange Calculator	Not mentioned in the preamble.	"Exchange calculator. The Exchange must establish and make available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions." P. 191
Call Centers	The Affordable Care Act includes several programs that aid consumers through the process of acquiring and using health insurance, including the State-based consumer assistance programs (for example, health insurance ombudsman programs created under Section 1002 of the Affordable Care Act) and the Navigator program, which we describe more fully in §155.210 below. We encourage Exchanges to use call centers as a conduit to these and any other State consumer programs, where appropriate. We also recognize there may be some instances where there is appropriate overlap between information provided by the Exchange call centers and information provided by customer service call centers operated by health insurance issuers, particularly in the area of health plan enrollment. We seek comments on ways to streamline and prevent duplication of effort by the Exchange call center and QHP issuers' customer call centers, but ensure that consumers have a variety of ways to learn about their coverage options and receive assistance on other health insurance coverage issues. P. 40	**"§155.205 Required consumer assistance tools and programs of an Exchange.** (a) Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance." P. 189
Exchange Outreach Beyond the Navigator Program	"We propose that the Exchange have a consumer assistance function (including but not limited to a Navigator program described more fully in §155.210) that provides assistance services to consumers. Exchanges will receive various types of requests for assistance from consumers, including assistance with eligibility and enrollment, appeals, and handling complaints, and must be able to direct consumers accordingly. We note that if an Exchange receives complaints of race, color national origin, disability, age, or sex discrimination, it may refer these individuals to the HHS Office for Civil Rights (OCR). In paragraph (e), we propose that the Exchange conduct outreach and education activities to educate consumers about the Exchange and to encourage participation, separate from the implementation of a Navigator program described in §155.210. Exchanges should aim to maximize enrollment of eligible individuals into QHPs to increase QHP participation and competition which in turn increases consumer choice and purchasing clout. This will also reduce the number of individuals without health insurance coverage. We encourage Exchanges to conduct outreach broadly as well as in ways that are accessible to people with disabilities, individuals with low literacy,	(d) Consumer assistance. The Exchange must have a consumer assistance function, including the Navigator program described in §155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate. (e) Outreach and education. The Exchange must conduct outreach and education activities to educate consumers about the Exchange and to encourage participation." P. 191

Subject	HHS Commentary From Preamble	Regulatory Provision
	and those with limited English proficiency. In addition, we encourage Exchanges to target specific groups including hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders." P. 44-45	

Appendix 16 – Superseded Proposed Regulations, Bulletins and Notices

Actuarial Value

On February 24, 2012, HHS released a bulletin that describes its approach to valuing plans that will be offered in the non-grandfathered small and individual markets after January 1, 2014 (whether or not offered as qualified health plans inside an exchange). The bulletin also describes HHS's intended approach for implementing one of the features of health care reform that is intended to make individual coverage obtained through an exchange affordable for eligible low-income individuals—the Actuarial Value (AV) calculator would be used to determine required cost-sharing reductions for such individuals who purchase Silver-level individual coverage through an exchange. Read the full 16-page bulletin.

Standard Data. HHS's proposed approach to the actuarial value requirements established by the ACA would be to create a national standardized approach to determining a plan's actuarial value (AV) and develop a national "actuarial value calculator" to score plans based on their included benefits. However, the bulletin also allows for a proposed degree of state-by-state flexibility. Since provider payment levels and utilization can vary substantially by state, the bulletin provides for a means for states to develop their own standardized deviation of the national actuarial value formula that insurers could use to come up with AV scores in that state.

AV Calculator Tool. HHS intends to develop a publicly available calculator tool, pre-loaded with standard data, which insurers would use to calculate their plans' AVs by inputting key information about benefit coverage and cost-sharing provisions. A plan's AV would need to be within two percentage points above or below the specified AV for the level (e.g., a Gold plan's AV could be between 78% and 82%). HHS is soliciting comments on exactly what input fields the calculator should consider and how AVs should be calculated for plan designs that do not fit within the calculator's logic.

The proposed 2016 AV methodology and a link to the proposed calculator were released on November 21, 2014.

Treatment of HSAs and HRAs. The bulletin also makes a provision to address the treatment of employer contributions to HSAs and HRAs linked to high-deductible health plans (HDHPs). HHS recognized that simply calculating the actuarial value of the HDHP based on the insurance product alone would understate the value of coverage and cause many HDHPs to fall below the Bronze level of coverage required. However, HHS also noted that accounting for the total coverage provided by the combination of the HDHP and the full value of the HSA or HRA could overstate actuarial value because, empirically, only a portion of these accounts are used toward health in a given year.

To address the issue fairly, HHS states in the bulletin, "we intend to propose that for purposes of calculating the AV of an employer health benefit plan, the annual *employer contribution* to the employee's HSA associated with a qualifying HDHP and the amount made available for the first time in a given year under a HRA that is linked to an employer health benefit plan shall be considered part of the benefit design of the health plan." (Editorial comment: "How will the insurer know what HSA contributions an employer will make?")

The November 26, 2012, proposed rule on EHBs:

- States that HHS will provide a calculator that must be used to determine actuarial value (with exceptions for unique plan designs); the proposed methodology for the calculator is provided in the proposed rule
  - For 2014 everyone must use a prescribed national standard population in the individual and small group markets
  - For 2015 and later state may elect to use a state standard population
- Provides a methodology document for the proposed calculator and the proposed calculator and continuance tables

Additional Medicare Tax

A Proposed Rule and FAQs were published December 5, 2012: Proposed Rule - Additional Medicare Tax

Questions and Answers for the Additional Medicare Tax were released on June 11, 2012.

Advanced Premium Tax Credit

On January 22, 2013, proposed regulations were issued that include rules addressing employer verification of an individual's eligibility for employer-sponsored health plan coverage and the procedures for an employer to dispute whether an individual is eligible for coverage under the health insurance exchanges. See Medicaid, CHIP, Exchange Eligibility and Appeals Proposed Rule.

An individual seeking eligibility for advance payment of the premium tax credit must provide to the exchange certain information regarding access to qualifying coverage in an employer-sponsored plan, including:

- The employer's contact information and employer identification number
- Whether the individual is employed on a full-time basis
- Whether the individual's employer provides minimum essential coverage and, if so, the required employee contribution for the lowest-cost plan offered by the employer

The exchanges can rely on methods that include HHS-approved electronic data sources (including any state-based data sources, for example, relating to a state CHIP). If an exchange cannot obtain information regarding enrollment in, and eligibility for, employer-sponsored coverage, it must undertake a random sampling process that includes:

- Informing an individual that it will contact any employer identified on the employee's application
- Making reasonable efforts to contact the employer to verify whether the individual is enrolled in an employer-sponsored plan or is eligible for qualifying plan coverage

The proposed regulations also include an appeals process under which employers can dispute a determination that either the employer:

- Does not provide minimum essential coverage under its plan
- Provides minimum essential coverage, but that coverage is not affordable for the employee identified in the notice from the exchange addressing the employer's potential tax liability

Under the appeals procedures, employers must be allowed to:

- Request an appeal within 90 days from the date the notice to the employer informing it of an employee's eligibility for advance payment of the premium tax credit or cost-sharing reductions is sent
- Submit relevant evidence to support an appeal request, for example, information addressing whether:
  - An employee is actually employed by the employer
  - Coverage is offered by the employer
  - The employee has taken this coverage

A draft application was issued by HHS on January 22, 2013: CMS-10440 | Centers for Medicare & Medicaid Services

Affordability

IRS Notice 2012-58, issued August 31, 2012, provides that at least for 2014:

- Although the availability of the credit is based on household income, under a safe harbor, an employer will be permitted to assume that an employee's household income is the same as the employee's *W-2 wages* from the employer.
- Therefore, if an employer sets employee portion of the cost of self-only coverage based on W-2 wages, the employer will *not* be subject to a penalty if the coverage turns out to be unaffordable because employee's household income is lower than W-2 wages.
- This safe harbor could result in an employee receiving the premium credit without a penalty applying to the employee's employer.

Agents and Brokers

On May 1, 2013, HHS issued guidance on the role of agents, brokers, and web-brokers in the exchanges. Agents and brokers will be required to complete training and pass a test. They will access QHPs through either the carrier's or exchange's portal (unless a web-broker). Agents and brokers may enroll individuals in an exchange plan, but they may not make determinations of eligibility for premium tax credits or cost-sharing reductions.

The above requirements were reiterated in proposed regulations issued June 19, 2013. In addition, agents and brokers in a federally facilitated exchange (FFE) must meet privacy and security requirements and must give HHS 30 days advance notice of an intent to terminate. HHS has the right to terminate an agent or broker's exchange access for cause.

Benefit and Payment Parameters

Proposed 2015 Benefit and Payment Parameters

Coverage Requirements

- Transition relief provided in proposed regulations published on January 2, 2013, on employer shared responsibility provide that six consecutive months, rather than the full 2013 calendar year, may be used to determine if the employer has averaged at least 50 full-time employees during 2013.
- Transition rules in proposed rules published January 2, 2013, provide that employers with a non-calendar year plan in effect on December 27, 2012, are not subject to penalties until the start of the 2014 plan year (a) with respect to employees eligible for coverage on December 27, 2012, and (b) with respect to those not eligible on December 27, 2012, if either 25% of all employees were covered on that date or coverage was offered to one-third of all employees during the most recent open enrollment, if affordable, minimum value coverage is offered to all full-time employees by the start of the 2014 plan year.

Employer Shared Responsibility - Proposed Rule.

Employee Waiting Periods

IRS Notice 2012-58 (issued August 31, 2012) provides that, at least for 2014, an employer that sponsors a group health plan will not be subject to the employer responsibility payment if it does not offer coverage to a new employee during the employee's first 90 days of employment.

IRS Notice 2012-59 (issued August 31, 2012) provides that:

- A measurement period that exceeds 90 days during which it is determined whether a seasonal or variable hours employee is full-time does not violate the 90 day limit.
- Other conditions for eligibility under the terms of a group health plan (full-time status, a bona fide job category, receipt of a license, etc.) are permissible, unless the condition is designed to avoid compliance with the 90-day waiting period limitation.
- A plan may provide that certain employees are eligible for coverage only after they complete a specified cumulative number of hours of service (not to exceed 1,200 hours) within a specified period.

On March 21, 2013, proposed regulations were issued that follow the two IRS Notices described above. The regulations make it clear that the 90 day limit is 90 calendar days – the first of the month following 90 days will not comply.

The proposed regulations confirm that a waiting period that is longer than 90 days is allowed for new variable hours employees while they complete their initial measurement period, and that a waiting period may be imposed after the measurement period is completed as long as both are completed by the first day of the month following completion of 13 months of employment. The proposed regulation clarifies that earnings and residual requirements under multiemployer plans are permitted types of eligibility requirements and that buying or banking hours does not violate the rule.

The waiting period limit is fully effective as of the start of the 2014 plan year. This means that starting on that date an employee may not be required to wait more than 90 days from his eligibility date to enroll, even if he was hired under the old plan terms.

See Eligibility Waiting Periods - Proposed Rule

A proposed rule would limit permitted orientation periods to one month.

Employer Reporting Obligations

On September 9, 2013, the IRS published proposed rules for reporting on minimum essential coverage to implement this requirement, which is under Code Section 6055.

On September 9, 2013, the IRS published proposed rules on reporting for large employers to implement this requirement, which is under Code Section 6056.

In June 2015 the IRS released draft reporting forms for the 2015 year, which include a few changes from the 2014 forms. The biggest difference between the 2014 and 2015 versions are on Form 1095-C, which in 2015 will likely include (assuming the draft forms are finalized as they currently appear) a "plan start month" field, allowing a filer to indicate the first month of the ALE's plan year. The draft instructions indicate this would be optional for 2015. ALEs could use the 2014 format instead of filling out the information, or in the alternative may either fill out the first month of the plan year or fill in "00" rather than the actual first month. Beginning in 2016 this field would be required. Currently it is unclear if employers can use the 2014 forms if they choose to use the 2014 format, or if they should use the 2015 format and leave the field blank.

In August 2015, the IRS released the draft instructions for 2015 reporting, which include a variety of changes from the 2014 instructions. For the 1094-C and 1095-C forms, the following important clarifications were provided: (1) who must file, (2) information on extensions and waivers, (3) how to correct returns, (4) an example and further information on the 98% offer method, (5) information on the new plan start month box, (6) multiemployer plan reporting, (7) offers of COBRA

coverage, (8) reporting on employee premiums, and (9) break in service information. For the 1094-B and 1095-B forms there were fewer updates, with information regarding penalties for not reporting and how to file for an extension. There is no target date for the final versions of either the forms or instructions, however it is generally anticipated they will be released in the fall of 2015.

However, the recent Draft Instructions for Forms 1094-B and 1095-B contain new information on page three:

Supplemental Coverage – Providers aren't required to report the following minimum essential coverage that is supplemental to other minimum essential coverage.

- Coverage that supplements a government-sponsored program, such as Medicare or TRICARE supplemental coverage.
- Coverage of an individual in more than one plan or program provided by the same plan sponsor (the plan sponsor is required to report only one type of minimum essential coverage).

Coverage isn't provided by the same plan sponsor if they aren't reported by the same reporting entity. Thus, an insured group health plan and a self-insured health reimbursement arrangement covering the employees of the same employer aren't supplemental.

This language regarding “reported by the same reporting entity” is also new. Taken at face value, this language in the draft instructions would require employers of all sizes to greatly increase their reporting obligations if they offer an HRA to employees.

- Draft 1094-C (Transmittal/cover sheet)
- Draft 1095-C (Reports to individuals and IRS on coverage offered)
- Draft 1094-B (Transmittal/cover sheet)
- Draft 1095-B (Report to individuals and the IRS on MEC)

Essential Health Benefits

On December 16, 2011, the Department of Health and Human Services (HHS) issued a bulletin outlining the approach (and proposed policies) that HHS intends to pursue in rulemaking to define essential health benefits (EHBs).

In February 2012, the Department of Health and Human Services (HHS) issued a Frequently Asked Questions (FAQ) document related to its December 16, 2011 Essential Health Benefits Bulletin which described the approach HHS intends to take in defining essential health benefits under the Patient Protection and Affordable Care Act.

Proposed rules published November 26, 2012 largely follow the approaches outlined in prior notices. The proposed rule on EHBs provides that:

- Individual and small group plans must cover the 10 essential health benefits at the prescribed “metal” levels (90%, 80%, 70% or 60%; a catastrophic option is available for those under age 30) and with allowed cost sharing levels
  - An actuarial value calculator to validate the metal levels is included
  - Each state will have its own EHBs, based on a selected benchmark plan
- Self-funded and large group plans will need to provide an actuarial benefit of at least 60% and provide coverage for certain “core” benefits – hospital and emergency care, physician and mid-level practitioner care, pharmacy, and laboratory and imaging – to be considered “minimum value.”
  - HHS and the IRS will provide a minimum value calculator similar to the actuarial value calculator for insured plans, but which uses data from self-funded plans’ standard population. They will also provide safe harbor plan designs that self-funded and large group plans could use to determine whether the

plan provides minimum value without using the calculator. Unique designs that are not suitable for either method could engage a certified actuary to make the calculation.

- Plans that cover EHBs beyond core benefits would be allowed to engage a certified actuary to determine the value of the benefit and add it to the result derived from the calculator.

- Current year employer contributions to an HSA or integrated HRA would be considered a first dollar benefit for valuation purposes.

Proposed rule: Standards Related to Essential Health Benefits, Actuarial Value and Accreditation

Excepted Benefits

A limited wraparound plan designed to equalize benefits for employees covered under the employer-sponsored health plan and those covered under a marketplace policy was proposed for 2015.

Exchanges/Tax Credits

Draft applications are at CMS-10440 - Centers for Medicare & Medicaid Services

Fixed indemnity plans

On January 24, 2013, DOL issued FAQs stating a plan with a fixed amount per procedure, visit, or prescription is not an exempt indemnity plan, as the fixed amount is not a per day or per period measure; on January 9, 2014 another FAQ was issued that allows fixed amounts on other than a per period basis if the individual policy supplements (but does not coordinate with) a group medical plan that provides minimum essential coverage.

Free Rider, Play or Pay, Employer Shared Responsibility Penalty

From Technical Release 2012-11 posted February 9, 2012: The upcoming guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer responsibility payment under Code section 4980H.

The guidance is also expected to provide that, in certain circumstances, employers have six months to determine whether a newly-hired employee is a full-time employee for purposes of section 4980H and will not be subject to a section 4980H payment during that six-month period for that employee. Treasury and the IRS intend to propose an approach under which the period of time that an employer will have to determine whether a newly-hired employee is a full-time employee (within the meaning of section 4980H) will depend upon whether, based on the facts and circumstances:

- The employee is reasonably expected as of the time of hire to work an average of 30 or more hours per week on an annual basis
- The employee's first three months of employment are reasonably viewed, as of the end of that period, as representative of the average hours the employee is expected to work on an annual basis

Specifically, it is intended that the upcoming proposed regulations or other guidance would provide, for purposes of section 4980H, that:

- If a newly-hired employee is reasonably expected to work full-time on an annual basis and does work full-time during the first three months of employment, the employee must be offered coverage under the employer's group health plan as of the end of that period in order to avoid the possibility that the employer would be subject to a section 4980H payment after the end of that three-month period.
- If, based on the facts and circumstances as of the time of hire, it cannot reasonably be determined that a newly-hired employee is expected to work full-time, the following rules will apply for purposes of determining whether the newly-hired employee is considered a full-time employee with respect to the employer's group health plan:
  - If the employee works full-time during the first three months of employment, and the employee's hours during that period are reasonably viewed, as of the end of that period, as representative of the average hours the employee is expected to work on an annual basis, the employee will first be considered a full-time employee for purposes of section 4980H as of the end of that three-month period. (If the employee works part-time during the first three months of employment, then no section 4980H penalty applies during the first or second three month period.)
  - If the employee works full-time during the first three months of employment, but the employee's hours during that period are reasonably viewed, as of the end of that period, as not representative of the average hours the employee is expected to work on an annual basis, the plan is permitted an additional three-month period to determine the employee's status, and no section 4980H payment would be required with respect to that employee during the first or second three-month periods. (If the employee works part-time during the second three months of employment, then no section 4980H penalty applies during the first, second, or third three-month period.)

This policy describes the applicability of a potential section 4980H payment with respect to newly-hired employees. Forthcoming guidance is expected also to coordinate the rules for newly-hired employees with those applicable to other employees (including employees who are transferred from one employment classification or status to another).

Two specific examples are provided in the FAQ regarding automatic enrollment, employer shared responsibility, and waiting periods.

Guaranteed Access and Renewal

A proposed rule on market rules published November 26, 2012, reiterates these requirements, with the following clarifications and modifications:

- The open enrollment for individuals would be the same both through and outside the exchange
- Small employers could enroll at any time
- Insurers could impose minimum participation and contribution requirements
- Insurers could not set commission rates so low it would discourage agents from enrolling those with significant health needs in qualified health plans

Health Insurance Providers Fee

Proposed regulations were issued March 4, 2013: Health Insurance Providers Fee - Proposed Rule

Individual Mandate

Proposed rules on the individual mandate were issued February 1, 2013.

MEWAs

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) has announced two proposed rules under the Affordable Care Act to protect businesses and workers whose health benefits are provided through a multiple employer welfare arrangement (MEWA). Comments on proposals listed below were due on or before March 5, 2012.

The proposed rules call for MEWAs to adhere to enhanced reporting requirements so that employers, workers, and their families will not unexpectedly be cut off from needed health care services. The rules also will increase the Labor Department's enforcement authority to protect participants in such plans and allow the department to shut down MEWAs engaged in fraud or other activities that present an immediate danger to the public safety or welfare.

- Proposed rule on Ex Parte Cease and Desist and Summary Seizure Orders: Multiple Employer Welfare Arrangements
- Proposed rule on Filings Required of Multiple Employer Welfare Arrangements and Certain Other Related Entities
- Notice of Proposed Revision of Annual Information Return/Reports
- Notice of Proposed Revision of the Form M-1
- Proposed Form M-1 Revisions
- Fact Sheet

Minimum Value

IRS Notice 2012-31, issued April 2012, proposed three different methods by which self-funded employers could value their plan coverage in order to determine whether or not it was “qualified/minimum value”:

- HHS intends to develop a minimum value (MV) calculator that would allow sponsors of self-funded health plans to input a limited set of information on the benefits offered under a plan, including specified cost-sharing features such as deductibles, co-insurance, and out-of-pocket maximums. The IRS expects that this information would be required for the following four “core” categories of benefits: physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services.
- An employer whose plan provides benefits in all four of the core categories described above could rely on any of several “safe-harbor checklists” to be developed by HHS and the IRS. Each such checklist would describe the cost-sharing attributes applicable to each of the four core categories of benefits.
- Plans with “nonstandard” features, such as quantitative limits on any of the core benefits (e.g., a limit on the number of physician visits or covered hospital days), could start by using the MV calculator and then have a certified actuary make the valuation adjustments needed to reflect the nonstandard features. In certain cases, an employer would even have the option of engaging a certified actuary to make the entire calculation.

The approach will be similar to that used for insured plans in the exchanges and small employer markets. HHS released a bulletin in February 2012 that describes approaches under consideration for determining actuarial value.

Under one approach *suggested* by Treasury in Notice 2011-36:

- An employer would calculate each employee's full-time status by looking back "at a defined period of not less than three but not more than 12 consecutive calendar months" to determine if the employee worked an average of 30 hours per week during this "measurement" period
- If the employee met the 30-hour standard by that measurement, the individual would be considered a full-time employee during a subsequent "stability" period, regardless of the number of hours the employee worked during that subsequent period
- For an employee determined to be a full-time employee during the measurement period, the stability period would be at least six consecutive months after the measurement period
- If an employee was determined not to be full-time during the measurement period, the employer would be allowed to exclude the individual in calculating its full-time employees during a stability period

Multi-State Plan

HHS issued a proposed rule on December 5, 2012, which reiterates the requirements described above. The proposed rule also:

- Provides that issuers will probably be charged a fee to cover administrative costs
- Provides that the multi-state plan (MSP) would need to follow all of the state rules that apply to the individual and small group market and would participate in the state risk pools
- Would allow the issuer to choose between offering the EHB package approved in each state in which it participates in the exchange, or offer any of the three largest Federal Employees Health Benefits (FEHB) Program plans by enrollment (supplemented to cover all 10 EHBs plus state mandated benefits) in all states
- The Office of Personnel Management (OPM) would handle all external claims appeals
- The state and OPM would review rates and policy forms; premiums would vary by state
- Would allow the issuer to state that OPM has certified plan and will oversee its administration
- Approval as MSP would constitute approval in all exchanges
- Would need to offer coverage in SHOP exchanges by 2018
- Is soliciting comments on whether an MSP must be available in all parts of a state (MSP would need to follow state’s designated service areas)
- Clarifies premium subsidy and cost-sharing reductions would be available on the same basis as they are in state exchanges
- Would need to provide reporting similar to that required of insurers participating in the FEHB Program
- MLR would be calculated on state-by-state basis, using a hybrid of usual and special FEHB Program rules

See the Multi-State Plan Program - Proposed Rule.

The OPM issued a draft application on September 21, 2012: Draft Multi-State Plan Program Application - Federal Business Opportunities: Opportunities

On November 21, 2014, OPM issued a proposed rule that would relax some of the coverage and timing requirements of the current rule.

Navigators

On April 5, 2013, HHS issued proposed regulations that set forth the requirements to be a navigator (up to 30 hours of training may be required; a navigator may not receive direct or indirect compensation from a health issuer or stop loss carrier): Standards for Navigators - Proposed Rule

PCORI Fee

Highlights of the proposed regulations on fees to fund the Patient Centered Outcomes Research Institute (PCORI), issued in April 2012 (and which may be relied upon pending the issuance of final regulations):

- Affected policies and plans
  - The fees paid by insurers generally apply to any accident or health insurance policy issued to U.S. residents.
  - The fees paid by self-insured plan sponsors generally apply to plans established or maintained by an employer or employee organization (or by certain other entities, including voluntary employee beneficiary associations (VEBAs)) that provide health or accident coverage, so long as any portion of that coverage is not provided through an insurance policy.
  - Policies and plans are not subject to the fees if they cover only excepted benefits.
  - Also exempt are employee assistance programs (EAPs), disease-management programs, and wellness programs if they do not provide significant benefits in the nature of medical care or treatment.
  - No exclusion is provided for retiree-only plans.
  - Comment: Under the proposed regulations, plan sponsors of fully insured health plans are not responsible for the fees; only plan insurers are.
- Definition of self-insured plan sponsor
  - Controlled group rules do not apply to PCORI fees. Consequently, if a plan is maintained by more than one employer, each employer that maintains the plan will generally be responsible for filing and paying its portion of the fees.
  - This result may be avoided if – before reporting and payment is due – an employer is designated in the plan document as sponsor, or designated as plan sponsor for purposes of the PCORI fee rules.
- Multiple self-insured arrangements
  - If the same plan sponsor maintains more than one arrangement that provides self-insured accident or health coverage – e.g., if the sponsor maintains an HRA or health FSA in addition to major medical coverage – the arrangements can be treated as a single self-insured health plan if the arrangements have the same plan year.
  - Comment: It seems unlikely that the minimal integration required in this context will be sufficient in other contexts, such as in connection with the exception to health care reform's annual limit restrictions.
- Average number of lives covered
  - For self-insured plans, any one of three methods may be used to determine the average number of lives covered:
    - An "actual count method" that takes into account the lives covered on each day during the plan year

  - A "snapshot method" based on the lives covered on one day during each quarter of the plan year (the snapshot method permits the number of lives covered by family coverage to be estimated by multiplying the number of participants by 2.35)
  - A "Form 5500 method" based on the number of participants as of the beginning and end of the plan year as reported on Form 5500 (under the Form 5500 method, the total number of lives is determined by simply adding the participant counts at the beginning and end of the year)
- Insurers cannot use the Form 5500 method, but they can use the actual count and snapshot methods as well as two other methods based on information reported to the National Association of Insurance Commissioners (NAIC) or state regulators.
- For health FSA and HRA coverage that is not disregarded under the rule for multiple self-insured arrangements (or because it offers only excepted benefits), each participant can be treated as a single life, regardless of how many other individuals (e.g., spouse, dependents, and other beneficiaries) are actually covered.

- Payment process and timing
  - PCORI fees are to be reported and paid once a year, even though they are reported on IRS Form 720 (Quarterly Federal Excise Tax Return).
  - Reports and payments for policy and plan years that end in a calendar year are generally due by July 31 of the following year.
  - Comment: While the amount of the PCORI fee is, by itself, unlikely to drive plan design, it is one more factor to be taken into account. It may be most significant with respect to health FSAs and HRAs, since failing to adequately integrate one of these account-based plans with a sponsor's self-insured major medical coverage (or to restrict the plan to excepted benefits) can result in effectively doubling the amount of the fee. (Note that integration with insured coverage will not lower total fees paid since the fee for insured coverage is paid by the insurer.)

Premium Stabilization Programs

On July 11, 2011, HHS released proposed regulations including three components that would encourage insurers to cover high-risk policy holders just as they would those who are healthy.

- A ***permanent*** risk adjustment formula that would pay insurers higher rates for sicker patients, such as those with chronic conditions. The adjustment would apply to those in the individual and small group markets ***inside and outside*** of the exchanges. Payments will essentially transfer money from plans that cover mostly low-cost individuals to those whose enrollees have higher costs. The federal government or the states would calculate the payment formulas.
- Establishing a nonprofit entity to handle temporary payments for insurers that cover patients with high medical claims in the individual market. The money will come from all insurance plans *and third-party administrators of self-insured group plans* which will contribute funds to a nonprofit that will dole out additional money to insurers who have higher claims.
- A three-year risk corridor program that would give insurers ***inside the exchanges*** more certainty by limiting losses and gains. Insurers whose claims are at least 3% higher than projected would get more federal funding, while those whose costs are at least 3% less than projected would get fewer federal dollars. (See details below.)

Requires states to provide payment to “high actuarial risk plans,” defined as plans whose enrollees’ actuarial risk for one year is greater than the average actuarial risk of all enrollees in all plans in the state for the same year.

- If a participating plan’s "allowable costs" are greater than 103% but not greater than 108% of a "target amount," the plan would be paid 50% of the amount in excess of 103% of the "target amount."
- If the "allowable costs" are greater than108%, the plan would be paid 2.5% of the "target amount" plus 80% of "allowable costs" greater than108% of the "target amount."

Requires states to assess a charge on “low actuarial risk plans,” defined as plans whose enrollees’ actuarial risk for one year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the same year.

- If a participating plan’s "allowable costs" are less than 97% but not less than 92% of a "target amount," the plan would pay in 50% of the excess of 97% of the "target amount" over the "allowable costs."
- If the "allowable costs" are less than 92%, the plan would pay in 2.5% of the "target amount" plus 80% of the excess of 92% of the "target amount" over the "allowable costs."

"Allowable costs" are defined as the total costs (other than administrative costs) of the plan in providing covered benefits, reduced by any risk adjustment and reinsurance payments received under ACA § 1341 and § 1343.

"Target amount" is total premiums (including any premium subsidies), less administrative costs.

Premium Tax Credit

Proposed rule: Health Insurance Market Rules; Rate Review

Preventive Care, Contraception

On January 23, 2012, HHS announced that nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage, will be given an additional year, until August 1, 2013, to comply with the new law. On August 15, 2012 HHS announced that the enforcement safe harbor is also available to non-profit organizations with religious objections to some but not all methods of contraception and those who unsuccessfully tried to limit or exclude tis coverage prior to February 10, 2012.

The new guidelines allow religious institutions that offer *group* insurance to their employees the choice of whether or not to cover contraception services. *This exemption does not apply to individual policies.* The definition used for religious institution is based on the definitions already in place in 28 states that allow exemptions to contraceptive coverage.

On February 6, 2013, HHS published proposed regulations that would exempt religious employers, as defined in Internal Revenue Code Section 6033(a)(3)(A)(i) or (iii) from providing contraceptive coverage if they have a religious objection to doing so. Non-profit religious organizations would not be required to offer, contract pay or refer for contraceptive coverage. The religious organization would self-certify its objection to its insurer or administrator. The insurer or administrator would be obligated to offer separate individual market coverage at no cost to interested members.

On June 28, 2013, HHS released a bulletin that provides that the temporary enforcement safe harbor with respect to religious employers covering contraception would be extended through plan years beginning on or after August 1, 2013, and ending on or before December 31, 2013. Religious organizations that previously executed the self-certification form do not need to sign another form for 2013, but they do need to re-distribute the participant notice as part of its open enrollment materials. The form and notice are contained in the June 28, 2013, CCIIO/CMS bulletin.

On June 28, 2013, HHS released final regulations that are effective with the 2014 plan year. These regulations exempt religious employers, as defined in Internal Revenue Code Section 6033(a)(3)(A)(i) or (iii), from providing contraceptive coverage if they have a religious objection to doing so. (These are churches, their integrated auxiliaries, and conventions or associations of churches, or any religious order.)

Risk Adjustments and Corridors

On December 7, 2012, HHS published a proposed rule on Benefit and Payment Parameters which:

- Includes an approval process for a state-run, permanent risk adjustment program (separate from the exchange approval process) if the state is running its own exchange
- Would impose a fee (estimated at $1 per enrollee per year) if the federal government runs the program for the state
- Describes the anticipated method of measuring risk (age, sex, diagnosis/diagnoses, metal plan and geographic region) and assign each person a risk score. The individual risk scores would be averaged for each plan, factored with plan-specific cost factors, and sums would be transferred annually between plans with high and low scores.
- Infants, children, adults, catastrophic, and student health plans each would have their own transfer program
- If the state has merged small and individual risk pools, these segments would also be combined for this program
- Only applies to non-grandfathered plans
- Applies to plans both in and outside the exchange
- Provides insurers with high-risk populations with transfer payments from insurers with lower risk populations

The temporary risk corridor program would give insurers *inside the exchanges* more certainty by limiting losses and gains. If a participating plan's "allowable costs" (claims and quality improvement expenses) are greater than103% but not greater than108% of a "target amount" (premiums less administrative costs and taxes), the plan would be paid 50% of the amount in excess of 103% of the "target amount." If the "allowable costs" are less than 97%, the plan would be paid 50% of the difference. Administrative costs, including profit, may not exceed 20% of premiums.

States could choose to change the details of reinsurance or risk adjustment from those set out by the federal standards. Any state that decides to make changes would need to publish a notice at least one year before the benefit year begins, and by March in the calendar year before the effective date.

Summary of Benefits and Coverage (SBC)

On December 30, 2014, proposed regulations that would update the requirement, including the SBC template, instructions, example calculator and uniform glossary were published. If adopted, the revised form would be used for open enrollments beginning on or after September 1, 2015, and for plan years beginning on or after September 1, 2015, for plans that do not have an open enrollment.

- The basic SBC distribution requirements would remain in effect, and a plan administrator that has multiple service providers, such as a major medical provider and a prescription drug provider, would still be allowed to provide multiple SBCs if it notified participants that the SBCs need to be considered together.
- Information about the plan's status as providing minimum essential and minimum value coverage would need to be included on the SBC itself and could no longer be provided separately. The SBC also would be required to state whether elective abortion is covered.

The SBC template itself would be shorter (about five pages compared to the current eight) to allow additional space for plans that need more room to adequately explain their benefits. A new example, involving emergency department care for a foot fracture, would be required, in addition to the current examples of a normal birth and diabetes management. The examples would still be based on figures supplied by HHS, and not actual plan data, although the figures in the HHS calculator have been updated. Most of the deletions from the SBC template involve text, not benefit information. The uniform glossary would be expanded, however.

In March 2015, the DOL issued an FAQ announcing that the regulations have been delayed and stating that the agency anticipates finalizing regulations by January 2016 to apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017.

Transitional Reinsurance Program

On December 7, 2012, a proposed rule that would make administration of the transitional reinsurance program (TRP) a largely federal function was published by HHS Proposed Rule - Payment and Benefit and Payment Parameters

- HHS would administer the program, although the state could have a supplemental program
- Each insurer or plan sponsor is to report average number of lives covered by major medical during calendar year
  - To avoid duplicate counting, the plan sponsor is responsible unless only one fully insured plan is offered
  - Counting methods are similar to those used for the PCORI program; however different counting methods could be used when counting for TRP and PCORI
  - Data would be reported by November 15 based upon covered lives during the first nine months of the calendar year. The amount to be available for this program is set out in the law ($10 billion in 2014, $6 billion in 2015, and $4 billion in 2016 for reinsurance in addition to collecting other funds from insurers such as $2 billion in 2014 to 2015 and $1 billion in 2016 for the general treasury).
  - HHS would divide that amount by the reported covered lives to create a national contribution rate. The rate multiplied by average covered lives would determine each entity's liability. That amount would be billed by the later of December 15 and 15 days after data is provided and would be due 30 days later.
  - Amounts would then be disbursed to insurers with non-grandfathered individual plans to cover 80% of claims costs in excess of a $60,000 deductible, to a maximum reimbursement of $250,000 per person. Reimbursements would be reduced pro rata if reinsurance dollars available were less than claims. Excess dollars would be rolled to the following year.

Requires one or more non-profit, state-run reinsurance entities in each state (states may jointly contract a common entity) to collect payments and use amounts collected to make reinsurance payments to health insurance issuers that cover high-risk individuals for any plan year beginning in such three-year period.

Requires HHS, in consultation with the NAIC, to establish a model regulation to carry out this provision. The model regulation:

- Must address establishing a method for determining high-risk individuals including a list of at least 50 but not more than 100 high-risk medical conditions or any other comparable objective method recommended by the American Academy of Actuaries
- Requires the formula for determining payment amounts to issuers to provide for the equitable allocation of available funds through reconciliation. Such formula may be designed to provide a schedule of payments that specifies the amount that will be paid for each of the specified conditions or may use any other comparable method recommended by the American Academy of Actuaries.

Permits contributions (that may be required to be paid to HHS in advance or periodically throughout a plan year) to be based on:

- Their fully insured commercial book of business for all major medical products and the total value of all fees charged and the costs of coverage administered by the issuer as a third party administrator, and
- The total costs of providing benefits for self-funded plans, **or** a specified amount per enrollee.

Requires all health insurance plans (individual and group markets) and third-party administrators (on behalf of group plans) to contribute $25 billion (excluding administrative expenses of the reinsurance entity) over this three-year period to a reinsurance program for individual policies, according to the following schedule:

- For 2014, $10 billion aggregate from the states, plus $2 billion in proportional payments from individual issuers
- For 2015, $6 billion aggregate from the states, plus $2 billion in proportional payments from individual issuers
- For 2016, $4 billion aggregate from the states, plus $1 billion in proportional payments from individual issuers

Contributions also can include an additional amount to fund the administrative expenses of the reinsurance entity.

Requires states to eliminate or modify and coordinate their high risk pools to the extent necessary to carry out the reinsurance program, to the extent not inconsistent with this provision.

Wellness Programs

Proposed rule - Incentives for Nondiscriminatory Wellness Programs, issued November 26, 2012.

Appendix 17 – Repealed Provisions

CLASS Act – Enrollment Eligibility *repealed January 1, 2013*

To be eligible, the participant must:

- Be 18 years old or more
- Receive taxed wages or taxed self-employment income
- Be actively employed

Ineligible employees are those who:

- Are In jail, prison, or other penal institution or correctional facility
- Receive Medicaid **and** are a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

It is unclear whether or not spouses will be eligible to enroll.

Note: In February 2011, HHS stated its intent to change the earnings and enrollment qualifications in order to insure the financial integrity of the program.

CLASS Act – Enrollment *repealed January 1, 2013*

Provides for auto-enrollment of all working individuals over age 18, but permits them to opt out.

- Employees may opt out at any time (and re-enroll during any open enrollment period).
- Requires employers who elect to offer the program to collect premiums through payroll deduction (employers without a payroll deduction program are **not** required to establish one).
- Allows employers to provide payroll deduction for premium costs for spouses not subject to automatic enrollment.

An alternative enrollment mechanism will be developed by HHS for:

- The self-employed
- People with more than one employer
- Employers who do not automatically enroll
- Those who do not earn wages

Employers appear to be required to communicate the program regardless of whether they offer it or not.

CLASS Act – Beneficiary Eligibility *repealed January 1, 2013*

"Eligible beneficiary" means any individual who:

- Is an active enrollee in the CLASS program
- As of the date the individual is determined to have a functional limitation that is expected to last for a continuous period of more than 90 days:
  - Has paid premiums in such program for at least 60 months (the vesting period)
  - Has earned, in the last three calendar years that occur during the first 60 months for which the individual has paid program premiums, at least an amount equal to the amount needed to be credited with a quarter of coverage under Social Security

If a lapse in program premiums of more than three months has occurred between the date of enrollment and the date of such determination, has paid program premiums for at least 24 consecutive months.

CLASS Act – Benefit Eligibility *repealed January 1, 2013*

All of the following are requirements for eligibility for benefits:

- A licensed health care practitioner certifies that an individual has a functional limitation that is expected to continuously last more than 90 days
- Individual is unable to perform a minimum number (which may be two or three) “activities of daily living” such that they cannot perform these functions without substantial assistance from another individual:
  - Eating
  - Toileting
  - Transferring
  - Bathing
  - Dressing
  - Continence
- Individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment or has a level of functional limitation similar to that noted above.

An active enrollee will be deemed to be presumptively eligible if the enrollee:

- Has applied for, or has attested their eligibility for, the maximum cash benefit available under the sliding scale established for the plan
- Is a patient in a hospital or long-term care nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Is in the process of, or about to begin the process of, planning to discharge from the institution, or is within 60 days of discharge from the institution

CLASS Act – Benefits *repealed January 1, 2013*

HHS, through the newly formed CLASS Independence Advisory Council, will decide the benefits, and are expected to create up to three benefit plans no later than October 1, 2012.

An eligible beneficiary will receive cash benefits, advocacy services, and advice and assistance counseling.

Eligible beneficiaries would receive not less than $50 per day (increased annually by the increase in the CPI-U), with between two and six benefit levels, scaled to the level of functional ability.

The benefit would not be subject to any lifetime or aggregate limit.

Payment of the cash benefit would go into a beneficiary's Life Independence Account for the purchase (via debit card by the beneficiary or their authorized representative) of non-medical services and supports needed to maintain independence at home or in another residential setting of their choice in the community:

- Personal assistance services
- Accessible transportation
- Home modifications
- Assistive technology
- Homemaker services
- Respite care
- Family caregivers providing community living assistance and supports
- Home care aides
- Nursing support
- Assistance with decision-making concerning medical care

Beneficiaries enrolled in Medicaid and receiving services in an institution would retain 5% of the daily or weekly cash benefit above the personal needs allowance under Medicaid, and the remainder would be applied toward the institution's cost of providing care.

Medicaid would provide secondary coverage for such care.

Beneficiaries enrolled in Medicaid and receiving Home and Community-Based Services would retain 50% of the daily or weekly cash benefit, and the remainder would be applied toward the cost to the state of providing such assistance (if the state does not include a waiver of related Social Security provisions **and** provides case management, personal care, habilitative care, and respite care services.

Medicaid would provide secondary coverage for the remainder of any costs incurred.

Note: In February 2011, HHS stated its intent to offer a range of payments instead of a single $50 daily payment indexed to inflation.

An eligible beneficiary may elect to:

- Defer and rollover the daily or weekly cash benefit from month to month, but not year to year
- Receive a lump sum payment of the accrued deferred benefits (not to exceed the annual benefit)

Benefits paid under the CLASS program are to be disregarded for purposes of determining that individual's eligibility for any other federal, state, or local assistance program (i.e., Social Security, Medicare, Medicaid, low-income housing assistance, etc.), and are paid in addition to applicable benefits from those programs.

Treats CLASS program in same manner as long-term care insurance for tax purposes.

CLASS Act – Premiums *repealed January 1, 2013*

Requires individuals to contribute monthly premiums (set by HHS based on an actuarial analysis of the 75-year costs of the program that ensures solvency through year 75).

- Charges only a nominal premium ($5/month, increased annually in advance by CPI-U) for:
  - Individuals with incomes 100% of the federal poverty level (FPL) or below
  - Actively employed individuals under age 22
  - Full-time students under age 22
- Premiums to remain the same for as long as an individual is an active enrollee in the program, although premiums can be increased if HHS determines that such increase is necessary to ensure program solvency.
- Individuals exempt from such premium increases:
  - Are age 65 or older
  - Have paid premiums for at least 20 years
  - Are not actively employed
- Permits higher age-adjusted premiums for individuals who re-enroll after a 90 day or more lapse in coverage.
- If re-enrollment occurs prior to a five-year lapse, any months of previously paid premium are credited to the individual's vesting period.
- For re-enrollment after a five-year lapse, new age-based rates apply plus a penalty of 1% of the age adjusted premiums during the lapse period (or such other penalty as HHS determines).

Note: In February 2011, HHS stated its intent to:

- Index premiums to projected benefits
- End the "loopholes" which allow beneficiaries to receive payments even if they only sporadically pay premiums

Estimated 2011 average monthly premiums:

- CMS estimate = $240 per month (factors in adverse selection)
- CBO estimate = $123 per month (no factoring for adverse selection)

After the CLASS program has been in effect 10 years, HHS shall establish future premiums such that accumulated reserves would not decrease in that year.

Employee "Free Choice" Voucher Requirement *repealed April 2011*

Employers that offer minimum essential coverage and provide any contribution are required to give "vouchers" to "qualified employees," which can be used to purchase coverage through an exchange.

Qualified employee is one:

- whose required contribution for minimum essential coverage exceeds 8.0% and does not exceed 9.8% of household income for the taxable year (which ends within the plan year), and
- whose household income is not greater than 400% of the Federal Poverty Level (FPL), and
- who does not participate in the employer-sponsored plan.

The 8.0% and 9.8% factors are to be indexed to the rate of premium growth after 2013.

The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the exchange) with respect to the plan to which the employer pays the largest portion of the cost.

- For self-insured plans, the cost is based on past experience OR a reasonable estimate for the cost of providing coverage for beneficiaries.
- Costs shall be adjusted for age and category of enrollment in accordance to regulations established by Treasury.
- Amount is equal to the premium for self-only coverage unless the employee elects family coverage. In the latter case, the voucher amount is equal to the employer contribution to family coverage.

The employer must pay the voucher amount to the exchange. If the voucher exceeds the cost of the exchange-based qualified health plan, any excess amount is paid by the employer to the employee.

The full amount of the free choice voucher is fully deductible to the employer, and the amount of the free choice voucher actually paid to the exchange is not included in the employee's gross income.

An individual receiving a voucher for a month may not receive a premium tax credit or cost-sharing subsidy for that month.

No employer mandate penalty will be assessed with respect to any employee that purchases exchange-based coverage using this voucher.

Free-Choice Voucher Qualification Table

An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute between 8.0% and 9.8% of the employee's household income toward the cost of coverage if:

- Such employee's household income is less than 400% of FPL and
- The employee does not enroll in a health plan sponsored by the employer.

The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the exchange) with respect to the plan to which the employer pays the largest portion of the cost.

% of FPL	Single Income	8.0% (Monthly)	9.8% (Monthly)	Family of 4 Income	8.0% (Monthly)	9.8% (Monthly)
100%	$10,830	$72.20	$88.45	$22,050	$147.00	$180.07
150%	$16,245	$108.30	$132.67	$33,075	$220.50	$270.11
200%	$21,660	$144.40	$176.89	$44,100	$294.00	$360.15
250%	$27,075	$180.50	$211.11	$55,125	$367.50	$450.19
300%	$32,490	$216.60	$265.34	$66,150	$441.00	$540.23
400%	$43,320	$288.80	$353.78	$88,200	$588.00	$720.29

* For the 48 contiguous states and the District of Columbia

Reporting of Income and Purchases on Form 1099 — *repealed April 14, 2011*

Requires information reporting to the IRS (on Form 1099) for payments to any person, including any corporation that is not an exempt organization under IRC § 501(a), regardless of Treasury regulations prescribed before enactment.

Generally, persons engaged in a trade or business that pays (as other fixed and determinable income or compensation) any amount greater than $600 during the year to providers of property and services will be required to file an information report with each provider and with the IRS.

Also expands the kinds of payments subject to reporting to include reporting of the amount of "gross proceeds" paid "in consideration for property or services".

Automatic Enrollment for Employers — *repealed November 2, 2015*

Employers with more than 200 full-time employees and that offer employees one or more health benefit plans must automatically enroll (and re-enroll existing) full-time employees into one of the health plans (subject to any waiting period authorized by law), in accordance with DOL regulations.

Employees must be provided with notice and an adequate opportunity to opt out of any coverage the individual or employee was automatically enrolled in.