

**Detailed Summary of Select Provisions of the  
Patient Protection and Affordable Care Act of 2010 (PPACA)  
As of January 2012**

This document provides a detailed and ongoing summary of select provisions of PPACA and related final rulemaking applicable to self-funded plans that are subject to ERISA. Most of the sections of PPACA that apply only to insurers and insured plans are omitted from this summary with the exception of those sections CoreSource determined might be of general interest to self-funded plans, such as information about health insurance Exchanges. This document is updated on a regular basis as new final rules and/or other guidance is produced by federal agencies.

This document is intended only as a summary. Nothing in this document may be construed as tax, legal or compliance advice.

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## **TITLE I, SUBTITLE A (IMMEDIATE CHANGES TO HEALTH COVERAGE)**

**Section 1001 of PPACA amends the Public Health Services Act as summarized below. Unless otherwise specified, the requirements under Section 1001 are effective for plan years beginning on or after 9/23/2010.**

### Sec. 2711 – No lifetime or annual limits

Self-funded and insured health plans (group and individual):

- 1) May not establish a lifetime limit on the dollar value of “essential health benefits.”<sup>1</sup>
  - a. Open Enrollment Right: Individuals who reached a lifetime limit prior to a plan/policy year on or after 9/23/2010 and are still otherwise eligible for coverage must be provided a notice that the lifetime limit no longer applies. If such individuals are no longer enrolled, then they must be provided with a notice and enrollment opportunity no later than the first day of the first plan year on or after 9/23/2010. The enrollment opportunity must last for at least 30 days and, in the group market, anyone enrolled under this opportunity is treated as a “special enrollee” and must have the opportunity to enroll in any benefit package available to similarly situated individuals. In the case of an individual who enrolls under this provision, coverage must be made effective no later than the first day of the first plan year on or after 9/23/2010.
    - i. Note: This notice and open enrollment opportunity requirement does not apply in the individual health market if the contract is no longer in effect as of the policy year beginning on or after 9/23/10. However, if the policy is still in force (for example, if it’s family coverage), then the individual must be given the notice and enrollment opportunity.
    - ii. Note: The notice obligation falls on both the “plan and issuer,” but once either the plan or the issuer provides notice, then the obligation has been satisfied. The notice may be provided to an employee on behalf of the employee’s dependent (or the primary subscriber on behalf of the subscriber’s dependent, in the case of an individual product). The notices may be included with other enrollment materials that a plan distributes to employees provided the statement is prominent.
- 2) May establish only a “restricted annual limit” on the dollar value of “essential health benefits” with respect to plan years beginning prior to 1/1/2014.

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<sup>1</sup> The Secretary of HHS is required to define “essential health benefits.” The law does not set a date by which this definition must be provided. At a minimum, the definition must include items and services in the following categories: (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and substance use disorder services, incl. behavioral health treatment; (F) Prescription drugs; (G) Rehabilitative and habilitative services and devices; (H) Laboratory services; (I) Preventive and wellness services and chronic disease management; (J) Pediatric services, including oral and vision care.

- 3) Annual limits on the dollar value of benefits that are essential health benefits may not be less than:
- a. \$750,000 for plan/policy years beginning on or after 9/23/10;
  - b. \$1.25 million for plan/policy years beginning on or after 9/23/11;
  - c. \$2 million for plan/policy years beginning on or after 9/23/12;
  - d. No annual dollar limits on essential health benefits are permitted on plan/policy years beginning on or after January 1, 2014.
- 4) WAIVER PROCESS –
- a. Links to guidance documents: Since the publication of the Interim Final Rule, HHS has issued a series of subsequent guidance documents describing the process for group health plans and insurers to follow to apply for a waiver from the annual dollar limit requirement imposed under PPACA as follows: September 3, 2010 [additional guidance](#); November 5, 2010 [bulletin](#); December 9, 2010 [additional guidance 1B](#) and [additional guidance 1C](#), June 17, 2011 a new Bulletin available at [http://cciio.cms.gov/resources/files/06162011\\_annual\\_limit\\_guidance\\_2011-2012\\_final.pdf](http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf).
  - b. The option to apply for the waiver is available only to those plans or policies in existence prior to September 23, 2010. With respect to a group covered by an insurance policy that was effective before 9/23/10 where the carrier was granted a waiver, the group may switch to a new insurance policy with a new carrier and keep the existing annual dollar limits in tact as long as the new carrier also receives a waiver. However, the "new" policy may not have an annual dollar limit lower than the annual dollar limit under the prior policy unless the prior carrier is no longer offering such coverage and the new carrier does not have a plan with the same annual dollar limit available.
  - c. For plan/policy years beginning on or after January 1, 2014, an annual dollar limit may not be imposed on essential health benefits.
  - d. Existing Waiver Recipients: A group health plan or insurer that received a waiver from the restricted annual dollar limit for the plan year beginning on or after 9/23/10 but before 9/23/11, and wants to extend its waiver, must complete the Waiver Extension form which will be available at: <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>
    - i. CCIIO will begin accepting Waiver Extension applications on June 24, 2011, and the deadline for receipt is September 22, 2011.
    - ii. The Waiver Extension form must be submitted by e-mail to [AnnualLimitExtension@cms.hhs.gov](mailto:AnnualLimitExtension@cms.hhs.gov) (use "Waiver Extension" as the subject of the e-mail). The applicant must also submit:
      1. Updated contact information
      2. Enrollment information
      3. Current annual dollar limit

4. Signed attestation (which will be available at <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>) attesting that: (a) the plan/policy was in existence prior to 9/23/10; (b) compliance with the annual dollar limit requirements would result in a significant decrease to access and/or a significant increase in premiums, and (c) the plan/issuer will comply with new “annual notice to consumers”.
- iii. Annual Update: In addition, applicants for the Waiver Extension must submit an “Annual Limit Update” (including the bulleted items above) by the end of each calendar year. Specifically, the first annual limit update must be submitted by 12/31/2012 and the second by 12/31/2013.
- e. New Waiver Applicants - No new waiver applications accepted after September 22, 2011.
  - i. A group health plan or insurer applying for a new waiver must complete the waiver application that will be available at: <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>
  - ii. CCIIO will begin accepting New Applications on June 24, 2011, and the deadline for receipt is September 22, 2011.
  - iii. The waiver application must be submitted by e-mail to [AnnualLimitExtension@cms.hhs.gov](mailto:AnnualLimitExtension@cms.hhs.gov) (use “New Waiver Application” as the subject of the e-mail). The applicant must also submit:
    1. A signed attestation (which will be available at <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>) attesting that: (a) the plan/policy was in existence prior to 9/23/10; (b) compliance with the annual dollar limit requirements would result in a significant decrease to access and/or a significant increase in premiums, and (c) the plan/issuer will comply with new “annual notice to consumers”.
  - iv. Annual Update: In addition, as a condition of receiving a waiver, the plan / issuer must submit an “Annual Limit Update” by the end of each calendar year. Specifically, the first annual limit update must be submitted by 12/31/2012 and the second by 12/31/2013. This update must include:
    1. Updated contact information
    2. Enrollment information
    3. Current annual dollar limit
    4. The signed attestation referenced above.
- f. Annual Notice Requirement: Every waiver recipient will be required to distribute an updated annual notice to eligible participants and subscribers as part of plan or policy materials that describe the terms of coverage (e.g. summary plan descriptions) for each plan year that the waiver applies.

- i. The notice language is available in Section V of the [Bulletin](#). The notice must be prominently displayed in 14 pt bold type on the front of plan/policy materials.

5) Note: *The annual dollar limitation provision does not apply to individual grandfathered plans.*

### Sec. 2712 Prohibition on Rescissions

Effective for plan/policy years on or after 9/23/2010, self-funded and insured group and individual health plans (both grandfathered and non-grandfathered) may not rescind coverage on the individual (or a group to which the individual belongs) unless the individual (or person seeking coverage on behalf of the individual, such as an employer) performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. This is a new “floor” for rescissions, meaning state law and case law may impose a more stringent standard. The regulations do not further define fraud or intentional misrepresentation and, therefore, existing statutory and case law would govern.

Notice of a rescission must be provided in writing at least 30 days in advance of the rescission to each participant who would be affected. Therefore, if an entire group is to be rescinded, all participants must receive this notice.

A rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance that is prospective only, or that is a result of failure to timely pay required premiums or contributions, is not a rescission.

### Sec. 2713 Coverage of Preventive Health Services

The following is a summary of the Interim Final Rule (IFR) regarding preventive services which was published in the Federal Register on July 19<sup>th</sup>.

1. **Out-of-Network Not Required** - A network plan is not required to provide coverage for, or may impose a cost-share requirement<sup>2</sup> on, preventive services if delivered by an out-of-network provider.<sup>3</sup>
2. **Covered Services** - Non-grandfathered group health plans (insured and self-funded) and individual policies with plan / policy years on or after September 23, 2010<sup>4</sup> must provide

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<sup>2</sup> The term “cost-share” as defined in Section 1302 of PPACA, applies to this provision and includes: deductibles, coinsurance, copayments, or similar charges, and any other expenditure required with respect to essential health benefits covered under the plan. Cost-share does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

<sup>3</sup> Applicable State laws that impose requirements stricter to those imposed under PPACA will continue to apply.

<sup>4</sup> Note that some of these services need not be covered until a later date. See item #3, “Delayed Applicability For Certain Services”.

coverage for the following items and services<sup>5</sup> without the imposition of any cost-sharing requirements (such as copayments, deductibles or coinsurance):

- a. A or B rated items in the current recommendations of the United States Preventive Services Task Force (USPSTF), except that USPSTF's recommendation regarding breast cancer screening, mammography and prevention issued in or around November 2009 is not considered "current". In other words, the guidelines recommending annual mammograms at 40, rather than 50, still apply.
  - b. Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  - c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
  - d. With respect to women, to the extent not already addressed by the recommendations of the USPSTF as described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. HHS is still developing these guidelines and expects to issue them by August 1, 2011.
    - i. On August 3, 2011, these guidelines supported by the HRSA were adopted. For plan years on or after August 1, 2012, non-grandfathered plans must provide a series of Women's Preventive Services including but not limited to FDA approved contraceptive methods and sterilization procedures. There is an exception to the requirement to provide coverage for contraceptives and sterilization for certain religious employers. For a complete list of women's preventive services, and the criteria for who qualifies as a "religious employer", refer to: <http://www.hrsa.gov/womensguidelines/>
3. **Delayed Applicability For Certain Services** – A plan / policy is not required to provide coverage for a particular preventive service until the plan year that begins one year after the date the recommendation or guideline was issued. For example, under the USPSTF's guidelines, screening and counseling for obesity in children was effective January 31, 2010. If the plan year begins October 1, 2010, then the plan is not required to provide coverage for screening and counseling for obesity in children under October 1, 2011.
4. **Office Visits** –
- a. If the office visit is billed separate from the preventive service, then the plan may impose a cost-share requirement on the office visit.

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<sup>5</sup> Links to complete lists of all of the recommended services and guidelines are available at: <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>. Note that these guidelines and recommendations describe several services that are not included in the list of preventive services covered by many Trustmark / CoreSource plans.

- b. If a preventive service is not billed separately from an office visit, and the primary purpose of the office visit is the delivery of the preventive service, then no cost-sharing requirements may be applied to the office visit.
  - c. If the preventive service is not billed separately from the office visit, but the primary purpose of the office visit was for something other than the delivery of the preventive service, then the plan may impose a cost-share requirement with respect to the office visit.
5. **Reasonable Medical Management** – The plan may use reasonable medical management techniques to determine appropriate frequency, method or setting for a preventive service to the extent not specified in the guidelines or recommendations. An [FAQ](#) issued by the Department of Labor ties the concept of reasonable medical management together with “value based insurance designs” and give the example that it would be acceptable for a plan to impose \$0 copayment for colorectal cancer preventive services performed at an in-network ambulatory care setting, but a \$250 copayment for the same services performed at an in-network outpatient hospital as long as the plan accommodates any individuals for whom it would be inappropriate (as determined by the attending provider) to have the services performed in the ambulatory setting.
6. **Changes to Guidelines / Recommendations** - A plan is not required to provide coverage for a service after the date the service is no longer part of a recommendation or guideline listed in #2 above. However, the Interim Final Rule (IFR) states that other Federal or State requirements may prevent the plan from discontinuing coverage for the particular service. The IFR identifies the requirement in PPACA that participants must be notified of a material modification to their plan 60 days in advance as an example.

*All grandfathered plans are exempt from this requirement.*

#### Sec. 2714 Extension of Dependent Coverage

Requires self-funded and insured plans (group and individual) that provide dependent coverage of children to cover children to age 26. This requirement is effective on the first day of the plan year (or policy year<sup>6</sup> in the case of the individual market) that is on or after 9/23/10.

Section 1251 of PPACA applies this requirement to grandfathered<sup>7</sup> plans, but group grandfathered plans may decline to extend coverage to an adult child who is eligible to enroll in another employer-sponsored health plan other than that of a parent. This limited exception for group grandfathered plans expires for plan years beginning on or after January 1, 2014.

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<sup>6</sup> “Policy year” for the individual market, means the 12-month period that is designated in the policy as “the policy year.” If there is no such designation, then the policy year is the “deductible or limit” year. If deductibles or limits are not imposed on a yearly basis, the policy year is the calendar year.

<sup>7</sup> A grandfathered plan is any individual or group health plan (whether self-funded or insured) that was in effect on 3/23/10.

On May 13, 2010, an **interim final rule** was published, setting forth the following additional requirements:

- 1) *Plan Definition:* A plan or insurer may not define a dependent child for purposes of eligibility other than in terms of the relationship between the child and the participant. Conditions of financial dependency, residency, student status, marital status, employment and availability of other coverage (except as allowed for group grandfathered plans as described above) are not permitted.
- 2) *Uniformity:* The terms of the plan may not vary based on age up to age 26. For example, a plan may not charge an additional premium or surcharge, or offer different benefit options, with respect to dependent children between age 19 and 26.
- 3) *Notice and Opportunity to Enroll:* A dependent child whose coverage ended or who was denied (or was not eligible for) coverage because the plan did not offer coverage to age 26, and who is otherwise eligible for coverage as of the first day of the first plan year beginning on or after 9/23/2010, must be given the opportunity to enroll in the plan.
  - a. Written notice of this opportunity must be provided.
  - b. The enrollment period must continue for at least 30 days.
  - c. The notice and 30-day enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after 9/23/2010.
  - d. Coverage of a child enrolled through this enrollment opportunity must take effect not later than the first day of the first plan year beginning on or after 9/23/10.
- 4) *Special Enrollee Treatment:* A child enrolling during the enrollment opportunity described above must be treated as a “special enrollee” as defined under existing law. If a plan does not allow “dependent only” coverage and an employee previously declined coverage, but the employee has a dependent child who is eligible to enroll as a result of this provision, the employee must be given the opportunity to enroll along with the dependent child if each is otherwise eligible. Further implications are discussed in the section below in reference to pre-existing conditions.

The healthcare reform legislation also amended the Internal Revenue Code effective March 30, 2010. The IRS issued [Notice 2010-38](#) regarding tax treatment of healthcare benefits for adult children. In general, several sections of the Tax Code were amended to exclude from gross income reimbursements for medical care for a child who has not attained age 27 as of the end of the taxable year. Also, the age limit, residency, support and other tests for defining a dependent child that are otherwise present in the Tax Code no longer apply in regard to reimbursements for medical care.

Notice 2010-38 also explains that cafeteria plans under §125 of the Internal Revenue Code may need to be amended no later than 12/31/2010 (with a retroactive effective date to no earlier than

3/30/2010) to allow employees to make pre-tax salary reduction contributions to cover children under age 27.

*Impact on Pre-existing Conditions:* Effective for plan years on or after 9/23/2010, pre-existing condition exclusions may not be imposed on individuals under age 19. *This pre-existing condition prohibition does not apply to grandfathered individual health plans.*

For group coverage, pre-existing condition limitations may still be imposed on children, age 19 and older, who take advantage of the enrollment opportunity described above, subject to current laws governing pre-existing conditions as they apply to “special enrollees.”

The Department of Labor issued a Frequently Asked Question which explains that the prohibition on applying traditional dependent child eligibility factors such as student status, marital status, residency or financial dependency only applies to children described in §152(f)(1) of the Internal Revenue Code which includes sons, daughters, stepchildren, adopted children (or placed for adoption) and foster children.

#### Sec. 2715 Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions

Not later than 3/23/2011, HHS (in consultation with the National Association of Insurance Commissioners, health insurers, consumer groups, patient advocates representing individuals with limited proficiency of English, and others) must develop standards for use by self-funded and insured plans (group and individual) to provide a “summary of benefits and coverage explanation” to applicants and enrollees.

Not later than 3/23/2012, the plan sponsor of a self-funded plan, or insurer of an insured plan, must, “prior to any enrollment restriction,” provide the summary of benefits and coverage explanation to: (a) an applicant at the time of application, (b) an enrollee prior to the time of enrollment or re-enrollment, and (c) a policy or certificate holder at the time of the issuance of the policy or delivery of the certificate.

At a minimum the following standards will apply to the document:

- 1) No more than 4 pages – no less than 12 pt. font.
- 2) Use of “culturally and linguistically appropriate” terminology understandable to the average plan enrollee.
- 3) Must use uniform terminology (to be provided by HHS).
- 4) Include a description of: cost-sharing requirements for essential benefits, exclusions / limitations, renewability, continuation of coverage, illustrations of common benefit scenarios (including pregnancy and chronic conditions).
- 5) Include a statement:
  - a. Whether the plan provides “minimum essential coverage,” defined in newly added Section 5000A(f) of the Internal Revenue Code as: Medicare, Medicaid,

CHIP, TRICARE, coverage through the Peace Corps, an eligible employer-sponsored health plan, an individual health plan, risk pool coverage and other coverage recognized by HHS. (Note: HIPAA Excepted Benefits<sup>8</sup> are not “minimum essential coverage”).

- b. Whether the plan’s coverage share is at least 60%.
  - c. That this is only a summary and the coverage document should be consulted.
- 6) Include a contact number for questions and a website where the actual policy or plan can be reviewed and obtained.

If the summary described above is materially modified, notice must be provided to enrollees 60 days in advance of the effective date of such modification. The Department of Labor posted an [FAQ](#) advising that group health plans are not required to provide a notice of material modification until such time that plans are provided with the format for uniform summary.

Similar state laws regarding coverage summaries are preempted to the extent they provide less information than described here.

The penalty for failure to provide the summary is not more than \$1,000 per enrollee.

#### Sec. 2715A Provision of Additional Information

A self-funded or insured plan (group or individual) that is not offered through an Exchange and is not seeking certification as a qualified health plan must still submit the information required under Section 1311(e)(3) of PPACA to the Secretary of HHS, the state insurance commissioner, and make such information available to the public.

Section 1311(e)(3) requires submission and public availability of the following information:

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<sup>8</sup> (1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof (B) Coverage issued as a supplement to liability insurance (C) Liability insurance, including general liability insurance and automobile liability insurance (D) Workers' compensation or similar insurance (E) Automobile medical payment insurance (F) Credit-only insurance (G) Coverage for on-site medical clinics (H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits (B) Benefits for long-term care, nursing home care, home healthcare, community-based care, or any combination thereof (C) Such other similar, limited benefits as are specified in regulation.

(3) Benefits not subject to requirements if offered as independent, non-coordinated benefits

(A) Coverage only for a specified disease or illness (B) Hospital indemnity or other fixed indemnity insurance

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under 42 USC 1395ss(g)(1)), coverage supplemental to the coverage provided under chapter 55 of Title 10, and similar supplemental coverage provided to coverage under a group health plan.

- 1) Claims payment policies and practices;
- 2) Periodic financial disclosures;
- 3) Data on enrollment and disenrollment;
- 4) Data on the number of claims denied;
- 5) Data on rating practices;
- 6) Information on cost-sharing and payments with respect to any out-of-network coverage;
- 7) Information on enrollee and participant rights under Title I of the PPACA;
- 8) Other information determined appropriate by HHS.

To date, no additional information about submitting this data has been published.

*This provision does not apply to any grandfathered plan.*

#### Sec. 2716. Prohibition on Discrimination in Favor of Highly Compensated Individuals

Requires insured group health plans to satisfy the requirements of 26 U.S.C §105(h)(2), which prohibits discrimination, with respect to eligibility for and benefits under a group health plan, in favor of highly compensated individuals (HCIs) as defined in §105(h)(5).<sup>9</sup> Rules “similar to” §105(h) (3), (4) and (8) shall apply.

*This requirement does not apply to any grandfathered health plan.*

On September 20, 2010, the IRS issued [Notice 2010-63](#) seeking comment from interested parties regarding additional information that would be helpful to assist in complying with the requirement. The Notice explains that a non-grandfathered, insured group health plan failing to comply with the nondiscrimination requirements of Code section 105(h) is subject to the taxes, remedies, and penalties as follows:

- 1) Under Chapter 100 of the Internal Revenue Code: An excise tax of \$100 per day, per individual discriminated against for each day the plan does not comply.
- 2) Under ERISA: A civil action to enjoin a noncompliant act or practice or for appropriate equitable relief
- 3) Under the Public Health Services Act: Civil money penalties of \$100 per day, per individual discriminated against for each day the plan does not comply.

On December 23, 2010, the IRS issued [Notice 2011-1](#) advising that the IRS, Department of Labor and Health and Human Services will not require compliance with Sec. 2716 until such

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<sup>9</sup> A highly compensated individual (HCI) means an individual who is: (a) one of the 5 highest paid officers, or (b) a shareholder who owns more than 10% in value of the stock of the employer, or (c) among the highest paid 25% of all employees. The following employees are excluded in determining the top 25%: employees who have not completed 3 yrs. of service, employees under age 25, part-time/seasonal employees, employees excluded by a collective bargaining agreement, non-resident aliens with no earned income.

time that the Departments issue further guidance, and the Departments anticipate that this guidance will not apply until plan years beginning after a specified period after such issuance.

#### Sec. 2717 Ensuring the Quality of Care

REPORTING: Not later than 3/23/2012, HHS must develop reporting requirements for self-funded plans and health insurers (for individual and group health coverage) with respect to benefits and healthcare provider reimbursement structures that:

- 1) Improve health outcomes through the implementation of activities such as quality reporting, case management, chronic disease management, medication/care compliance initiatives.
- 2) Prevent hospital readmissions.
- 3) Improve patient safety and reduce medical errors.
- 4) Implement wellness programs/health promotion activities. Such wellness programs:
  - a. May include smoking cessation, weight and stress management, physical fitness, heart disease and diabetes prevention, and healthy lifestyle support.
  - b. May not require disclosure of information about firearm possession, use or storage. May not discriminate against someone for lawful use, possession or storage of a firearm.

This report will be submitted annually to HHS (to be posted on a website) and provided to enrollees at time of each open enrollment period.

Not later than 9/23/2012, a federal study will be conducted regarding the impact of the above activities on the quality and cost of healthcare.

*This provision does not apply to any grandfathered plan.*

#### Sec. 2718 Bringing Down the Cost of Healthcare Coverage (a.k.a. Loss Ratio)

On December 1, 2010, HHS published the [Interim Final Rule](#) addressing Medical Loss Ratio (MLR) requirements and issued [Technical Corrections](#) to the IFR on December 30, 2010.

The MLR Rule applies to individual, small group and large group insurance coverage, both grandfathered and non-grandfathered.

The MLR is the ratio of the numerator (incurred claims + cost of quality improvement activities) to the denominator (premium revenue minus federal and state taxes and licensing and regulatory fees).

The target MLR is 80% for individual and small group insurance and 85% for large group insurance. Small group means 1 to 100 employees except that a state may substitute 50 for 100.

The Rule allows States to apply for a “waiver” of the MLR requirement with respect to the individual market only.

An MLR report must be submitted to HHS by June 1<sup>st</sup> following the end of an MLR reporting year, which is a calendar. The first report is due June 1, 2012 to report on 2011. A separate report is required for each state in which the carrier has business, separated by individual, small and large group business.

There are also special reporting rules for expatriate plans and for “mini-med” plans that have retained an annual dollar limit of \$250,000 or less. These plans must submit quarterly reports for the 2011 calendar year, with the first report being due on May 1, 2011.

Issuers with 50% or more of total premium for an MLR reporting year attributable to new policies (less than 12 months experience) may exclude this experience from the HHS report, but must then add the excluded experience in the following MLR reporting year.

The Rule details items that must be included, may be included and must be excluded from both premium and claims.

Certain activities that improve health care quality may be added to the numerator (with incurred claims) for purposes of calculating the MLR. These activities must be designed to accomplish one or more of the following:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
- Prevent hospital readmissions through a comprehensive program for hospital discharge.
- Improve patient safety, reduce medical errors, and lower infection and mortality rates.
- Implement, promote and increase wellness and health activities.

In addition, the activity must meet all of the following criteria. The activity must be designed to:

- Improve health quality
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
- Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
- Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

The Rule lists specific items that do not “improve health care quality”.

The carrier must also report on its other administrative expenses (i.e.: how premium revenue is used other than for incurred claims and quality improvement activities).

All of the reporting elements must include a disclosure of the methodology used to allocate expenses and evaluate quality improvement activities.

The MLR is calculated over a 3-year period, with the exception of the 2011 and 2012 MLR reporting years. Tiered “credibility adjustments” are available, with experience of less than 1,000 “life years” being non-credible and experience of 75,000 or more “life years” being fully-credible. Adjustments are also available for plans with higher deductibles.

No “life year” credibility adjustment is available if the current MLR reporting year and each of the two previous years included experience of at least 1,000 life years and, without applying the credibility adjustment, the MLR for all 3 years was below the minimum MLR threshold.

Carriers must issue a rebate to each enrollee (current or former) if the issuer’s MLR does not meet or exceed the minimum MLR. The rebate must be paid no later than the August 1 following the end of the MLR reporting year. Rebates may be in the form of a premium credit in lieu of a lump sum payment. There are reporting, record keeping and “de minimis” rules with respect to the rebates.

Penalties for non-compliance with the Rule may not exceed \$100 per day per individual affected.

Section 2718 also requires hospitals to establish, publish and update a list of their “standard charges” for items and services provided by the hospital, including for “diagnosis related groups.”

#### Sec. 2719 Appeals

Sec. 1001 of PPACA amends Sec. 2719 of the Public Health Services Act to address minimum requirements for claim, appeal and external review rights applicable to non-grandfathered group health plans (both insured and self-funded) and non-grandfathered individual policies. The requirements under this section do not apply to grandfathered plans / policies.

On July 23, 2010, the Departments of Treasury, Labor and Health and Human Services issued the Interim Final Rule (IFR) relating to internal claims and appeals and external review processes.

Since that time, the agencies have issued a series of Notices and Guidance documents designed to further define a “federal external review process” and to afford “enforcement delays” with respect to certain provisions set forth in the IFR.

On June 24, 2011, an [amendment](#) to the Interim Final Rule was published in the Federal Register, and the Departments issued a new series of supplemental guidance documents as follows: [Department of Labor Technical Release on External Review 2011-02](#); [HHS Guidance](#)

[of June 22, 2011 on External Review for Insured and Self-Funded Non-Federal Governmental Plans](#); and [HHS Guidance of June 22, 2011 on Instructions for Calculating County Level Estimates for the Culturally and Linguistically Appropriate Requirement](#). All of this information is summarized below.

The amendment to the IFR is effective on July 22, 2011. However, enforcement grace periods previously granted under prior guidance, as described in the summary below, remain in effect until the date specified.

#### 1. Claims and Internal Appeals

- a. Definitions: Except as described below, the definitions, standards and requirements set forth in 29 CFR § 2560.503-1 apply to all non-grandfathered group health plans (whether insured or self-funded) and individual health plans. Noteworthy, post-PPACA definitions include:
  - i. An “adverse benefit determination” means an adverse benefit determination as defined in 29 CFR § 2560.503-1 as well as any rescission of coverage<sup>10</sup>.
  - ii. A “final internal adverse benefit determination” means an adverse benefit determination that has been upheld by the plan or issuer at the completion of the internal appeal process (including when that process is “deemed exhausted”).
- b. Urgent Care Claims: The requirement in 29 CFR 2560.503-1 that notification of a benefit determination with respect to a claim involving urgent care must be provided in 72 hours is retained. A claim involving urgent care has the meaning given in 29 CFR 2560.503-1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.
- c. Only One Level of Appeal Allowed for Individual Health Insurers: Whereas 29 CFR 2560.503-1 allows group health plans to require two levels of internal appeals, an individual health plan may not impose more than one level of appeal before issuing a final determination.
- d. Full and Fair Review: A plan or issuer must allow a claimant to review the claim file and present evidence and testimony as part of the internal claim and appeal process. Specifically, in addition to the requirements of 29 CFR 2560.503-1(h)(2), the plan or issuer must:
  - i. Provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim.

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<sup>10</sup> Note: FAQ C-12 of the Department of Labor’s Frequently Asked Question publication available at <http://www.dol.gov/ebsa> classifies the application of any cost-sharing requirements as a “failure to make payment” and therefore as an “adverse benefit determination”. However, the scope of adverse benefit determinations subject to External Review is limited. See “Scope of Determinations Subject to External Review”.

- ii. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of a final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date.
  - iii. Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date.
- e. **Avoiding Conflicts of Interest:** In addition to the requirements of 29 CFR 2560.503-1(b) and (h) regarding full and fair review, 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. Decisions regarding hiring, compensation, termination, promotion and other similar matters with respect to any individual (e.g.: claim examiner or medical expert) must not be based upon the likelihood that the individual will support the denial of benefits.
- f. **Notices:** The Department of Labor published New Model Notices that may be used for Adverse Benefit Determinations, Final Internal Adverse Benefit determinations and Final External Review Decisions. See the Appendix of [Technical Release 2011-02](#) which was published on June 22, 2011. In addition to the notice requirements of 29 CFR 2560.503-1(g) and (j), a plan or issuer must ensure that any notice of an adverse benefit determination:
  - i. Includes information sufficient to identify the claim involved including the date of service, provider, and claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings. The plan / issuer must provide the diagnosis and treatment codes and meanings as soon as practicable upon request, and such request may not be treated as a request for an appeal.
    - 1. Regarding the requirements related to information sufficient to identify the claim other than diagnosis and treatment codes – *Enforcement delayed until plan years beginning on or after July 1, 2011.*
    - 2. Regarding the requirements related to diagnosis and treatment codes/meanings – *Enforcement delayed until plan years beginning on or after January 1, 2012.*
  - ii. Includes the reason(s) for the adverse benefit determination including 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. A

final internal adverse benefit determination must include a discussion of the decision. *Enforcement delayed until plan years beginning on or after July 1, 2011.*

- iii. Describes available internal appeals and external review processes including information regarding how to initiate an appeal. *Enforcement delayed until plan years beginning on or after July 1, 2011.*
- iv. Discloses the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with internal claim and appeal and external appeal processes. *Enforcement delayed until plan years beginning on or after July 1, 2011.*
- g. Notices in a Culturally and Linguistically Appropriate Manner: *Enforcement delay until plan years beginning on or after January 1, 2012.*
  - i. The plan / issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
  - ii. The plan / issuer must provide, upon request, a notice in any applicable non-English language; and
  - iii. The plan / issuer must include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.
  - iv. “Applicable Non-English language” – with respect to any address in any U.S. county to which a notice is sent, a non-English language is an applicable non-English language if 10% or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the Department of Labor, IRS and HHS.
    - 1. The “Supplementary Information” section of the [Amended IFR](#) contains a chart identifying counties and applicable non-English languages which may be relied upon until such time that updated information is published.
- h. Deemed Exhaustion of Internal Claim and Internal Appeal Processes: *Enforcement delay until plan years beginning on or after January 1, 2012.*
  - i. Except in the circumstances described in (ii) below, if a plan or issuer fails to adhere to all of the internal claim and internal appeal processes outlined above with respect to a claim, then the claimant is deemed to have exhausted the internal claims and internal appeals process. Accordingly, the claimant may initiate an external review as described below. Further,

for group health plans, the claimant is entitled to pursue remedies available under Section 502(a) of ERISA or under State law on the basis that the plan or issuer failed to provide a reasonable internal claim and appeal process that would yield a decision on the merits of the claim. If the claimant pursues remedies under Section 502(a) of ERISA, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary<sup>11</sup>. For individual health plans, the claimant is entitled to pursue any remedies available under State law on the basis that the plan or issuer failed to provide a reasonable internal claim and appeal process that would yield a decision on the merits of the claim.

- ii. The claim / internal appeal process will not be “deemed exhausted” based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The claimant may request a written explanation of the violation from the plan / issuer, and the plan / issuer must provide such explanation within 10 days for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or court rejects the claimant’s request for immediate relief on the basis that the plan / issuer met this standard, then the claimant has the right to resubmit and pursue internal appeal of the claim, and the plan/issuer must notify the claimant of this right within 10 days of the external reviewer’s / court’s rejection.
  - a. Requirement to Provide Continued Coverage Pending the Outcome of an Appeal: A plan or issuer must provide continued coverage pending the outcome of an appeal with respect to “ongoing” courses of treatment consistent with 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.
  - b. Record Keeping Requirements for Individual Health Insurers: A health insurance issuer offering coverage in the individual market must maintain for 6 years records of all claims and notices associated with the internal claim and appeals process<sup>12</sup>. Such records must be available for examination upon request of the claimant, State or Federal oversight agency.

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<sup>11</sup> This may impact the standard of review (a “de novo” vs. “abuse of discretion” standard) a court may apply in a civil action.

<sup>12</sup> This mirrors the minimum standards currently in place for group plans.

## **2. External Review Requirements**

- a. General: All non-grandfathered health plans are subject to an external review requirement. Which external review requirement applies depends on whether the coverage is insured, self-funded but exempt from ERISA, self-funded but subject to ERISA, whether state or federal law applies and, to the extent state law is applicable, whether the applicable state has enacted an external review law.
- b. HHS Review of States with External Review Laws
  - i. This sub-section (b) is not relevant to self-funded plans that are subject to ERISA.
  - ii. By July 31, 2011, HHS will determine whether each State's external review process meets certain standards that it has selected from the NAIC Model Law on External Reviews. HHS has decided to loosen some of the prior standards until January 1, 2014.
  - iii. If a state does not meet the "loosened" standards by December 31, 2011 then, effective January 1, 2012, an insurer or self-funded nonfederal governmental plan must utilize one of the Federal External Review Processes further described below.
    - 1. If a state does not meet the more "stringent" standards by January 1, 2014, then an insurer or self-funded nonfederal governmental plan must utilize one of the Federal External Review processes further described below.
- c. Federal External Review Process
  - i. There are 2 different Federal External Review Processes:
    - 1. The HHS-Administered Process, and
    - 2. The Private Accredited IRO Process
- d. HHS-Administered Process
  - i. Applicability: The HHS-Administered Process applies to: (1) fully insured, non-grandfathered group health plans; (2) fully-insured non-grandfathered individual health plans, and (3) self-insured nonfederal governmental plans (ex: states, cities, townships, etc.). However, as further described below, these issuers and plans will be permitted to choose between either the HHS-Administered Process or the Private Accredited IRO Process.
  - ii. Timing and Choice of Federal External Review Processes:
    - 1. Timing: If a state has any external review law in place, continue to follow that law through December 31, 2011.
    - 2. Choice: If a state does not have any external review law in place (Alabama, Nebraska, Mississippi, Virgin Islands, Guam, American Samoa and Northern Mariana Islands), then the insurer / plan may choose to follow either the HHS-Administered Process, or the Private Accredited IRO process.

- a. By the earlier of January 1, 2012 or the date by which the insurer / plan uses one of the above processes, the insurer/plan must submit to HHS via e-mail at: [externalappeals@cms.hhs.gov](mailto:externalappeals@cms.hhs.gov) a statement as to whether they will comply with the HHS-Administered Process or the Private Accredited IRO Process.
  3. Additional Reporting Requirements: By the earlier of January 1, 2012 or the date on which a plan or issuer uses the HHS-Administered Process, the issuer / plan must also send the following information to HHS via e-mail at: [externalappeals@cms.hhs.gov](mailto:externalappeals@cms.hhs.gov) :
    - a. Indicate whether PHS Act Section 2719 is applicable<sup>13</sup>;
    - b. List the products to which Sec. 2719 applies;
    - c. List the products to which Sec. 2719 does not apply and explain why the section is not applicable (ex: individual grandfathered product);
    - d. Contact information for designated personnel in the appeals department (name, address, phone and fax number, and e-mail address) – this is the person who will be contacted in the event of a request for an external review, and
    - e. Contact information for designated individual available to address urgent care cases outside of normal business hours (including weekends and holidays).
- iii. Description of HHS-Administered Process
  1. Request for External Review: The claimant or authorized representative will have four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to file a written request for an external review.
  2. Notice to Claimants: In addition to all of the content requirements outlined above, when the HHS-Administered Process applies, a notice of adverse benefit determination or final internal adverse benefit determination must also include notice that:
    - a. The claimant may request an external review by sending such request: (a) electronically to [DisputedClaim@opm.gov](mailto:DisputedClaim@opm.gov); (b) by faxing it to: 202-606-0036, or (c) by mailing it to: P.O. Box 791, Washington, DC 20044;
    - b. If the claimant has questions, they may call 877-549-8152;

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<sup>13</sup> Note: Sec. 2719 is applicable to non-grandfathered major medical business.

- c. The claimant may submit additional written comments to the external reviewer at the mailing address above;
    - d. If the claimant submits any additional information to the external reviewer, that information will be shared with the insurer and the insurer will be given the opportunity to reconsider the denial;
    - e. Includes a [Privacy Act Statement](#) the text of which is available at:  
[http://www.hhs.gov/ociio/regulations/consumerappeals/notice\\_of\\_privacy\\_act\\_rights.pdf](http://www.hhs.gov/ociio/regulations/consumerappeals/notice_of_privacy_act_rights.pdf).
  - 3. Copies of Sample Notices to HHS: Insurers must electronically provide HHS with samples of each of the notices they use containing the above information. Samples should be emailed to [externalappeals@hhs.gov](mailto:externalappeals@hhs.gov) as should any subsequently updated notices.
  - 4. Issuer / Plan Sends Information to Independent Reviewer: The Office of Personnel Management (OPM) will refer the external review request to an IRO. The IRO will then contact the insurer or plan. Within 5 business days of receipt of request from the IRO, the insurer / plan must provide the IRO:
    - a. The policy / certificate of coverage;
    - b. A copy of the adverse benefit determination;
    - c. A copy of the final internal adverse benefit determination;
    - d. A summary of the claim;
    - e. An explanation of the health insurance issuer's adverse benefit determination and final internal adverse benefit determination; and
    - f. All documents and information considered in making the adverse benefit determination or final internal adverse benefit determination including any additional information that may have been provided to the health insurance issuer or relied upon by the health insurance issuer during the internal appeals process.
      - i. All of the above information can be provided electronically at [DisputedClaim@opm.gov](mailto:DisputedClaim@opm.gov), by fax at 202-606-0036 or by priority mail to PO Box 791, Washington, DC 20044.
  - 5. IRO Timeframes and Process: Once the review is with the IRO, the same timeframes and guidelines apply as those described below under the Private Accredited IRO Process.
- e. Private Accredited IRO Process

- i. **Applicability:** The Private Accredited IRO Process applies to self-funded plans that are subject to ERISA.
- ii. **Timing:** Self-funded plans that are subject to ERISA have been subject to the Private Accredited IRO Process since plan years on or after September 23, 2010.
- iii. **Description of the Private Accredited IRO Process:**
  1. **Request for External Review:** The plan must give the claimant or authorized representative at least 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review.
  2. **Preliminary Review:** Within 5 business days of receipt of the request for an external review (or “immediately” in the case of a request for an expedited external review), the plan must determine whether:
    - a. The claimant has or had coverage at the time of the health care item or service is or was provided or requested;
    - b. External review is available based on the reason for the adverse benefit determination;
    - c. The claimant exhausted the internal appeals process, unless exhaustion is not required under the terms of the IFR (such as in the case of “deemed exhaustion” or an “expedited” external review), and
    - d. The claimant provided all information needed to process the external review.
  3. **Response to Preliminary Review:** Within 1 business day of the preliminary review determination (or “immediately” in the case of a request for an expedited external review), the plan must send written notice to the claimant (or their authorized representative) as to whether the request has been accepted. If the claimant is not eligible for external review, the notice must explain the reason for the ineligibility and give contact information for the Employee Benefits Security Administration (toll-free number: 866-444-ESBA(3272)). If the request is not complete, the notice must describe what information or materials are needed and must give the claimant until the end of the 4 month period or 48 hours, whichever is later, to provide such materials/information.
  4. **Contracting with IROs:** The plan must contract with an Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized organization. By January 1, 2012, the plan must contract with at least 2 such IROs and by July 1, 2012, the plan must contract with at least 3 such IRO.

5. Referrals to IROs and rotation: The plan must refer external reviews to the IROs on a rotating basis or other random selection method designed to ensure an independent, unbiased review. The IRO may not be eligible for financial incentives based on a likelihood that the IRO will support the denial.
6. Contract Provisions: Refer to [Technical Release 2010-01](#) for the exact language but, in general, a contract between a plan and an IRO must provide for the following:
  - a. The IRO will utilize legal experts where appropriate to make coverage determinations under the plan;
  - b. The IRO will timely notify the claimant in writing whether the request for external review has been accepted and, if accepted, that the claimant may submit in writing, within 10 business days of receipt of the notice, additional information for the IRO to consider. The IRO may, at its option, accept and consider information submitted after the 10 days;
  - c. Within 5 business days after the date of assignment of the IRO (or immediately, by e-mail, telephone, fax or any other expeditious means in the case of an expedited, external review), the plan must provide the IRO the documents and any information considered in making the adverse determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review and, in the event of such failure, the IRO may decide to reverse the plan's determination. Within 1 business day after making a decision, the IRO must notify the claimant and the plan.
  - d. Any additional information provided to the IRO by the claimant must be sent to the plan within 1 business day of receipt. The plan may reconsider its determination based on the additional information, but this must not delay the external review. If the plan reverses its decision it must, within 1 business day of such reversal, provide written notice to the IRO who will then terminate the external review.
7. The IRO will review the claim de novo and will, when appropriate, consult the claimant's medical records, physician statements, the plan document and applicable clinical guidelines and criteria.
8. IRO Decision / Notice: The IRO must provide written notice of their decision to the plan and the claimant within 45 days of receipt

of request for the external review. In the case of an expedited external review, the decision must be provided as expeditiously as the claimant's medical condition require, but in no event more than 72 hours after receipt of the request. In the case of an expedited review, if the notice is provided in some format other than in writing, written confirmation must also be provided within 48 hours of the initial notification of the determination. Technical Release 2010-10 describes the content that the IRO must include in its notice, including a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant.

9. Reversal of the Plan's Decision: If the IRO reverses the plan's adverse determination, the plan must immediately provide coverage or payment.
10. Expedited external review for self-insured group health plan: A plan must allow a claimant to request an expedited external review at the time the claimant receives:
  - a. An adverse benefit determination if such determination involves a medical condition for which the timeframe to complete an expedited internal appeal would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal appeal, or
  - b. A final internal adverse benefit determination if such determination involves a medical condition for which the timeframe to complete a standard external review would seriously jeopardize the claimant's life or health or ability to regain maximum function or if the determination concerns an admission, availability of care, continued stay, or health care item/service for which the claimant received emergency services, but has not been discharged from a facility.

f. Scope of Determinations Subject to External Review

i. For external reviews initiated before September 20, 2011:

1. The HHS-Administered Process and Private Accredited IRO Process (described above) apply to all adverse benefit determinations except for a denial, reduction, termination or failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the plan.

2. In States with an External Review law, the scope of determinations subject to external review is governed by the applicable State law, at least through December 31, 2011<sup>14</sup>.
- ii. For external reviews initiated on or after September 20, 2011:
1. The HHS-Administered Process and Private Accredited IRO Process (described above) apply only to (a) an adverse benefit determination that involves medical judgment (including, but not limited to medical necessity, appropriateness, experimental / investigational, health care setting, level of care, or effectiveness of a covered benefit), and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).
  2. In States with an External Review law, the scope of determinations subject to external review is governed by the applicable State law, at least through December 31, 2011<sup>15</sup>.

#### Sec. 2719A Patient Protections

*Nothing in Sec. 2719A applies to any grandfathered plan.*

*Provider Choice:* For plan years on or after 9/23/2010, if a plan or policy requires or provides for the designation of a participating primary care provider (PCP), then the participant may designate any participating provider available to accept the participant as the PCP. A participating provider specializing in pediatrics may be designated as a child's PCP. A female participant may not be required to obtain an authorization or referral in order to receive services from a participating OB/GYN. These provisions do not apply to any grandfathered plan.

Plans requiring designation of a PCP must provide notices regarding the rights described above in the participants summary plan description or similar description of benefits. The regulation provides the following model language:

#### Model notice language for designation of a PCP:

[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].

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<sup>14</sup> See Section titled "HHS Review of States with External Review Laws".

<sup>15</sup> See Section titled "HHS Review of States with External Review Laws".

Model notice language for designation of pediatrician as a PCP:

Include the same text as above, but add: “For children, you may designate a pediatrician as the primary care provider.”

Model notice language for OB/GYN care on plans requiring designation of a PCP:

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].

*Emergency Services:* Effective for plan/policy years on or after 9/23/2010, non-grandfathered self-funded and insured health plans (group and individual) that provide benefits for emergency services are subject to the following requirements:

- 1) May not impose a prior authorization requirement.<sup>16</sup>
- 2) May not impose any administrative requirement or limitation that is more restrictive than that applied to emergency services from in-network providers.
- 3) Any copayment and coinsurance rate requirement must be imposed equally in and out of network.
- 4) An additional deductible or out-of-pocket limit requirements may be imposed on out-of-network emergency services only as part of a deductible or out-of-pocket limit that applies generally to all out-of-network benefits.
- 5) For out-of-network providers, benefits (subject to cost-share requirements) must be in an amount equal to the greatest of: (a) the amount negotiated with in-network providers for emergency services or, if there is more than one negotiated amount, the median of these amounts,<sup>17</sup> (b) the amount using the same method generally applied by the plan to determine payments for out-of-network services such as usual and

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<sup>16</sup> The regulations, through the examples, seem to distinguish between “prior authorization” (which is not permitted) and “notification” (which is permitted). For example: A plan imposes a 25% coinsurance both in and out of network for emergency services. If the person notifies the plan within 2 days of receiving emergency services, then the plan reduces this coinsurance rate to 15%. This is permitted. However, if the plan imposed a \$60 copayment on both in and out of network emergency services, but waives the copayment if the individual receives prior authorization for the services, this is not permitted.

<sup>17</sup> Example: The plan imposes an 80% coinsurance requirement in-and-out of network and has agreements with multiple in-network providers regarding reimbursement of a particular emergency service: 1 at \$85, 2 at \$100, 2 at \$110, 3 at \$120 and 1 at \$150. The median number (the number in the middle) is \$110. (85, 100, 100, 110, **110**, 120, 120, 120, 150), so the plan would pay 80% of \$110 (\$88).

customary calculations, or (c) the amount that would be paid under Medicare for the emergency service.

*Definitions:* The regulations define the terms emergency medical condition, emergency services and stabilize by cross-referencing statutory sections of the Social Security Act. I've plugged in that "crossed referenced" language into the definitions below and then paraphrased.

- Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; a serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient.
- Stabilize means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

**Section 1002 of PPACA amends the Public Health Services Act as follows:**

Sec. 2793 – Health Insurance Consumer Information

Effective 3/23/2010, HHS will award grants to States (or Exchanges operating in States) to establish, expand or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs, that:

- Receive/respond to complaints concerning health insurance coverage;
- Assist with filing of complaints and appeals;
- Collect, track, and quantify problems and inquiries encountered by customers;
- Educate consumers on rights and responsibilities in regards to health coverage;
- Assist consumers with enrollment in health coverage; and
- Resolve problems with obtaining premium tax credits.

As a condition of receiving the grant, imposes reporting and data collection duties on state entities.

**Section 1003 of PPACA amends the Public Health Services Act as follows:**

Sec. 2794 Ensuring that Consumers Get Value For Their Dollars

Requires HHS to establish a process for the annual review of unreasonable health insurance premium increases. Carriers must provide a justification for an unreasonable increase to HHS and the relevant state prior to implementation of the increase, and the information shall be prominently posted on the issuer's website.

HHS will award grants to the states to develop programs designed to:

- 1) Review and, if appropriate under state law, approve premium increases;
- 2) Provide information about trends in premium increases and make recommendations on whether a health plan should be excluded from participation in the Exchange; and
- 3) Collect, analyze, and organize medical reimbursement information from health insurance issuers for the purpose of establishing "Medical Reimbursement Data Centers," which are non-profit institutions that analyze and publicize market rates for medical services.

Beginning with plan year 2014, HHS and the state will monitor premium increases of health insurance coverage offered both through and outside of the Exchange.

On May 19, 2011, HHS issued the final rule on this requirement. While HHS will be primarily responsible for issuing additional forms and guidance, CMS is the agency that will conduct the review.

1. **Applicability:** The rule applies to issuers offering health insurance coverage in the individual and small employer market. The rule does not apply to large group, grandfathered plans or HIPAA excepted benefits.
  - a. Small employer has the meaning given under the applicable State's rate filing laws or, if not defined, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
  - b. The rule applies "by product". A "product" is defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State."
2. **Rate increases subject to CMS review:** A rate increase filed in a State on or after September 1, 2011, or effective on or after September 1, 2011 in a State that does not require rate increases to be filed, is subject to review if:
  - a. The average rate increase for all enrollees weighted by premium volume is 10% or more, applicable to a 12-month period that begins on September 1; or

- b. For a 12-month period that begins on September 1, 2012, the average rate increase for all enrollees weighted by premium volume meets or exceeds a State-specific threshold, if such a threshold has been established.
  - c. HHS will publish a notice no later than June 1 of each year concerning whether the 10% threshold or the state-specific threshold applies.
  - d. 12 month aggregation requirement: To determine if the 10% or State specific threshold has been met or exceeded, a product rate increase must be combined with any other increases for the same product in the 12 months preceding the date on which the rate increase would become effective. Any review will include the aggregate increases during the applicable 12-month period.
3. **Unreasonable rate increase defined:** CMS will determine a rate increase to be unreasonable if the increase is:
- a. *Excessive:* Premium is unreasonably high in relation to the benefits. CMS will consider whether the increase results in a projected loss ratio below the Federal MLR (after accounting for adjustments allowed under the MLR rule), and whether the assumptions for the increase are reasonable and supported by substantial evidence.
  - b. *Unjustified:* Data is incomplete or inadequate to support reasonableness of increase.
  - c. *Unfairly discriminatory:* Increase results in premium differences between insureds within similar risk categories that are not permissible under applicable State law or, in the absence of State law, do not reasonably correspond to the differences in expected costs.
4. **CMS adoption of a State’s determination:** CMS will post and maintain on its website a list of States that it has determined to have an “Effective Rate Review Program”<sup>18</sup> in place, by market segment. CMS will adopt the “reasonableness” determination of such a State if the State provides its final determination and analysis to HHS within 5 business days following its determination on a form and in a manner prescribed by HHS.
5. **Process For Submitting Preliminary Justification of Rate Increase and Content Requirements:** For each rate increase subject to review, the issuer must submit a “Preliminary Justification” for each product affected by the increase on a form and in the manner prescribed by HHS. This Preliminary Justification will always consist of Part I

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<sup>18</sup> In order to have an Effective Rate Review Process, a State must have in place a statute or regulation that that allows it to make an effective and timely determination of whether a rate increase in the individual and small group market is unreasonable by examination of the information listed in Part 3 – “Rate filing documentation” of the Preliminary Justification as described in this Memo. In addition, the State must provide access from its website to Part I and Part II of the Preliminary Justification of the proposed rate increases that it reviews and have a mechanism for receiving public comment on those proposed rate increases.

and Part 2, but will include Part 3 only when CMS is reviewing the increase because a State does not have an Effective Rate Review Program in place.

- a. Part 1 - A rate increase summary consisting of:
  - Historical and projected claims experience;
  - Trend projections related to utilization, and service or unit cost;
  - Any claims assumptions related to benefit changes;
  - Allocation of the overall rate increase to claims and non-claims costs;
  - Per enrollee per month allocation of current and projected premium, and
  - 3-year history of rate increases for the product associated with the increase.
- b. Part 2 - A written description justifying the rate increase consisting of:
  - Simple and brief narrative describing the data and assumptions that were used to develop the rate increase to include the following:
    - i. Explanation of most significant factors causing the rate increase (including a brief description of the relevant claim and non-claim expense increases reported in the rate increase summary), and
    - ii. Brief description of the overall experience of the policy, including historical and projected expenses and loss ratios.
- c. Part 3 - Rate filing documentation. The Rule states that CMS will provide additional guidance, but that the documentation must consist of:
  - Information sufficient to examine the reasonableness of the assumptions used by the issuer to develop the increase and the validity of the historical data underlying the assumptions;
  - Data related to past projections and actual experience;
  - Medical loss ratio;
  - Capital and surplus;
  - The impact of:
    - i. medical trend, utilization and cost-sharing changes by major service categories;
    - ii. benefit changes;
    - iii. changes in enrollee risk profile;
    - iv. any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
    - v. changes in reserve needs;
    - vi. changes in administrative costs related to programs that improve health care quality;
    - vii. changes in other administrative costs, and
    - viii. changes in applicable taxes, licensing and regulatory fees.
- ix. If an issuer is also required to submit a rate filing to a State in connection with a rate increase under State law, then CMS will also accept a copy of that State filing as long as it includes all of the bulleted items for Part 3 above.
- x. If CMS requests additional information, the issuer must provide it within 10 business days of receipt of the request.

- xi. The issuer may submit a single, combined preliminary justification for rate increases subject to review affecting multiple products if the claims experience of all products has been aggregated to calculate the rate increases and the increases are the same across all products.
6. Timing for Submitting Preliminary Justification of Rate Increase: If the issuer is required to submit the rate increase filing to the applicable State prior to implementation, the issuer must submit the Preliminary Justification to CMS and the applicable State at the same time. If there is not a State filing requirement, the issuer should submit the Preliminary Justification to CMS “prior to the implementation of the rate increase”.
7. Website Posting Requirements: During the Preliminary Justification review period: CMS will post on its website the information under Parts 1 and 2 above (rate increase summary and written description). CMS will also post any information under Part 3 (rate filing documentation) that is not trade secret or confidential commercial or financial information as defined in CMS’s Freedom of Information Act regulations (45 CFR § 5.65).
  - a. CMS will post the information with a disclaimer that explains the purpose and role of the Preliminary Justification. CMS will also include information on the website concerning how the public can submit comments on the proposed rate increases that CMS reviews.
8. *Following a final determination:* If a rate increase is determined to be unreasonable (whether by CMS or by a State that CMS has identified as having an Effective Rate Review Program in place, but where the State does not have the authority to prohibit implementation of such increase), then the issuer will be notified of that determination, and HHS will post that determination on its website, both within 5 business days of the final determination.
9. *Issuer’s decision to implement an “unreasonable” increase:* If the issuer decides to implement the “unreasonable” rate increase then, within the later of 10 business days after the implementation of the increase or receipt of CMS’s final determination, the issuer must:
  - 1) Submit to CMS a Final Justification in response to CMS’s or the State’s final determination, and
  - 2) Prominently post on its website the following information in a form and manner prescribed by HHS:
    - The information under Parts 1, 2 and 3 (i.e.: rate increase summary, written description and rate filing documentation);
    - CMS’s or the State’s final determination and their explanation; and
    - The issuer’s Final Justification.
    - a. This information shall remain posted on CMS’s website and the insurer’s website for at least 3 years.

10. *Issuer's decision not to implement an increase or to implement a lower increase:* If, after an increase is determined to be unreasonable, the issuer declines to implement the increase or implements an increase lower than the threshold triggering rate review under the proposed rule, then the issuer must notify CMS of this in a timely manner on a form and in the manner prescribed by HHS. If the issuer decides to implement an increase that is lower than originally proposed, but that is still in excess of the threshold triggering rate review, then it must submit a new Preliminary Justification and the review process starts over again.

## **TITLE I, SUBTITLE B (IMMEDIATE ACTIONS TO EXPAND COVERAGE)**

*Subtitle B is effective March 23, 2010 unless otherwise specified below.*

### **Sec. 1101 - Immediate Access to Insurance For Uninsured Individuals With A Pre-existing Condition**

By June 23, 2010, HHS must establish a temporary Preexisting Condition Insurance Plan (PCIP) Program to provide coverage to individuals who have a pre-existing condition and did not have creditable coverage during the 6 months prior to applying for coverage in the pool.

On July 30, 2010, the Department of Health and Human Services issued the Interim Final Rule (IFR) relating to this Program as summarized below.

- *Program Administration:* A State (or its designated non-profit private entity) may submit a proposal to HHS to establish and administer a PCIP. If the State does not submit such a proposal, or if HHS rejects the proposal, HHS will contract with a non-profit entity directly to administer the PCIP in that State.
- *Eligibility:* An individual is eligible to enroll in a PCIP if he or she: (a) is a citizen or national of the U.S. or lawfully present in the U.S., (b) is a resident of a state within the service area of a PCIP, (c) has not been covered under creditable coverage<sup>19</sup> for a continuous 6 month period prior to applying for PCIP coverage, and (c) has a pre-existing condition<sup>20</sup>.
- *Enrollment / Disenrollment:* A PCIP must establish a system for verifying eligibility and enrollment. An individual must be allowed to remain enrolled unless: (a) the individual obtains other creditable coverage, (b) the PCIP program terminates, (c) an individual's monthly premium is not timely paid following notice and a reasonable grace period not to exceed 61 days, (d) the individual no longer resides in the PCIP service area, or (e) as specified by the PCIP and approved by HHS. A PCIP may stop taking applications for enrollments to comply with funding limitations and may employ strategies to manage enrollment as approved by HHS.

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<sup>19</sup> Definition of creditable coverage at 45 CFR 146.113(a)(1) applies.

<sup>20</sup> Definition of pre-existing condition at 45 CFR 144.103 applies.

- *Covered Benefits:* Each PCIP benefit plan will cover services in at least the following categories: inpatient and outpatient hospital services; mental health and substance abuse; professional services for injury and illness; non-custodial skilled nursing; home health services; durable medical equipment and supplies; diagnostic lab and x-ray; physical, occupational and speech therapy; hospice; emergency and ambulance services; prescription drugs; preventive care and maternity care. *Excluded Benefits:* Cosmetic services; custodial care; specified fertility services; abortion except in cases of rape, incest or life of mother endangered and experimental care.
- *No preexisting conditions or waiting periods:* Pre-existing condition exclusions and waiting periods are prohibited.
- *Premiums and cost-sharing:* PCIP premiums may not exceed 100% of the premium for the applicable standard risk rate that would apply to the coverage offered in the State<sup>21</sup>. The coinsurance rate (paid by the insurer) may not be less than 65%, and the maximum out-of-pocket (including deductibles) may not exceed the limits set forth in the Tax Code for HSA-eligible high deductible health plans (\$5,950 in 2010 for single coverage).
- *Access to Services:* A PCIP plan may specify a network of providers, but emergency services must be covered out-of-network.
- *Appeals:* A PCIP must have an appeal process for eligibility and coverage determinations.
- *Fraud, Waste and Abuse:* A PCIP must have operating procedures to prevent, detect, recover and report incidences of fraud, waste and abuse to HHS and other authorities as appropriate.
- *“Dumping” of risk by insurers and employers:*
  - A PCIP must establish procedures to identify and report to HHS instances in which health insurers or employer-based group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in instances in which such individuals subsequently are eligible to enroll in the high risk pool. The procedures, whether through the PCIP enrollment application or other vehicles, should identify instances where:
    - The individual was provided financial consideration or other reward for disenrolling from existing coverage or disincentive for remaining enrolled, or

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<sup>21</sup> The “standard risk rate” is determined by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance to individuals in the applicable State or States, using actuarial techniques that are approved by HHS and that reflect anticipated experience and expenses. Premiums may vary on the basis of age by a factor not greater than 4 to 1.

- The premium for the existing coverage was increased to an amount that exceeds the premium required by the PCIP and “this increase is not otherwise explained”.
- If HHS determines that an issuer or group health plan “dumped” a risk, the issuer or plan will be billed for the medical expenses incurred by the PCIP and will be referred to appropriate Federal and State authorities for further enforcement action if warranted.
- *Funding*: Currently \$5 billion in Federal funds is designated for the PCIP program. No more than 10% of Federal funds granted to a PCIP may be used for administrative expenses of the PCIP without HHS approval. HHS has the authority to adjust or reallocate funding.
- *Termination of PCIP*: Coverage under the PCIP program ends on January 1, 2014. Prior to termination of the Program, HHS will develop procedures to transition PCIP enrollees into Exchanges.

#### Sec. 1102 - Reinsurance for Early Retirees

NOTE: On April 5, 2011, CMS and HHS posted notice in the federal register that **no new applications for the Early Retiree Program will be accepted after May 5, 2011**. This decision is based on the availability of remaining funds appropriated to the program and the rate at which the program has been disbursing reimbursements to day. Applications received in the program’s Intake Center after May 5, 2011 will not be processed.

HHS is tasked with establishing a temporary reinsurance program to reimburse employment-based group health plans<sup>22</sup> (both insured and self-funded) a portion of the cost of providing health benefits to retirees (and to eligible dependents of retirees) between age 55 to 64 who are not actively at work and not Medicare eligible. The program is effective on June 1, 2010 and terminates ends January 1, 2014.

On May 5, 2010, Health and Human Services (HHS) issued an interim final rule, adding 45 CFR § 149.1 through 149.700 to the Code of Federal Regulations, as summarized below.

*Application to Participate*: The plan sponsor (usually the employer) applies for, and receives the reimbursement under, the early retiree reinsurance program. The plan sponsor must submit an application to HHS in order for the health plan it sponsors to be “certified” for participation under the program.

For the application and requirements see: [www.hhs.gov/ociio/regulations/index.html#early\\_retiree](http://www.hhs.gov/ociio/regulations/index.html#early_retiree)

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<sup>22</sup> HIPAA “excepted benefits” (disability income, accident only, specified disease, long term care, hospital indemnity, etc.) are excluded from the reinsurance program and payments under these plans may not be included in the cost of a claim.

At a minimum, the following are required:

1. A description of the programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with chronic and high-cost conditions. “Chronic and high-cost conditions” mean those conditions for which \$15,000 or more in claims are likely to be incurred by a single participant in a plan year.
2. The plan sponsor must:
  - a. Agree to make information and records available to HHS upon their request and to retain such information for at least 6 years after the expiration of the plan year in which costs were incurred.
  - b. Have a written agreement with its health insurer (if the plan is insured) or the group health plan (if the plan is self-funded) regarding the right of the insurer or health plan to disclose information, including Protected Health Information (PHI), to HHS on behalf of the plan sponsor for purposes of the reinsurance program.
  - c. Ensure it has policies and procedures in place to protect against fraud, waste and abuse under the reinsurance program and be able to produce and substantiate such policies/procedures.
  - d. Provide a summary indicating how the plan sponsor will use any reimbursement received under the program to reduce premium contributions and cost-sharing requirements (deductibles, copays, etc). Note: proceeds under this program may not be used as general revenue for the plan sponsor.

*Reimbursement Amount:* For each early retiree (or their dependent) enrolled in a certified plan in a plan year, the plan sponsor receives reimbursement of 80% of the costs for health benefits (net discounts, rebates, and similar consideration) for cumulative claim amounts between the “cost threshold” and the “cost limit” that are incurred during the plan year by a single early retiree (or their dependent) and are paid by the plan, insurer and/or early retiree. The cost threshold and cost limit for plan years that begin before October 1, 2011 are \$15,000 and \$90,000, respectively. These amounts will be adjusted by a percentage of CPI thereafter.

For a certified plan that has a plan year that begins before June 1, 2010, with respect to claims incurred before June 1, 2010, the amount of such claims up to \$15,000 count towards cost threshold and cost limit. The amount of claims incurred before June 1, 2010 that exceed \$15,000 are not eligible for reimbursement and do not count toward the cost limit. The reinsurance amount to be paid is based only on claims incurred on and after June 1, 2010 that fall between the cost threshold and the cost limit.

*Claim Submission:* Claims for reimbursement may not be submitted until claims paid for the early retiree have exceeded the applicable cost threshold for the plan year for the early retiree. Evidence of payment must be submitted, and if the sponsor seeks reimbursement of any portion paid by the early retiree, then evidence of the early retiree’s portion of the payment must also be

submitted. The rule describes the process for appealing in the event that HHS denies a request for reimbursement.

#### Sec. 1103 - Immediate Information That Allows Consumers To Identify Affordable Coverage Options (a.k.a. Web Portal)

By July 1, 2010, HHS is to establish a mechanism, including a website, through which individuals and small employers may identify affordable coverage options including private insurance, Medicare, Medicaid, and high-risk pool coverage.

Sec. 1103 requires HHS to collect, at a minimum, information on eligibility, availability, premium rates, cost sharing and the percentage of total premium revenue expended on non-clinical costs (as described in this memo above under Sec. 2718 of the Public Health Services Act, as amended by PPACA).

To this end, HHS created the “Office of Consumer Information and Insurance Oversight” (OCIIO), and is in the process of building an Internet-based “Health Insurance Oversight System” (HIOS).

On April 30, 2010, the OCIIO published a memo and interim final rule requiring the submission of information by state departments of insurance and insurers in the individual and small group market. In May, insurers completed, and submitted to the OCIIO, a template containing high-level product information including product name, enrollment data, availability by geographic area, provider network information and whether or not the product is open for new enrollment. The OCIIO may use this data for their July 1, 2010 HIOS launch.

In September 2010, insurers are required to submit more detailed information about “open” blocks of business including information about specific benefits, premiums, cost-sharing options and coverage limitations/exclusions. The OCIIO intends to use this data to update the HIOS by October 1, 2010.

The rule states that the OCIIO will collect additional data to supplement the HIOS by 2011. Such additional data may include: percent of rescissions, percent of policies sold at manual rate, percent of claims denied and data on appeals.

According to the OCIIO, insurers may rely on a State’s definition of “small employer” for purposes of reporting data on the small group market.

#### Sec. 1104 – Administrative Simplification

Requires HHS to adopt and update standards, specifications and rules for the electronic exchange of health information for financial and administrative transactions in order to: reduce the “clerical burden” on patients, providers and health plans; make determinations of an individual’s eligibility and financial responsibility at the point of care; reduce the need for paper and other non-electronic communications; and have a transparent claim and denial management process.

HHS is to create the following rules:

- 1) Eligibility verification and claims status operating rules by 2011, effective January 1, 2013.
  - a. On July 8, 2011, HHS issued an interim final rule outlining the Operating Rules for “Eligibility For a Health Plan Transactions” (ASC X12 270/271) and “Health Care Claim Status Transactions” (ASC X12 276/277).
  - b. Issuers and health plans must be in compliance with these operating rules by January 1, 2013.
  - c. An operating rule is the “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.
  - d. CAQH CORE is the operating rule authoring entity designated in the rule.
- 2) Claims remittance/payment, and electronic funds transfer operating rules by 2012, effective 2014.
- 3) Health claim, enrollment and disenrollment, premium payment, referral certification and authorization operating rules by 2014, effective 2016.
- 4) Unique health plan identifier rules effective not later than October 2012.
- 5) Standards for health claim attachments by 2014, effective 2016.

Plans will need to certify compliance with these operating rules. There are tiered penalties for non-compliance, not to exceed \$40 per day per covered life, for knowingly inaccurate or incomplete information.

## **TITLE I, SUBTITLE C (INSURANCE COVERAGE FOR ALL AMERICANS)**

**Section 1201 of PPACA amends the Public Health Services Act as summarized below. Unless otherwise specified, the requirements under Subtitle C are effective for plan years beginning on or after January 1, 2014. Unless otherwise specified, the provisions below apply to grandfathered plans.**

### **Sec. 2704 – Prohibition Against Pre-existing Condition Exclusions Or Other Discrimination Based on Health Status**

Self-funded and insured health plans (group and individual) may not impose a pre-existing condition exclusion (or deny coverage on the basis of a pre-existing condition) on any individual. With respect to individuals under age 19, this prohibition is effective for plan years on or after September 23, 2010 but is otherwise effective for plan years on or after January 1, 2014.

*This section does not apply to individual grandfathered plans.*

## Sec. 2701 – Fair Health Insurance Premiums

With respect to insured individual and small group<sup>23</sup> coverage, insurers may vary premium rates only by:

- 1) Individual vs. family coverage;
- 2) Rating area (states to establish, subject to HHS review);
- 3) Age (3:1) – bands to be established by HHS in consultation with the NAIC, and
- 4) Tobacco use (1.5: 1)

If, on or after 2017, an insurer issues coverage through the Exchange in the large group market, the above rating restrictions will also apply to such large group business.

This section does not apply to individual or group grandfathered plans.

## Sec. 2702 – Guaranteed Availability of Coverage

Insurers in the individual and group (small and large)<sup>24</sup> market must accept every employer and individual who applies for coverage. This requirement previously applied only to the small group market and to certain “eligible individuals” in the individual market. The insurer may apply open and special enrollment periods and the federal government is to issue regulations regarding such periods.

*This section does not apply to individual or group grandfathered plans but, because these grandfathered plans are already issued, this exemption appears insignificant.*

## Sec. 2703 – Guaranteed Renewability of Coverage

Insurers in the individual and group (small and large) market must renew coverage at the option of the employer or individual subject to exceptions under current law, which include: non-payment of premium, fraud/intentional misrepresentation, cessation of association membership,

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<sup>23</sup> Large employer and small employer group markets are defined under Sec. 1304 of PPACA, and these definitions apply to all of Title I of PPACA unless otherwise specified. Section 1304 defines a large employer as one employing an average of at least 101 employees, and a small employer as one employing at least 1 but not more than 100 employees. However, for plan years beginning before January 1, 2016, a state may define a large employer as one employing at least 51 employees, and a small employer as one employing at least 1 but not more than 50 employees. Other criteria for counting employees and determining group size apply.

<sup>24</sup> Large employer and small employer group markets are defined under Sec. 1304 of PPACA, and these definitions apply to all of Title I of PPACA unless otherwise specified. Section 1304 defines a large employer as one employing an average of at least 101 employees, and a small employer as one employing at least 1 but not more than 100 employees. However, for plan years beginning before January 1, 2016, a state may define a large employer as one employing at least 51 employees, and a small employer as one employing at least 1 but not more than 50 employees. Other criteria for counting employees and determining group size apply.

move outside of service area, product discontinuance and market exit. Basically, PPACA recodified existing law on this point.

*This section does not apply to individual or group grandfathered plans, but current law makes this exemption for grandfathered plans insignificant.*

#### Sec. 2705 – Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

Under this section, the non-discrimination laws already applicable to group coverage were extended to individual coverage. Self-funded and insured health plans (individual and group) may not establish rules for eligibility or benefits on the basis of any health-status related factor (i.e. health status, claims, receipt of care, medical history, genetic information, evidence of insurability, disability, or any other health-status related factor determined appropriate by HHS).

Prior to PPACA, the criteria for wellness programs were defined by federal regulations, not by statute. PPACA basically codified the existing regulations into law with three notable changes: (1) a reward under a “standard based” wellness program may be up to 30% of the cost of coverage under PPACA (previously 20% under the regulations) with the ability of federal regulators to increase this reward to 50%, (2) creation of a “Wellness Program Demonstration Project,” and (3) additional reporting requirements.

*Wellness Programs Generally and Rewards for Standard Based Programs* – A wellness program that conditions the attainment of a premium discount, rebate, cost-share reduction or other reward on an individual’s satisfaction of a standard that is related to a health status factor must comply with the following requirements:

- 1) The reward may not exceed 30% of the cost of coverage (employer and employee contributions) under the plan. The Secretaries of HHS, Labor and Treasury may increase the reward to 50% if deemed appropriate.
- 2) The program must have a reasonable chance of improving health or preventing disease, may not be overly burdensome, may not be a subterfuge for discriminating on the basis of health status, and may not be “highly suspect” in the method chosen to promote health or prevent disease.
- 3) Individuals must have the opportunity to qualify for the reward at least once each year.
- 4) The reward must be available to all similarly situated individuals and there must be a “reasonable alternative standard” or waiver of an otherwise applicable standard for individuals for whom it is unreasonably difficult, due to a medical condition, to satisfy the standard, or it is medically inadvisable to attempt to satisfy the standard. If “reasonable under the circumstances,” the plan or insurer may verify the existence of a medical condition or inadvisability. The availability of an alternative standard or waiver must be disclosed in plan materials.

The requirements above do not apply: (1) if the wellness program does not condition attainment of a premium discount, rebate, cost-share reduction or other reward on an individual's satisfaction of a standard that is related to a health status factor; (2) the program is available to all similarly situated individuals; and (3) the wellness program consists of one or more of the following programs: (a) reimbursement of all or part of the cost of membership at a fitness center; (b) diagnostic testing that provides a reward just for participating; (c) cost-share reductions for waivers for preventive care; (d) smoking cessation programs without regard to whether the individual actually quits; and (e) attendance at a health education seminar.

*Wellness Program Demonstration Project* – Not later than 7/1/2014, HHS, in consultation with the Dept. of Labor and Treasury, will establish a 10-state demonstration project under which participating states shall apply the wellness program provisions described above to “programs of health promotion” offered by a health insurer in the individual market. If the program is determined to be effective, it may be expanded to other states beginning on 7/1/2017. States that participate in the program may permit premium discounts, rebates or cost-share modifications for adherence to or participation in the program upon verification from the health insurer that such programs do not create undue burden on individuals in the individual market, do not lead to cost-shifting, and are not a subterfuge for discrimination.

*Additional Reporting Requirements* – Not later than 3/23/2013, HHS, in consultation with the Dept. of Labor and Treasury, will submit a report to Congress (using data collected from employers) concerning the effectiveness of wellness programs (and the different types of rewards) on promoting health, preventing disease, providing access to and increasing the affordability of coverage, and changing behaviors.

*This section does not apply to group or individual grandfathered plans, but existence of current regulations makes this exemption less significant.*

#### Sec. 2706 - Non-Discrimination in Health Care

Self-funded and insured health plans (group and individual) may not discriminate with respect to participation against any health care provider who is acting within the scope of his or her license or certification under applicable state law.

*This section does not apply to group or individual grandfathered plans.*

#### Sec. 2707 - Comprehensive Health Insurance Coverage

Insurers that offer coverage in the individual and small group market must ensure that such coverage includes the “essential health benefit package” described in Sec. 1302 of PPACA (summarized below).

Further, a “group health plan” is also subject to the annual cost-share and deductible maximum requirements provided for in Sec. 1302 (summarized below).

*This section does not apply to group or individual grandfathered plans.*

#### Sec. 2708 – Prohibition on Excessive Waiting Periods

Self-funded and insured group health plans may not apply a waiting period of greater than 90 days.

#### Sec. 2709 – Coverage for Individuals Participating in Approved Clinical Trials

Self-funded and insured plans (group and individual) may not deny a “qualified individual” participation in a clinical trial for cancer or a life-threatening disease, or deny, limit or impose additional conditions on coverage of “routine patient costs” for items and services furnished in connection with participation in the trial.

“Approved clinical trial” means a phase I, II, III or IV trial that is federally funded by specified agencies<sup>25</sup> or is conducted under an investigational new drug application reviewed by the FDA (if such application is required).

A “qualified individual” means a participant who is eligible to participate in an approved clinical trial according to the trial protocol, and either: (a) the referring provider is a participating provider who has concluded that participation is appropriate; or (b) the participant provides medical information establishing that their participation is appropriate.

“Routine patient costs” means all items and services consistent with the coverage provided in the plan that are typically covered for an individual not participating in a clinical trial. Routine patient costs do not include investigational items or services, data collection/analysis not used in the direct clinical management of the patient, or a service clearly inconsistent with widely accepted and established standards of care for the diagnosis.

Insurers are not required to provide benefits for routine patient costs provided out-of-network unless out-of-network benefits are otherwise provided under the plan.

State laws providing benefits beyond those required here will still apply.

*This section does not apply to group or individual grandfathered plans.*

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<sup>25</sup> National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines.

Sec. 1251 of PPACA – Preservation of Right to Maintain Existing Coverage (a.k.a. Grandfathered Plans)

On June 17, 2010, interim final regulations were published in the Federal Register describing the events that cause a group and individual health plan (whether insured or self-funded) to lose its grandfathered status.

The Preamble to the Interim Final Rule explains that the Federal agencies (DOL, IRS and HHS) will not enforce the market reform provisions of PPACA against retiree-only plans, plans with less than 2 participants who are current employees on the first day of the plan year or HIPAA excepted benefits<sup>26</sup>.

On November 17, 2010, the interim final regulation was amended to allow a group health plan to change insurers without losing grandfathered status in certain situations as further described below.

A grandfathered health plan means the coverage in which an individual was enrolled on March 23, 2010. The following rules apply separately to each “benefit package” made available under the plan. Footnotes provide examples derived from the regulation.

1. **Continuity:** One person must be covered under the plan from 3/23/10 forward (and this one person does not need to be the same person) in order for the plan to remain grandfathered. Any insurance policies sold in the group or individual market to new entities or individuals after 3/23/10 are not grandfathered even if the product was sold in the group or individual market prior to 3/23/10.
2. **Dependents and New Employees:** Family members of an individual who was enrolled on 3/23/10 and new employees (whether newly hired or not) may be added to the plan without losing grandfathered status. However, if the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered plan, then the plan ceases to be grandfathered.
3. **Transfer Employees:** If an employer maintains two separate plans/benefit packages on 3/23/10, the forced transfer of employees from one plan to another for a reason other than a “bona fide employment based reason” will cause both plans to lose grandfathered status if such transfer results in the occurrence of one of the events described in item #4 immediately below. A bona fide employment based reason does not include changing the terms or cost of coverage.<sup>27</sup>
4. **Plan Changes:** The following changes cause a plan to lose grandfathered status:

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<sup>26</sup> HIPAA excepted benefits include, for example: accident only, disability income, stand alone dental and vision, long term care, specified disease, hospital or other fixed indemnity, Medicare supplement or similar supplemental coverage provided to coverage under a group health plan if offered as a separate policy.

<sup>27</sup> An employer offers Plan Option A and Plan Option B on 3/23/10. On 3/23/11 the employer eliminates Option A because of its high cost and transfers employees to Option B, which has much higher cost share requirements. Both Option A and B are no longer grandfathered. In contrast, if all employees at location ABC are enrolled in Option A and all employees at location XYZ are enrolled in Option B and location ABC closes its doors then Option A may be eliminated and employees from location ABC may be transferred into Option B without Option B losing its grandfathered status.

- *Elimination of benefits*: The elimination of all or substantially all benefits or “necessary elements” to treat or diagnose a particular condition.<sup>28</sup>
- *Coinsurance increase*: The increase of any percentage cost-share requirement such as a coinsurance.
- *Deductible or out-of-pocket limit increase beyond permitted amount*: Any fixed amount cost-share requirement (such as a deductible or out-of-pocket limit) may not be increased by more than medical inflation plus 15%, measured from 3/23/2010.
  - 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. The increase in the overall care component is computed by subtracting 387.142 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.<sup>29</sup>
- *Copayment increase beyond permitted amount*: The increase to a copayment is measured from 3/23/10 and may not exceed the greater of:
  - Medical inflation (as defined above) on \$5.00, plus \$5.00 (i.e.: \$5.00 x medical inflation, plus \$5.00),<sup>30</sup> or
  - Medical inflation (as defined above) plus 15%<sup>31</sup>
- *Employer contribution decrease beyond permitted amount*: The employer decreases its contribution on the cost of coverage (applied on a tier-by-tier basis) by more than 5% below the contribution rate in effect for the coverage period that includes 3/23/10.
  - On September 20, 2010, the U.S. Department of Labor issued a series of [frequently asked questions \(FAQs\)](#), one of which acknowledges that issuers don’t always know when employer contributions decrease. Until such time that new guidance is issued, the DOL, IRS, and HHS will not treat the plan as losing grandfathered status where the issuer does not know of an employer contribution decrease as long as: (1) Upon renewal, the issuer requires the plan sponsor to make a representation regarding its contribution rate, and (2) The issuer’s policies/certificates/contracts disclose in a “prominent and effective manner” that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.

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<sup>28</sup> If a plan provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the plan is treated as having eliminated all or substantially all benefits for that mental health condition.

<sup>29</sup> On 3/23/2010 a plan has a \$500 deductible. Any number of years later, the employer wants to increase the deductible but does not want to lose grandfathered status. Within the 12-month period before the increase is to take effect, the greatest value of the overall medical care component of the CPI-U is 475. Medical inflation is 22.69% (the formula to determine medical inflation from March 2010 is:  $475 - 387.142 = 87.858 / 387.142 = 0.2269 = 22.69\%$ ). Therefore the increase may not exceed 37.69% ( $22.69\% + 15\% = 37.69\%$ ) of \$500, or \$188.45.

<sup>30</sup> On 3/23/10 a plan has a \$30 copay. Any number of years later, the employer wants to increase the copay but does not want to lose grandfathered status. Within the 12-month period before the increase is to take effect, the greatest value of the overall medical care component of the CPI-U is 485. Medical inflation is 25.27% (the formula to determine medical inflation from March 2010 is  $485 - 387.142 = 97.858 / 387.142 = 0.2527 = 25.27\%$ ). The plan may increase the copay by \$6.26 ( $\$5.00 \times 0.2527 + \$5.00 = \$6.26$ ).

<sup>31</sup> Alternatively, the plan may increase the copay by a maximum of 40.27% ( $25.27\% + 15\% = 40.27\%$ ), which is \$12.08.

- The health plan will cease to be grandfathered as of the date that the issuer knows of the 5% or more decrease or, if earlier, the date that another event causing the plan to lose its grandfathered status occurs.
  - Sponsors of multi-employer plans should follow practices similar to those above.
- *Changes in Annual Limits:* (1) The decrease from the annual dollar limit in place on 3/23/10. (2) The imposition of an overall annual dollar limit if the plan did not impose an overall annual or lifetime dollar limit on 3/23/10, or (3) The imposition of an overall annual dollar limit that is less than the lifetime dollar limit in place on 3/23/10 if the plan imposed an overall lifetime dollar limit but not an annual dollar limit on 3/23/10<sup>32</sup>.
- *Change of Insurer:* The amendment to the interim final rule issued on November 17, 2010 addresses situations where a group health plan may enter into a new insurance contract without losing grandfathered status. Note: A group health plan “enters into a new contract” if it contracts with a new insurer, or if a new policy is issued with an existing insurer. A group health plan that was in existence on or before 3/23/10 (whether insured or uninsured) that subsequently enters into a new insurance contract after 3/23/10, but before 11/15/10, will cease to be grandfathered. However, a group health plan that was in existence on or before 3/23/10 that subsequently enters into a new insurance contract on or after 11/15/10 does not cease to be grandfathered as long as none of the other conditions jeopardizing grandfathered status (as described above) result. To maintain status as a grandfathered plan, the prior issuer must provide (and the new issuer must require) documentation of the plan terms under the prior coverage sufficient to determine whether any of the conditions jeopardizing grandfathered status has occurred. Examples of such documentation include the policy of insurance or the summary plan description.
  - *Note:* persons covered under individual medical insurance policies may not change carriers without losing grandfathered status.

**5. Collectively Bargained Plans:** Insured plans maintained pursuant to a collective bargaining agreement (CBA) that was ratified before 3/23/10 are grandfathered at least until the date the CBA terminates. This is true even if the plan switches insurance providers. If the CBA ratified before 3/23/10 terminates and is replaced by a new CBA, the plan may continue to retain grandfathered status only if none of the plan changes described in item #4 occur.

**6. Transitional Rules:**

- A plan will not lose its grandfathered status with respect to changes effective after 3/23/2010 if such change is made pursuant to:
  - A legally binding agreement (including an amendment) entered into or adopted on or before 3/23/2010; or
  - A filing with a state insurance department on or before 3/23/2010.
- If a plan made one or more of the changes described in #4 above, and such changes were adopted prior to 6/14/2010 (the date these interim final rules were publicly

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<sup>32</sup> Note, however, that the IFR addressing lifetime and annual dollar limits prohibits any plan, except for individual grandfathered plans, from imposing an annual dollar limit on essential health benefits less than: \$750,000 for plan/policy years beginning on or after 9/23/10; \$1.25 million for plan/policy years beginning on or after 9/23/11; \$2 million for plan/policy years beginning on or after 9/23/12; No annual dollar limit may be imposed after January 1, 2014.

available), the plan will not lose its grandfathered status if such changes are revoked or modified as of the first day of the first plan year beginning on or after 9/23/2010. Also, the federal agencies will take into account good faith efforts made prior to 6/14/10 to reasonably comply with the grandfathering provision in PPACA and may disregard plan changes that were adopted before 6/14/10 that modestly exceed the limitations set forth in #4 above.

7. **Disclosure Requirement:** To maintain grandfathered status, the plan must include a statement in any materials provided to a participant describing the benefits provided under the plan that the plan believes it is grandfathered and must provide contact information for questions and complaints. The regulations provide the following model language:

*This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].*

*[For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]*

8. **Documentation Requirement:** Records documenting the terms of the plan in effect on 3/23/10 and any other documents necessary to verify, explain or clarify its status as a grandfathered plan must be maintained if a plan is claiming grandfathered status. Such records must be made available for examination upon request of a subscriber, state or federal agency.
9. **Impact of Grandfathering:** The following is a high-level summary of provisions in PPACA that do not apply to some or all grandfathered plans as specified below:
- Annual Limits: *Individual* grandfathered plans may apply an annual limit on the dollar value of essential health benefits. *Sec. 2711 of PHSA*

- Preventive Services: All grandfathered plans are exempt from the requirement to provide coverage for designated preventive services without the imposition of any cost-share requirement. *Sec. 2713 of PHSA*
- Dependent to Age 26: If a dependent child under the age of 26 is eligible to enroll in an employer-sponsored health plan other than that of a parent, then a *group* grandfathered plan is not required to provide coverage to that dependent child. *Sec. 2714 of PHSA*
- Provision of Additional Information: All grandfathered plans are exempt from the requirement to provide HHS, the state insurance department and the public information required under Section 1311(e)(3) of PPACA which includes information about claim payment policies and procedures, financial disclosures, data on enrollment/disenrollment, data on claim denials, data on rating practices, information on cost-sharing, information on enrollee rights and any other information deemed appropriate by HHS. *Sec. 2715A of PHSA*
- Non-discrimination in Favor of Highly Compensated Individuals: All grandfathered plans are exempt from the prohibition against favoring highly compensated employees with respect to eligibility and benefits (Note, however, that this prohibition already applies to self-funded plans). *Sec. 2716 of PHSA*
- Ensuring the Quality of Care: All grandfathered plans are exempt from the requirement to report information to HHS and enrollees regarding benefits and reimbursement structures that: improve health outcomes, prevent hospital readmissions, improve patient safety, promote health and wellness. *Sec. 2716 of PHSA*
- Appeals: All grandfathered plans are exempt from the new claim appeal processes in PPACA. *Sec. 2719 of PHSA*
- Patient Protections: All grandfathered plans are exempt from the requirements regarding access to emergency services without prior authorization and from out-of-network providers and are also exempt from the requirements allowing designation of an OB/GYN or pediatrician as a primary care provider. *Sec. 2719A*
- Ensuring that Consumers get Value For Their Dollars: All grandfathered plans are exempt from the annual review of “unreasonable” health insurance premium increases. This provision does not apply to self-funded plans regardless. *Sec. 2794 of PHSA*
- Pre-Existing Conditions: *Individual* grandfathered plans may continue to apply pre-existing condition limitations. *Sec. 2704 of PHSA.*
- Fair Health Insurance Premiums: All grandfathered plans are exempt from the requirement that insured individual and small group rates may not use health status as a rating factor. This provision does not apply to self-funded plans regardless. *Sec. 2701 of PHSA*

- **Guaranteed Availability and Renewability:** All grandfathered plans are exempt from these requirements, but current law under HIPAA makes these exemptions less significant. *Secs. 2702 and 2703 of PHSA*
- **Prohibiting Discrimination Based on Health Status:** All grandfathered plans are exempt from the requirement that the plan/insurer may not establish rules for eligibility or benefits on the basis of any health-status related factor, but current law under HIPAA makes this exemption less significant. All grandfathered plans are also exempt from the requirements for bona fide wellness programs but, again, current regulations on this point make this exemption less significant. *Sec. 2705 of PHSA.*
- **Comprehensive Health Insurance:** All grandfathered plans are exempt from the requirements to provide the “essential health benefit package” and limit cost-sharing to certain maximums. *Sec. 2707 of PHSA.*
- **Clinical Trials:** All grandfathered plans are exempt from requirements to provide clinical trial coverage. *Sec. 2709 of PHSA*

Stated differently, nothing in Subtitle A or Subtitle C of Title I of PPACA applies to a grandfathered health plan except as follows:

- 1) Sec. 2715 (uniform explanation of coverage documents)
- 2) Sec. 2718 (loss ratio, but not applicable to any self-funded plan)
- 3) Sec. 2708 (waiting periods)
- 4) Sec. 2711 (regarding lifetime and annual limits, except that the prohibition on annual limits does not apply to individual grandfathered plans)
- 5) Sec. 2712 (rescissions)
- 6) Sec. 2714 (dependent coverage to age 26, except that for plan years beginning before 1/1/2014 a group grandfathered plan may exclude coverage for a child who is eligible for employer-sponsored coverage other than through a parent)
- 7) Sec. 2704 (no pre-existing conditions for enrollees under 19 with respect to group health plans)

#### Sec. 1252 of PPACA – Rating Reforms Must Apply Uniformly To All Health Insurance Issuers and Group Health Plans

Requires States to apply standards and requirements under Title I uniformly to all health plans in an applicable insurance market.

#### Sec. 1253 of PPACA – Annual Report on Self-Insured Plans

Not later than 3/23/2011, and annually thereafter, the Secretary of Labor must submit a report to the appropriate committees in Congress about self-funded group health plans. The report data will be pulled from Form 5500 and other financial filings and will include plan type, number of participants, benefits offered, funding arrangement descriptions, assets, liabilities, contributions, investments and expenses.

## Sec. 1254 of PPACA – Study of the Large Group Market

Not later than 3/23/2011, HHS will submit a report to the appropriate committees in Congress regarding a study conducted of the self-funded and fully insured group health markets. The purpose of the study is to: (1) compare employer characteristics, health benefit plans, financial solvency and capital reserve levels; and (2) determine the extent to which new market reforms are likely to cause adverse selection in the large group market and encourage small and mid-size employers to self-fund.

The study will collect information and analyze whether self-funded plans are less costly than insured plans and why, claim denial rates, benefit fluctuations, participant recourse options, and the impact a conflict of interest between an employee’s needs and the employer’s financial considerations has on the administration of the plan.

## **TITLE I, SUBTITLE D (COVERAGE CHOICES)**

**Subtitle D is effective January 1, 2014 unless otherwise specified.**

### Sec. 1301 – Qualified Health Plans Defined

A “qualified health plan<sup>33</sup>” is a health plan<sup>34</sup> that:

1. Has been certified
2. Provides the essential health benefits package (summarized under Sec. 1302 below.)
3. Is offered by a health insurer that:
  - a. Is licensed and in good standing to offer health insurance in each state in which it offers coverage;
  - b. Offers at least one silver level plan and one gold level plan;
  - c. Charges the same premium rate regardless of whether the plan is offered through the Exchange or directly from the insurer or through an agent outside of the Exchange; and
  - d. Complies with regulations developed by the Secretary (summarized under Sec. 1311 below).

A qualified health plan may vary premiums by rating area.<sup>35</sup>

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<sup>33</sup> Any reference to a qualified health plan includes a co-op plan developed under Sec. 1322 and a multi-State plan developed under section 1334.

<sup>34</sup> The term “health plan” does not include a self-funded plan that is exempt from state insurance regulation on the basis of ERISA preemption.

<sup>35</sup> Each State shall establish 1 or more rating areas within that State. The Secretary shall review the rating areas established by each State to ensure the adequacy of such area. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

## Sec. 1302 - Essential Health Benefits Requirements

The term “essential health benefits package” means, with respect to any health plan<sup>36</sup>, coverage that:

1. Provides for essential health benefits;<sup>37</sup>
2. Limits cost-sharing as follows:
  - a. The cost-share (deductible, coinsurance, copays and similar charges<sup>38</sup>) for self-only and family coverage may not exceed the dollar amounts in effect for high deductible health plans under 26 USC § 223(c)(2)(A)(ii).<sup>39</sup> These amounts will be adjusted annually.
  - b. For small group health plans, the deductible may not exceed \$2,000 for self-only coverage or \$4,000 for any other coverage. These amounts will be adjusted annually. Deductibles may be increased by the amount of reimbursement available to participants under health flexible spending accounts.
3. Provides either bronze, silver, gold or platinum coverage (subject to the exception for ‘catastrophic only’ coverage).
  - a. Bronze = 60%<sup>40</sup>
  - b. Silver = 70%
  - c. Gold = 80%
  - d. Platinum = 90%

*Catastrophic Coverage* - The requirements applicable to the bronze, silver, gold and platinum options do not apply to “catastrophic plans.” A catastrophic plan may only be offered in the individual market, may only cover individuals under age 30 or who are exempt from the individual coverage mandate, may not pay benefits (except preventive benefits) until the maximum out-of-pocket thresholds applicable to high deductible health plans (\$5,950 for self-only and \$11,900 for family in 2010) have been met, and must cover at least 3 primary care visits.

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<sup>36</sup> The term “health plan” does not include a self-funded plan that is exempt from state insurance regulation on the basis of ERISA preemption.

<sup>37</sup> The term essential health benefits is to be further defined by regulation but includes at least the following categories of services: (a) ambulatory patient services, (b) emergency services, (c) hospitalization, (d) maternity and newborn services, (e) mental health and substance abuse services, (f) prescription drugs, (g) rehabilitative and habilitative services and devices, (h) laboratory services, (i) preventive and wellness services and chronic disease management, (j) pediatric services, including oral and vision care.

<sup>38</sup> The term cost-share does not include premiums, balance bill amounts for non-network providers or spending on non-covered services.

<sup>39</sup> For 2010, the maximum cost share for high deductible health plans is \$5,950 for self-only coverage and \$11,900 for family coverage.

<sup>40</sup> These percentages represent the percent of the full actuarial value of benefits provided under the plan. Employer contributions to health savings accounts (HSAs) may be taken into account in determining this value. Further regulations will be issued.

*Child Only Coverage* – If the insurer offers a bronze, silver, gold or platinum plan, it must also offer such coverage as a plan in which only individuals under the age of 21 may enroll.

### Sec. 1303 – Special Rules

*Abortion Coverage:* A qualified health plan is not required to provide coverage for abortion. To the extent that a qualified health plan does provide coverage for abortion, a State may enact a law prohibiting abortion coverage in qualified health plans offered through its Exchange. If a qualified health plan does provide coverage for abortion except in the case of rape, incest or when the mother’s life is threatened, federal funds (whether in the form of a premium tax credit or cost-share reduction) may not be used to pay for abortion services. Instead, the issuer must separately collect amounts attributable to such services from enrollees and deposit such payments into a separate account. Pursuant to an Executive Order issued by President Obama, the Office of Management and Budget and HHS are to issue guidelines regarding this segregation of funds by September 2010.

### Sec. 1304. Definitions

The following definitions apply to Title I.

1. **Group Market** = The health insurance market where individuals obtain health insurance coverage through a group health plan maintained by an employer.
2. **Individual Market** = The health insurance market where coverage is offered to individuals other than in connection with a group health plan.
3. **Large Employer** = An employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the first plan year.
4. **Small Employer** = An employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
  - a. *Group Size prior to 1/1/2016:* For plan years beginning before January 1, 2016, a State may adjust the number of employees in the above definitions to define a large employer as 51+ employees, and a small employer as 1 to 50 employees.
  - b. *New Businesses:* If the employer did not exist in the preceding calendar year, the determination of group size will be based on the average under of employees the employer reasonable expects to employ in the current calendar year.
  - c. *Aggregation Rules:* For purposes of determining which entities should be viewed as a single employer (in order to determine the number of employees), the “aggregation” rules set forth in Section 414 (b), (c), (m) and (o) of the Internal Revenue Code apply (addressing controlled groups for corporations, other business structures under common control, affiliated service groups, etc.)
  - d. *Growing Employee Count:* At least until 1/1/2017, only individuals and small employers may participate in the Exchange. However, a small employer providing

coverage through the Exchange who ceases to meet the definition of a small employer because of an increase its employee population may continue to provide such coverage.

### Sec. 1311 – Affordable Choices of Health Benefit Plans

- *Funding*: No later than 3/23/2011, HHS will begin to make awards to the States to establish an American Health Benefit Exchange. No grants will be awarded after 1/1/2015, but the Exchange may charge assessments to participating health insurance issuers. The Exchange will publish information about its administrative costs and information about money lost to fraud, waste and abuse.
- *Creation*: No later than 1/1/2014, each State will establish an Exchange that facilitates the purchase of qualified health plans by individuals and small employers. Each Exchange will have a Small Business Health Options Program (“SHOP Exchange”) designed to assist small employers. A State may “merge” its individual and small employer Exchanges services. An Exchange will be a governmental agency or non-profit entity established by a State.
  - A State may contract with an “eligible entity” to carry out the responsibilities of the Exchange. The entity must have demonstrated experience in individual and small group insurance and benefits and may not be health insurance issuer or under common control with a health insurance issuer.<sup>41</sup>
  - An Exchange may operate in more than one State or with approval from HHS or have geographically distinct “subsidiary” Exchanges.
- *Minimum Functions of Exchange*: The Exchange must: (a) implement procedures for certification, recertification, and decertification, (b) provide a toll-free customer service line, (c) maintain an Internet website for comparative plan information, (d) rate each plan, (e) use standardized plans options and benefit outlines, (f) provide information on eligibility for Medicaid, CHIP and other governmental programs, (g) establish an electronic calculator to determine the cost of coverage including premium tax credits or cost-share reductions, (h) provide a certification an individual may use to avoid the “individual responsibility penalty” and share information about the existence of coverage with the Dept. of Treasury / IRS and employers, if applicable, and (i) provide a “Navigator” program.
- *Navigators*: Exchanges may award grants to entities to provide services to and for prospective and enrolled Exchange participants including, but not limited to: facilitating enrollment in qualified health plans, referring grievances / questions to the appropriate resources, conduct education activities, distributing impartial information about health plans and eligibility / tax information and other services. Navigators may not be health insurers or receive any consideration directly or indirectly from health insurers.
- *Certification and Premiums*: HHS will establish criteria for certification of a plan as a “qualified health plan”. The criteria will address:

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<sup>41</sup> As determined by 26 U.S.C. §52(a) and (b).

- marketing requirements;
- provider choice and access including in low-income/underserved areas;
- accreditation on clinical quality measures, consumer access, utilization management, quality assurance, provider credentialing, complaints/appeals, network adequacy;
- implementation of a “quality improvement strategy” which provides increased reimbursement or other incentives for improving health outcomes, preventing hospital readmissions, improving patient safety, implementing wellness promotion activities, reducing health care disparities, all as described in guidelines issued by HHS.
- utilization of a uniform enrollment form and standardized plan option format; and
- public reporting (via Internet website) of ‘performance information’ summarizing data on quality measures and annual reporting to HHS on pediatric quality reporting measures.

An Exchange may not exclude a health plan through the imposition of premium price controls, but an Exchange will require health plans seeking certification to submit a justification for any premium increase prior to implementation of the increase and post such information on the Internet.

- *Rating and Enrollee Satisfaction:* HHS is to develop a system to “rate” qualified health plans on the Exchange on the basis of relative quality and price. Qualified health plans with more than 500 enrollees would be subject to an enrollee satisfaction survey the results of which would be available on the Internet.
- *Internet Portals:* The portals established under Sec. 1103 of PPACA will be expanded to support the Exchanges and will be used for individuals and small employers to view standardized information on qualified health plans and determine eligibility to participate, and receive a tax credit / cost-share reduction.
- *Enrollment Periods:* Future regulations will define the periods during which individuals and small employers may enroll through the Exchange including an initial enrollment period, annual open enrollment period, special enrollment periods, and monthly enrollment periods for Native Americans.
- *More than Essential Health Benefits:* A qualified health plan must offer essential health benefits, but a State may require the plan to offer additional benefits. If a State imposes an “additional benefit” requirement, the State must make payments to the enrolled individual or to the plan to defray the cost of the additional benefits.
- *Dental Plans:* Dental coverage, whether stand alone or offered in conjunction with a qualified health plan, may be offered through the Exchange as long as it provides pediatric dental benefits.
- *Transparency:* Certified qualified health plans must submit to HHS, the Exchange and the State Insurance Commissioner and make available to the public: (a) claim payment policies / practices, (b) periodic financial disclosures, (c) data on enrollment / disenrollment, (d) number of claims denied, (e) rating practices, (f) cost-sharing data, (g) information on participant rights. Information to the public must be in “plain language”, using standards developed by the government.

## Sec. 1312 – Consumer Choice

- *Choice:*
  - Qualified individuals<sup>42</sup> may select any qualified health plan (keeping in mind the eligibility restrictions for catastrophic coverage) and, although the qualified employer<sup>43</sup> purchasing coverage through the Exchange will select the level of coverage, employees of the qualified employer may select any plan offered at that level.
  - Health insurance issuers may offer, and individuals and employers may select, health plans offered outside of the Exchange.
  - Members of Congress and congressional staff must purchase qualified health coverage through the Exchange.
- *Single Risk Pool:* Insurers must consider all enrollees in all plans in the individual market or small employer market, respectively, whether marketed inside or outside of the Exchange (other than grandfathered plans), members of a single risk pool for individual coverage or small employer coverage, respectively.
- *Merger of Markets:* A State may require the individual and small group markets to be merged.
- *Agents / Brokers:* The Secretary is to establish procedures under which a State may allow agents or brokers to enroll individuals or employers through the Exchange and assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the Exchange.
- *Extension to Large Group Market:* In 2017, each State may allow issuance of qualified health plans to large employers through the Exchange.

## Sec. 1313 - Financial Integrity

An Exchange will account for all activities, receipts and expenditures in an annual report submitted to HHS, which will also have investigative and audit authority. No later than 2019, the Comptroller General will conduct a study of the Exchanges with respect to expenses, claim statistics, complaints, utilization and affordability among other considerations.

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<sup>42</sup> “Qualified individual” means, with respect to the Exchange, any citizen or national of the U.S. or alien lawfully present in the U.S. who is seeking to enroll in a qualified health plan in the individual market through the Exchange and is not incarcerated at the time of enrollment.

<sup>43</sup> “Qualified employer” means a small employer that elects to make all full-time eligible employees eligible for 1 or more qualified health plans offered in the small group market through the Exchange.

### Sec. 1321 – State Flexibility In Operation and Enforcement of Exchanges and Related Requirements

HHS will consult with the NAIC, insurers and consumer group in issuing regulations regarding the establishment and operation of the Exchanges.

If a State decides not to operate an Exchange, or HHS may determine that a State will not have their Exchange operational by 2014, then HHS (either directly or through a not-for-profit entity) will establish and operate the Exchange in that State.

### Sec. 1322 – Federal Program to Assist Establishment and Operation of Nonprofit, Member-run Health Insurance Issuers

H.R. 1473 decreases the \$6 billion originally appropriate for this Program by \$2.2 billion, leaving \$3.8 billion appropriated for HHS to establish a Consumer Operated and Oriented Plan (CO-OP) Program to foster the creation of qualified nonprofit health insurance issuers (which would be tax exempt under Sec. 501(a) of the Internal Revenue Code) to offer qualified health plans to individuals and small employers.

There will be a process for reviewing and awarding loans and grants to cover the start up and solvency requirements of CO-OPs seeking licensure by the States, and these will be awarded no later than July 1, 2013. By July 1, 2013, HHS will issue regulations regarding repayment of such loans and grants.

In addition to meeting licensing and solvency requirements, for purposes of the CO-OP Program, a qualified nonprofit health insurance issuer must:

- be organized under state law as a nonprofit, member corporation whose activities are primarily the issuance of qualified health plans to individuals and small groups with a strong customer focus;
- not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization nor sponsored by state or local government;
- be governed by majority vote of the members and have governing documents that incorporate ethics and conflict of interest standards protecting against insurance industry involvement and influence;
- ensure that profits inure to the benefit of members through lower premiums, benefit improvements or other programs intended to improve quality of health care delivery.

Qualified nonprofit health insurance issuers participating in a CO-OP Program may establish a private purchasing council to enter into collective purchasing arrangements for services that increase administrative and other cost efficiencies.

Sec. 1331 – State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid

HHS will establish a basic health program under which States may contract with “offerors” (an HMO, health insurer, or provider network) to provide standard health plans outside of the Exchange to individuals under age 65 who are not eligible for other qualifying coverage and who have household incomes of more than 133%, but not greater than 200%, of the poverty line.

The standard health plan must provide coverage for essential health benefits and the premium may not exceed the rate charged for the “silver” plan through the Exchange. Individuals with household incomes at 150% of the poverty line or below must have no less than a 90% coinsurance plan and individuals between 150% and 200% of the poverty line must have no less than an 80% coinsurance plan. If the plan is offered through an insurer, the loss ratio must be at least 85%.

There must be a competitive bidding process for offerors with emphasis placed on innovation, care coordination, preventive care, and incentives for appropriate utilization of physician services.

States may provide multiple plans to low income individuals through the program, and regional compacts may be formed between states to include coverage of eligible individuals in all of the participating states.

If HHS approves the state’s program, the program may receive federal funding, on a per enrollee basis, in the amount equal to 95% of applicable premium tax credits and cost-sharing reductions that would have been provided for eligible individuals had they enrolled in traditional qualified health plans through the Exchange.

Sec. 1332 – Waiver for State Innovation

A State that wants to establish a state program as an alternative to the Exchange (meaning, the State does not want to establish an Exchange nor have the Federal Government run their State Exchange) may apply to HHS for a “waiver” from the requirement with respect to plan years beginning on or after January 1, 2017.

In determining whether to grant a waiver, HHS will consider whether the state program alternative: provides coverage at least as comprehensive as the essential health benefits plan offered through the Exchange; protects against excessive out-of-pocket spending; provides coverage to a comparable number of residents as coverage otherwise required by PPACA would provide, and does not increase the federal deficit.

### Sec. 1333 – Provisions Relating to Offering of Plans in More Than One State

By July 1, 2013, HHS in consultation with the NAIC, will issue regulations for the creation of health care choice compacts allowing qualified health plans offered in the individual market to be sold in multiple states, but the plans would only be subject to laws and regulations of the state in which the plan was written or issued, with exceptions for market conduct enforcement and other consumer protection related standards. Health care choice compacts may not take effect before January 1, 2016.

### Sec. 1334 – Multi-State Plans

The Director of the Office of Personnel Management (which is the same Federal agency that governs the Federal Employees Health Benefit Program) will enter into contracts with health insurers (at least one of which must be non-profit) to offer at least 2 multi-State qualified health plans to individuals and small employers through each Exchange in each State. A competitive bidding process is not required. These OPM contracted plans will compete against the private plans offered through the Exchange.

The Director of OPM may set, through negotiations with multi-State plans, the standards regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrollees.

The benefits available under the multi-State plans must meet or exceed the benefit standards established for other qualified health plans offered through the Exchanges.

The contracted issuer must offer the multi-State plan in every state that had a community-rating requirement in place on 3/23/10. Further, the contracted issuer must provide the multi-state plan:

- In at least 60% of States in year 1
- In at least 70% of States in year 2
- In at least 85% of States in year 3, and
- In all States in subsequent years.

### Sec. 1341 – Transitional Reinsurance Program For Individual Market in Each State

By January 1, 2014, as the Exchanges become available (including to high-risk individuals with preexisting conditions who participated in the temporary high-risk program described in Sec. 1101), States must contract with reinsurers to cover high risks.

HHS, in consultation with the NAIC, will establish a regulation requiring health insurance issuers and third party administrators to make payments to the contracted reinsurer(s) for any plan year beginning in the 3 year period beginning January 1, 2014.

The payments must be used to make reinsurance payments to health insurance issuers that cover high-risk individuals in the individual market (excluding grandfathered plans) for any plan year beginning in such 3-year period.

The regulations will establish a method for determining high-risk individuals including a list of at least 50 but not more than 100 high-risk medical conditions and will require a formula that ensures equitable allocation of available funds.

Based on an NAIC estimate, the amount of total contribution that will be required of insurers and third party administrators over the 3 year period is \$25 billion.

#### Sec. 1342 Establishment of Risk Corridors for Plans in Individual and Small Group Market

The Secretary of HHS is required to establish and administer a program of risk corridors for 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market must participate.

- If a plan's allowable costs<sup>44</sup> for a plan year are more than 103%, but not more than 108%, of the target amount<sup>45</sup>, HHS will pay the plan 50% of the target amount that is in excess of the 103%.
- If a plan's allowable costs for a plan year are more than 108% of the target amount, HHS will pay the plan an amount equal to the sum of 2.5% of the target amount plus 80% of allowable cost in excess of 108% of the target amount.
- If a plan's allowable costs for a plan year are less than 97%, but not less than 92%, of the target amount, the plan will pay HHS 50% of the excess of 97% of the target amount over the allowable costs.
- If a plan's allowable costs for a plan year are less than 92% of the target amount, the plan will pay HHS an amount equal to the sum of 2.5% of the target amount plus 80% of excess of 92% of the target amount over the allowable costs.

#### Sec. 1343 - Risk-Adjustment

Requires States to assess a charge on insured, non-grandfathered health plans offering coverage in the individual and small group market in that State if the actuarial risk for the plan's enrollees for a year is less than the average actuarial risk of all enrollees in all plans in the State for the same year.

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<sup>44</sup> Allowable costs = an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan. Allowable costs will be reduced by any risk adjustment and reinsurance payment received under sections 1341 and 1343 of PPACA.

<sup>45</sup> Target amount = the total premiums (including any premium subsidies under any governmental program) reduced by the administrative costs of the plan.

Requires HHS to establish criteria and methods (similar to the criteria and methodologies used for Medicare Part C and D) for carrying out risk adjustments. Using this criteria, States must provide payment to 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.

This provision does not apply to self-insured plans subject to ERISA.

## **TITLE I, SUBTITLE E (EXCHANGE TAX CREDITS AND SUBSIDIES)**

**Subtitle E is effective January 1, 2014 unless otherwise specified.**

### **Sec. 1401. Tax Credit – Premium Assistance For Coverage Under A Qualified Health Plan**

Adds section 36B to the Internal Revenue Code to provide a premium-assistance tax credit to certain individuals who purchase individual health insurance coverage through the Exchange and who are not eligible for Medicare or Medicaid. Individuals eligible for employer-sponsored “minimum essential coverage” are not eligible for the credit unless the employer plan’s share of the cost of benefits is less than 60%, or the cost of coverage exceeds 9.5% of the employee’s income.

The premium credit is the lesser of: (a) the total monthly premium, or (b) the excess of the “adjusted monthly premium” for the second-lowest cost “silver” plan, over a percent of household income. The credit is available on a sliding scale based on the percentage of income that the cost of coverage represents, rising from 2% of income for those up to 133% of the poverty line to 9.5% of income for those between 300% and 400% of the poverty line. No credit is available to individuals with household income of more than 400% of the poverty line.

The percent of income caps will be adjusted to reflect the excess rate of premium growth over the rate of income growth for the preceding year, subject to a “failsafe” if the amount of premium tax credits and cost-sharing reductions (described under Sec. 1402 below) exceeds 0.504% of the gross domestic product.

It appears (based on Sec. 1412 summarized below) that the amount of the tax credit will be determined by HHS and the Treasury and will be paid to the issuer providing coverage to the eligible individual through the Exchange. The issuer then decreases the premium owed by the credited amount.

By 2015, the Comptroller General will conduct a study on the affordability of health insurance to include: (1) The impact of the tax credit; (2) The availability of affordable health benefit plans including whether the percentages of household income in this Section are appropriate, and (3) The ability of individuals to maintain “essential health benefits” coverage.

### Sec. 1402. Cost Sharing Subsidy – Reduced Cost-Sharing For Individuals Enrolling In Qualified Health Plans

An individual with household income less than 400% of the poverty line who purchases a “silver” individual health insurance plan through the Exchange may be eligible for a cost-sharing subsidy.

The Secretary will notify the issuer of such eligibility, and the issuer will then reduce that individual’s “cost-share” (out-of-pocket) requirement as follows:

- 100% to 200% of FPL - 2/3 reduction
- 201% to 300% of FPL – 1/2 reduction
- 301% to 400% of FPL - 1/3 reduction

The “plan’s share of the total allowed costs of benefits provided under the plan” will be:

- 100% to 150% of FPL – 94%
- 151% to 200% of FPL – 87%
- 201% to 250% of FPL – 73%
- 251% to 400% of FPL – not more than 70%

### Sec. 1411 – Eligibility Determinations for Exchange Participation, Premium Tax Credit, Cost-Sharing Subsidy and Individual Exemptions

When applying for coverage through an Exchange, the applicant will provide information that will allow the Secretary of HHS to work with the Secretaries of the Treasury, Homeland Security and Social Security to verify eligibility of the applicant to: participate in the Exchange; receive tax credits; receive a cost-share subsidy, or receive an exemption from the individual coverage mandate.

A fine of not more than \$25,000 may be assessed against an individual for negligently providing incorrect information and no more than \$250,000 for knowingly providing false information.

### Sec. 1412 – Advance Determination and Payment of Premium Tax Credits and Cost-Sharing Subsidies

During the applicable annual open enrollment period, HHS (working with the Treasury) will make an “advanced determination” regarding whether an individual applying for individual coverage through the Exchange is eligible for a tax credit or cost-sharing subsidy. If the individual is eligible, the Secretary of Treasury will make advance payments of such credit or subsidy to the issuer of the qualified plan in order to reduce the premiums payable and/or the cost-share requirement otherwise applicable under the plan. The issuer then notifies the Exchange and the Secretary of the credit / reduction.

The issuer must reflect the premium credit on the individual's billing statement. If the individual fails to pay their premium, the issuer must notify the Secretary and must allow a 3-month grace period for nonpayment of premium before discontinuing coverage.

Secs. 1413, 1414, 1415 and 1416 – Streamlining Federal Program Eligibility Determinations, Credit/Subsidy Not Income, Study of Geographic Variation of FPL

The Secretary will develop a program whereby an individual applying for coverage through the Exchange will be screened for eligibility for medical assistance under Medicaid or CHIP. Tax return information and social security numbers may be disclosed for purposes of making such eligibility determinations including credit and subsidy determinations.

Premium credits and cost-share reductions will not be counted as income to the individual.

HHS will conduct a study to examine the feasibility and implications of adjusting the Federal poverty level and submit a report to Congress by January 1, 2013.

Sec. 1421 – Credit for Employee Health Insurance Expenses of Small Businesses

*(Related IRS Rev. Rul. 2010-13 and Notice 2010-44 also summarized below)*

Amends Sec. 45R of the Tax Code to provide a tax credit to certain small employers that provide health insurance coverage to their employees. On September 7, 2010, the IRS issued a draft of [Form 8941](#) that employers will be required to complete in order to claim the credit. This form is subject to change pending to final release.

To be eligible for the tax credit, the employer must:

- Have fewer than 25 full-time equivalent employees for the taxable year;
- Have average annual employee wages of less than \$50,000 per FTE; and
- Pay at least 50% of the insurance premiums under a “qualifying arrangement”. In addition to medical insurance, a qualifying arrangement also includes limited scope dental / vision, long-term care, specified disease, hospital / fixed indemnity, Medicare supplemental coverage and certain other supplemental plans. The 50% contribution requirement applies separately to each plan.
  - The 50% contribution must be uniform for all employees subject to a transition rule for the 2010 taxable year. Under the ‘transition rule’, the employer must pay at least 50% of the premiums for “single” coverage uniformly, and must pay no less than half of that amount for family or self-plus-one coverage.
  - For states that provide a subsidy payment or tax credit to small employers providing health insurance benefits, such subsidy or credit will not reduce the amount of federal tax credit, but the credit is based upon the actual amount paid by the employer (net of any state subsidy).

Counting employees –

- Sole proprietors, partners, more than 2% shareholders in an S-corporation and any owners of more than 5% of other businesses are not taken into account, nor are their family members or dependents, for purposes of determining the number of FTEs, average annual wages, or premiums paid on their behalf for purposes of the credit.
- Seasonal workers working less than 120 days per year are disregarded in determining the number of FTEs and average annual wages, but premiums paid on their behalf may be counted in determining the credit.
- All employers treated as a single employer under Sec. 414(b)(c)(m) or (o) are treated as a single employer for purposes of this tax credit.
- IRS Notice 2010-44 provides detailed rules and examples for calculating the number of FTEs but, in general, the employer takes the total hours of service for all employees (not to exceed 2,080 hours for any employee) divided by 2,080.

Tax Credit -

- For 2010 through 2013, the maximum credit is 35% of the employer's premium expense (25% for tax-exempt and non-profit small employers). The credit is phased out if the number of FTEs exceeds 10 or if the average annual wage exceeds \$25,000.
  - FTE-based Phase Out: The phase out is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15.
  - Average Income Phase Out: If the average annual wages exceed \$25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed \$25,000 and the denominator of which is \$25,000.
    - If the employer has over 10 FTEs with average annual salaries over \$25,000, both reductions apply.
    - In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled.
- On January 1, 2014 the maximum tax credit amount increases to 50% of the employer's premium cost for coverage purchased through the Exchange.

**TITLE I, SUBTITLE F (INDIVIDUAL AND EMPLOYER RESPONSIBILITIES)**

**Subtitle F is effective January 1, 2014 unless otherwise specified.**

Sec. 1501 – Requirement to Maintain Minimum Essential Coverage (“Individual Mandate”)

This Section includes a discussion about why the requirement for individuals to maintain minimum essential coverage is “commercial and economic in nature” and substantially affects interstate commerce.

Unless an exemption applies, “applicable individuals<sup>46</sup>” and their dependents must be covered under minimum essential coverage<sup>47</sup> or pay a penalty (to be paid with submission of their tax return) with respect to any month they are not so covered.

The monthly penalty is equal to 1/12 of the greater of the:

- A flat dollar amount detailed below, or
- A percentage of gross income detailed below.

The flat dollar amount is \$95 in 2014, \$325 in 2015 and \$695 in 2016, indexed for inflation thereafter. The total penalty for a family may not exceed 300% of the per person flat dollar penalty or the national average annual premium for the “bronze” level of coverage through the Exchange.

The percent of income is 1% in 2014, 2% in 2015 and 2.5% in 2016 and beyond.

The following applicable individuals are exempt from the individual mandate:

- An individual eligible to purchase minimum essential coverage through an employer-sponsored plan where the individual’s contribution to the annual premium for self-only coverage would exceed 8% of household income.
- An individual eligible to purchase “bronze” level individual coverage through the Exchange where the annual premium, reduced by any allowable credit, would exceed 8% of household income.
- Individuals with incomes below the federal income tax filing threshold.
- Members of Indian Tribes.
- Individuals with short coverage gaps of less than 3 continuous months.
- Individuals granted a “hardship” exception by HHS.

#### Sec. 1502 – Reporting of Health Insurance Coverage

In order to implement the individual mandate, “every person” who provides minimum essential coverage to an individual during a calendar year must file a return, in a form prescribed by the Secretary, that includes the name, address, TIN of the individual, the dates of coverage, and the amount of any tax credit or cost-sharing subsidy.

If the minimum essential coverage is employer-provided health insurance the return will include the employer’s name, address and TIN, the portion of premium paid by the employer and, if it’s

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<sup>46</sup> The term “applicable individual” means, with respect to any month, an individual who: (1) does not have a certified “religious exemption”; (2) is a U.S. citizen or national or is an alien lawfully present in the U.S.; (3) is not incarcerated.

<sup>47</sup> Minimum essential coverage means: Medicare, Medicaid, CHIP, TRICARE, Peace Corps coverage, employer-sponsored small or large group major medical coverage, or individual health coverage. “Excepted benefits” are not minimum essential coverage.

a qualified health plan in the small group market offered through the Exchange, any additional information the Secretary requires for administration of the credit for employee health insurance expenses of small employers.

#### Sec. 1511 – Automatic Enrollment For Employees of Large Employers

Effective March 1, 2013, the Fair Labor Standards Act is amended to require employers with more than 200 full-time employees that offers enrollment in 1 or more health benefit plans to automatically enroll new full-time employees in one of the plans offered, with notice of the opportunity to “opt-out” of coverage. An [FAQ](#) issued by the Department of Labor states that employers are not expected to comply with this requirement until such time that the Department issues rules on this requirement.

#### Sec. 1512 – Employer Requirement to Inform Employees of Coverage Options

Effective March 1, 2013, employers are to provide each new hire and each current employee written notice that informs the employee: (1) about the Exchange; (2) that he may be eligible for a premium tax credit or cost-share reduction if the employer’s plan share of the total allowed costs of benefits is less than 60% and the employee purchases coverage through the Exchange, and (3) that if he purchases coverage through the Exchange he will lose the employer contribution and that all or a portion of such contribution may be excludable from taxable income.

#### Sec. 1513 – Shared Responsibility For Employers

The Internal Revenue Code is amended to add the following requirements:

An employer with at least 50 full-time employees, regardless of whether the employer offers employer-sponsored minimum essential coverage to its employees, will pay a fee for any month that an employee has qualified health coverage through the Exchange and is certified as eligible for a premium tax credit or cost-share reduction.

If the employer does *not* offer minimum essential coverage, the annual fee is \$2,000 (\$166.67 per month) per full-time employee, and the first 30 full-time employees are discounted for purposes of calculating the penalty.

If the employer *does* offer minimum essential coverage, the annual fee is the lesser of:

- \$3,000 (\$250 per month) per full-time certified as eligible for the tax credit or subsidy, or
- \$2,000 (\$166.67 per month) per full-time employee, and the first 30 full-time employees are discounted for purposes of calculating the penalty.

In general:

- Full-time employment is based on a 30-hour work week.

- “Equivalents” are also considered in the calculation (take the total number of hours worked in a month by part-time employees divided by 120 and add to the number of full-time employees for purposes of calculating the penalty).
- Aggregation rules from 26 U.S.C. 414(b),(c),(m) and (o) apply for purposes of counting the number of employees when there are multiple employers under common control.

#### Sec. 10108 – Free Choice Vouchers

REPEALED BY H.R. 1473

#### Sec. 1514 – Reporting on Employer Health Insurance Coverage

Employers with 50+ full-time employees must file an return with the Secretary of Treasury (IRS) that contains:

1. The name and EIN of the employer
2. A certification as to whether the employer offers full-time employees minimum essential coverage and, if so:
  - a. The length of the waiting period;
  - b. The months of the year coverage was available;
  - c. The monthly premium of the lowest cost option;
  - d. The employer’s share of the cost of coverage (including in the plan for which the employer pays the largest portion);
  - e. The number of FTEs in each month of the year;
  - f. The name, address and TIN of each employee (and any dependents) covered under the plan, and
  - g. Any other information the secretary requires.

If an employee is listed on this return, the employer must also provide such employee with a written statement regarding the information that was included in the return with respect to such employee.

#### Sec. 1515 – Offering Exchange Plans Through Cafeteria Plans

Amends Section 125 of the Internal Revenue Code to provide that a section 125 cafeteria plan may not be used by employees to pay premiums for individual qualified health plans on the Exchange. A Sec. 125 plan may be used with employer-sponsored group coverage purchased through the Exchange.

## **TITLE I, SUBTITLE G – MISCELLANEOUS PROVISIONS**

### **Sec. 1563 [sic] – Conforming Amendment**

Amends 42 U.S.C. 300gg-21 to reduce the number of provisions that a self-funded non-federal governmental group health plan may elect not to provide from seven to four. On September 21, 2010, HHS issued [guidance](#) explaining that, for plan years on or after 9/23/2010, a self-funded non-federal governmental group health plan may elect (following the defined opt-out process) to continue to opt-out of only the following provisions: (1) 48 / 96 allowance for newborn deliveries, (2) mental health / substance abuse parity, (3) reconstruction following mastectomy, (4) coverage of dependents on a medically necessary leave of absence from school (i.e.: Michelle's Law). This guidance also explains that a non-federal governmental group health plan that is maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010 may continue to be exempted from the following provisions: (1) limitations on preexisting condition exclusions, (2) requirements for special enrollment periods, and (3) prohibitions against discriminating against individuals based on health status until the commencement of the first plan year following the expiration of the last plan year governed by the collective bargaining agreement.

## **TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY**

### **Sec. 6301 – Fee on Health Plans to Fund Patient-Centered Outcomes Research**

The Act establishes a new patient-centered outcomes research fund (PCORTF) to fund comparative effectiveness research of health care services that is mandated by the Act. This will be funded by a fee imposed on health insurers and health plan sponsors of self-funded plans. The fee applies for each plan year ending after September 30, 2012 and is \$2 x the average number of lives covered under the plan (\$1 in the case of plan years ending during fiscal year 2013).

## **TITLE VIII –CLASS ACT**

### **Sec. 8002 – Community Living Assistance Services and Support**

PPACA amends the Public Health Services Act and establishes a national voluntary insurance program for purchasing “community living assistance services and support” program (CLASS Program). In order to initially enroll in the CLASS Program, the individual:

- 1) Must be at least 18 years old,
- 2) Must be “actively employed” (meaning, reporting for work at his usual place of employment, on his regular schedule for his usual and customary duties),
- 3) Must not be a patient in a hospital, nursing or intermediate care facility, and
- 4) Must not be confined in jail or another penal institution.

Once enrolled in the CLASS Program, an “eligible beneficiary” is an individual who, as of the date on which the individual is determined to have a “functional limitation”, has: (1) paid CLASS Program premiums for at least 60 months, and (2) earned wages for at least 3 calendar year during this 60 month period sufficient to earn a quarter of Social Security credit each year<sup>48</sup>.

An individual with a lapse of premium payments of more than 90 days during this 60-month period must pay premiums for at least 24 consecutive months in addition to the requirements above to be eligible for benefits. Individuals with more than a 90 day lapse who reenroll in the CLASS Program will be subject to then current premium rates.

Individuals who reenroll after more than a 5-year lapse will be subject to an additional penalty to be further defined by regulations and will not receive credit for any premium paid prior to the lapse.

A functional limitation must: (1) be certified by a licensed health care practitioner, (2) be expected to last at least 90 consecutive days, and (3) meet one of the following criteria:

- (a) Render the individual unable to perform the number of ADLs<sup>49</sup> required under the plan,
- (b) Require substantial supervision to protect from threats to health and safety due to substantial cognitive impairment, or
- (c) The individual has a level of functional limitation similar to (a) or (b) above as determined by standards set forth in future federal regulations.

Also, an active enrollee (meaning an individual who is enrolled in the CLASS Program and has paid the requisite premiums) will be presumed eligible for benefits if such individual is eligible for the maximum cash benefit, is a patient in a nursing facility, intermediate care facility for the mentally retarded, institution for mental diseases or a hospital for the purpose of long term care, and is in the process of being discharged.

*CLASS Independence Benefit Plan:* The Secretary will develop at least 3 benefit plan alternatives with premiums designed to ensure solvency of the CLASS Program for 75 years. The 3 alternatives will be evaluated by the CLASS Independence Advisory Council<sup>50</sup> who will recommend to the Secretary the plan that best balances price and benefits. Taking into account

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<sup>48</sup> The federal government will issue regulations detailing exceptions to this requirement.

<sup>49</sup> Activities of Daily Living (ADLs) include eating, toileting, transferring, bathing, dressing, continence, as specified in section 7702(c)(2)(B) of the Internal Revenue Code.

<sup>50</sup> The CLASS Independence Advisory Council will advise the Secretary of the Treasury on the benefit plans, premiums and the solvency of the program. The Council will be composed of no more than 15 members who are not otherwise employees of the United States Government, who are appointed by the President for 3 year terms (no more than 2 consecutive terms) and who are representative of individuals likely to participate in the CLASS Program.

this recommendation, the Secretary will designate a plan as the CLASS Independence Benefit Plan no later than October 1, 2012.

Premiums should be designed to remain the same for as long as the individual is enrolled in the program (subject to the rules for a lapse in coverage of more than 3 months), but may be adjusted if the Federal Government deems necessary to maintain solvency<sup>51</sup>.

Premiums will be age adjusted, but there are no medical underwriting requirements. The cost for administering the Program may be built into the premiums, but may not exceed 3% of all premiums paid during the year. Also, premiums for individuals at or below the poverty line, and for individuals under age 22 who are actively employed and full-time students, shall not exceed \$5 (increased by the percent increase in the CPI-U) per month. Self-attestation will be used to verify poverty line status and student status.

*Enrollment and Disenrollment Requirements and the CLASS Independence Fund:* The Secretaries of HHS and Treasury will establish procedures for individuals to automatically enroll in the CLASS Program through their employer, but an alternative enrollment process will be defined if: (a) the employer elects not to participate in the automatic enrollment process, (b) the individual has more than 1 employer, or (c) the individual is self-employed. For employers who participate, premiums will be deducted from wages. Procedures will also be developed for individuals to opt-out of participation.

Individuals who chose not to enroll when first eligible must wait for an “open enrollment” opportunity to be further defined in future regulations. Future regulations will also establish a “disenrollment” period as the only time that an individual may disenroll from the program (except by non-payment of premium).

The Government will deposit the premiums into a CLASS Independence Fund established by the Secretary of Treasury, who will serve as Managing Trustee. The Fund will be held for investment on behalf of the individuals enrolled in the CLASS Program and will be used to pay administrative expenses and benefits.

The Fund will have a Board of Trustees composed of the Secretaries of the Treasury, Labor and Health and Human Services, two members of the public nominated by the President and confirmed by the Senate for 4-year terms.

*Benefits:* The minimum benefit will be an average of \$50 per day, will vary based a scale of functional ability, and will not be subject to a lifetime limit.

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<sup>51</sup> Certain enrollees would be exempt from any adjustments as follows: those age 65+, those who have paid premiums for at least 20 years and those not actively employed.

The benefits will be deposited into a Life Independence Account that is established by the Government on behalf of each eligible beneficiary. The Account shall be used to purchase nonmedical services and support that the beneficiary needs to maintain his independence<sup>52</sup> or pay for institutional care. The Government must establish procedures to allow beneficiaries to access the account through a debit card. Benefits may be rolled over from month-to-month for up to 12 months. Benefits not recouped at the end of the 12 months are forfeited and paid into the Class Independence Fund.

*Interaction with Medicaid* – A CLASS Program participant enrolled in Medicaid who is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded or an institution for mental disease may retain 5% of their CLASS Program benefits and the remainder will go to the facility. A CLASS program participant enrolled in Medicaid who is receiving Medicaid assistance for “home and community based services” may retain 50% of their CLASS Program benefits with the remainder to the State providing the Medicaid benefits as long as the State meets certain criteria.

*Solvency / Annual Report* : Beginning January 1, 2014, the Secretary of Treasury will submit an annual report to Congress regarding the number of enrollees, the number of eligible beneficiaries, the amount of benefits provided, instances of fraud and abuse, recommendations to improve the program and ensure solvency.

*Inspector General’s Report*: The Inspector General of HHS will submit an annual report to the Secretary of Treasury and Congress relating to waste, fraud and abuse, the eligibility determination process, the provisions of benefits and recouping unpaid and accrued benefits.

*Tax Treatment*: For tax purposes, the CLASS Program is treated the same as a long-term care insurance contract.

## **TITLE IX – REVENUE PROVISIONS**

Sec. 9001 – Excise Tax on High Cost Employer-Sponsored Health Coverage (“Cadillac Plans”)

Effective 1/1/2018, a 40% excise tax will be imposed on the “excess benefit” provided in any month under “applicable employer-sponsored coverage”. The tax is imposed on the “coverage provider” which can be the health insurer, the employer, or the plan administrator depending on the type of coverage. The threshold, indexed for inflation is \$10,200 per year for individuals and \$27,500 per year for families.

In general, an “excess benefit” is the amount by which the annual “cost” of applicable employer-sponsored coverage exceeds \$10,200 for self-only coverage or \$27,500 for family coverage.

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<sup>52</sup> Examples include, but are not limited to, home modifications, assistive technology, homemaker services, respite care, nursing support.

“Applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer that is excludable from the employee’s gross income under section 106 of the Internal Revenue Code, or would be excludable if it were employer-provided coverage. Applicable employer-sponsored coverage includes employer contributions to FSAs, HSAs and MSAs. Applicable employer-sponsored coverage does not include stand-alone dental insurance, stand-alone vision insurance, accident only, disability income or long-term care. It does not include specified disease or hospital indemnity if the payment is not excludable from gross income and is not deductible by a self-employed individual.

#### Sec. 9002 - Inclusion of Cost of Employer-Sponsored Health Coverage on W-2

Amends Sec. 6051 of the Internal Revenue Code to require employers to report the “aggregate cost<sup>53</sup>” of “applicable employer-sponsored coverage<sup>54</sup>” on the employee’s W-2 form.

While PPACA makes this provision effective for taxable years beginning on January 1, 2011, [IRS Notice 2010-69](#) and [IRS Notice 2012-9](#) provide that such reporting is optional, not mandatory, for W-2 Forms issued for 2011.

Instead, W-2 reporting obligations will begin with the 2012 W-2 Forms (which are typically provided no later than January 31, 2013). A summary of Notice 2011-28, as updated by Notice 2012-9 is provided below:

- *Where to Report:* The aggregate cost of applicable employer-sponsored coverage is reported on Form W-2 in box 12, using code “DD”.
- *When to Report:* The reporting obligations apply beginning with the 2012 W-2 forms (which are typically provided no later than January 31, 2013). Reporting is not required for Forms W-2 issued for the 2010 or 2011 calendar years.
- *Employer Applicability:* Most employers that provide “applicable employer sponsored coverage” during a calendar year are subject to the reporting requirement.
  - *Smaller Employers:* In the case of the 2012 Forms W-2, and until the issuance of further guidance, an employer required to file fewer than 250 Forms W-2 for the

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<sup>53</sup> The aggregate cost is calculated using rules similar to those for determining the “applicable premium” for COBRA continuation purposes as described at 26 U.S.C.A. § 4980B(f)(4). If you need a copy of these rules, please contact me.

<sup>54</sup> “Applicable employer-sponsored coverage” does not include HSA, MSA or salary reduction FSA contributions, stand-alone dental insurance, stand-alone vision insurance, accident only, disability income or long-term care. It does not include specified disease or hospital indemnity if the payment is not excludable from gross income and is not deductible by a self-employed individual.

preceding calendar year is not subject to the reporting requirements. (See Q&A-3 in IRS Notice 2012-9).

- Self-insured plans not subject to federal continuation requirements: An employer is not required to include in the aggregate reportable cost the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements. Federal continuation coverage requirements include the COBRA requirements under the Code, the Employee Retirement Income Security Act of 1974, or the Public Health Service Act and the temporary continuation coverage requirement under the Federal Employees Health Benefits Program. (See Q&A-21 in IRS Notice 2012-9).
- *What to Report:* Report the aggregate cost of applicable employer-sponsored coverage.
- *Applicable Employer Sponsored Coverage:* Means, with respect to any employee, coverage under any group health plan made available to the employee by the employer that is excludable from the employee's gross income or would be so excludable if it were employer-provided coverage. Applicable employer sponsored coverage does not include:
  - Long term care
  - Accident or disability income
  - Liability insurance
  - Workers' compensation
  - Automobile insurance
  - Credit only insurance
  - Dental and vision coverage if offered through a separate policy, certificate or contract of insurance
  - Specified disease or illness the payment for which is not excludable from gross income.
  - Hospital indemnity or other fixed indemnity the payment for which is not excludable from gross income.
- *Terminated Employees and Continuation coverage:* In the case of an employee who elects continuation coverage under the group health plan after his employment is terminated, an employer may decide whether or not they want to report the cost of the continuation coverage on Form W-2. However, the decision and method for reporting must be applied consistently to all terminated employees with continuation of coverage. An employer is not required to report any amount in box 12 with Code DD for a terminated employee who has requested to receive a Form W-2 before the end of the calendar year during which the employment terminated.
- *Aggregate Cost of Applicable Employer Sponsored Coverage:* Means the total cost of coverage under all applicable employer-sponsored coverage including employer and employee contributions, and including those cost of coverage amounts that are includible in the employee's gross income. This includes contributions attributable to dependent coverage. (See Q&A 11, 14 and 15 in IRS Notice 2012-9). The following amounts are excluded from the aggregate reportable cost:

- Contributions to an Archer MSA;
- Contributions to an Health Savings Account (HSA);
- The amount of any salary reduction election to a flexible spending arrangement (FSA). However, if the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year, then the amount of that employee's health FSA minus the employee's salary reduction election for the health FSA must be included in the aggregate reportable cost;
- The cost of coverage under a Health Reimbursement Arrangement (HRA);
- The cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation of coverage requirements;
- The cost of coverage under a multiemployer (collectively bargained) plans as defined in §54.4980B-2, Q&A-3, and
- The cost of coverage provided by the federal government, the government of any State or political subdivision thereof, or any agency or instrumentality of any such government, under a plan maintained primarily for members of the military.
- The cost of coverage includible in income under § 105(h), or payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S corporation who is required to include the premium payments in gross income.
  - See Q&A 16 through 23 of IRS Notice 2012-9.
- Also, the cost of coverage provided under an employee assistance program (EAP), wellness program, or on-site medical clinic is only includible in the aggregate reportable cost to the extent that the coverage is provided under a program that is a group health plan for purposes of § 5000(b)(1). An employer is not required to include the cost of coverage provided under an EAP, wellness program, or on-site medical clinic if that employer does not charge a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements. (See Q&A-32 of IRS Notice 2012-9).
- *Calculating the Reportable Cost:* The employer must determine the reportable cost under a plan on a calendar year basis. If an employee adds, terminates or changes coverage during the year, impacting the cost, the reportable cost for the employee must take into account those events. The employer may use:
  - The COBRA applicable premium method (See Q&A-25 of IRS Notice 2012-9)
    - The reportable cost = the COBRA applicable premium as determined under §4980B of the Internal Revenue Code consistent with regulations at §54.4980B-1, Q&A-2.
  - The premium charged method (See Q&A-26 of IRS Notice 2012-9)
    - Available only for insured plans. The reportable cost = the premium charged by the insurer.
  - The modified COBRA premium method (See Q&A-27 of IRS Notice 2012-9)

- Available only when the employer subsidizes the cost of COBRA or where the actual premium charged by the employer to COBRA beneficiaries for each period in the current year is equal to the COBRA applicable premium for each period in a prior year.
- Employers that charge a composite rate may calculate and use the same reportable cost for a period for (1) the single class of coverage under the plan, or (2) all the different types of coverage under the plan for which the same premium is charged to employees, provided this method is applied to all types of coverage provided under the plan. (See Q&A-28 of IRS Notice 2012-9)

### Sec. 9003 - Distributions For Medicine Qualified Only if for Prescribed Drug or Insulin

Sec. 9003 of PPACA revises the Internal Revenue Code to require that medicine / drugs other than insulin be prescribed in order to be reimbursed through health FSA, HRA, HSA or MSA. On September 3, 2010, the IRS issued [Notice 2010-59](#) regarding this requirement and on December 27, 2010, the IRS issued [Notice 2011-5](#), which modifies Notice 2010-59 and further addresses the use of debit cards for OTC drug purchases.

Expenses incurred after December 31, 2010 for medicines or drugs may be paid or reimbursed by a FSA, HRA, HSA or MSA only if the medicine or drug: (1) requires a prescription, or (2) is available without a prescription (over-the-counter) and the individual obtains a prescription, or (3) is insulin. Medicines or drugs purchased before January 1, 2011 are not impacted by this requirement, regardless of when the plan reimburses the expense. This effective date applies regardless of whether the plan year is a fiscal or calendar year or whether there is no plan year, and regardless of any applicable grace period for a health FSA.

For purposes of this requirement, a “prescription” means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

On or after 1/16/2011, OTC medicine or drug purchases must be substantiated before reimbursement from a health FSA or HRA may be made. Substantiation is accomplished by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) for the OTC medicine or drug, and other information from an independent third party that satisfies the requirements under Prop.Treas. Reg. § 1.125-6(b)(3)(i). Thus, for example, a customer receipt issued by a pharmacy which identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number satisfies the substantiation requirements for OTC medicines or drugs, as does a receipt without an Rx number accompanied by a copy of the related prescription.

*Health FSA and HRA Debit Cards:* Notice 2011-5 permits health FSA and HRA debit cards to be used at drug stores, pharmacies and mail-order / web-based vendors that sell prescription drugs to purchase OTC medicines or drugs if all of the following conditions are met:

1. Prior to purchase:

- a. The prescription is presented to the pharmacist;
  - b. The OTC medicine or drug is dispensed by the pharmacist; and
  - c. An RX number is assigned.
2. The pharmacy or vendor retains a record of the RX number, the name of the purchaser (or the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS record keeping requirements;
3. The above records are available to the employer or its agent upon request;
4. The debit card system will not accept a charge for an OTC drug or medicine unless it an RX number has been assigned, and
5. The additional rules from prior IRS guidance regarding the use of health FSA or HRA debit cards are satisfied.

Further, according to Notice 2010-59, debit cards may be used at a pharmacy if 90% of the store's gross receipts during the prior taxable year consists of items which qualify as expenses for medical care under § 213(d). Until further guidance is issued, debit cards may be used at a pharmacy that satisfies the 90% test to purchase OTC medicines or drugs that have been prescribed, provided that substantiation is properly submitted. Solely for the purpose of determining whether a pharmacy meets this 90% test, sales of OTC medicines and drugs at the pharmacy may continue to be taken into account after 12/31/10.

*Transition Rule For Cafeteria Plan Amendments:* Cafeteria plans may need to be amended to conform to the new over-the-counter drug requirements. An amendment to conform a cafeteria plan to the requirements set forth in this Notice that is adopted no later than June 30, 2011, may be made effective retroactively for expenses incurred after December 31, 2010 (or after January 15, 2011 for health FSA and HRA debit card purchases).

#### Sec. 9004 - Increase in Additional Tax on Distributions From HSAs and Archer MSAs Not Used For Qualified Medical Expenses

Effective for distributions made on or after January 1, 2011, the additional tax imposed on non-qualified distributions from HSAs is increased from 10% to 20% and from 15% to 20% for MSAs.

#### Sec. 9005 - Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans

Effective January 1, 2013, salary reduction contributions through a cafeteria plan to a health FSA may not exceed \$2,500. Effective, January 1, 2014, this amount will be increased by a cost of living adjustment.

#### Sec. 9006 – Expansion of Information Reporting Requirements (1099s)

REPEALED by H.R. 4.

## Sec. 9010 - Imposition of Annual Fee on Health Insurance Providers

Beginning January 1, 2014, an annual fee will be imposed on health insurance providers as follows:

2014 - \$8 billion

2015 and 2016 - \$11.3 billion

2017 - \$13.9 billion

2018 - \$14.3 billion

2019 – indexed to the rate of premium growth.

A health insurance provider is an insurer who derives at least 25% of gross premiums from health insurance plans. The fee will be based on the legal entity's market share of 50% of net premiums over \$25m and 100% over \$50m. Market share will be computed as the ratio of the insurers' premium to total reported of all health insurance providers. The fee will be non-deductible for tax purposes. The fee does not apply to accident, disability, long-term care or Medicare-supplement insurance.

## Sec. 9012 – Elimination of Deduction For Expenses Allocable to Medicare Part D Subsidy

Effective 1/1/2013, employers will no longer be allowed to deduct the rebate received from the Government on qualifying retiree drug costs. Going forward, this will be taxable income to Employers.

## Sec. 9014 – Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers

A deduction limit of \$500,000 per year is placed on employee, director and certain independent contractor compensation paid by health insurers for tax years beginning 1/1/2013. The limit is for all companies within a controlled group with respect to services performed as of 1/1/2010 and is based on the year the income is earned, rather than the year in which the deduction is claimed for the payment. The limit applies to both current and deferred earnings. The IRS issued to [IRS Notice 2011-02](#) clarifying which insurers are subject to the rules, which independent contractors are exempt from the deduction limitations, which reinsurers are exempt from the deduction limitations and providing examples of how the rule works.

## Sec. 9015 – Additional Hospital Insurance Tax on High Income Payers

Beginning 1/1/2013, an additional Medicare Hospital Insurance Tax (HI tax) of 0.9% will be imposed on self-employed persons and employees paid wages in excess of \$200,000, (\$250,000 if married filing jointly). The tax is not indexed for inflation.

**HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (TITLE I,  
SUBTITLE E)**

Sec. 1402 – Unearned Income Medicare Contribution

Beginning 1/1/2013, a 3.8% Medicare Tax will be imposed on the lesser of an individual's net investment income for the tax year or modified adjusted gross income in excess of \$200,000 (\$250,000 for joint filers). Net investment income does not include items currently excluded such as tax-exempt interest or gain on the sale of a principal residence otherwise excluded from income.

Sec. 1410 – Time For Payment of Corporate Estimated Taxes

For corporations with at least \$1 billion in assets, increases the required payment of estimated tax otherwise due in July, August or September 2014 by 15.75 percentage points, with the next required payment being reduced by 15.75 percentage points.