PART VII: PHSA COVERAGE MANDATES AND ENFORCEMENT

Coverage Mandates and Enforcement

170. What are the coverage mandates imposed by health reform and incorporated into the Public Health Services Act (PHSA)?

As discussed earlier in connection with grandfathered plans, health reform’s revision of the Public Health Services Act imposes numerous coverage mandates for policies and plans covering essential health benefits. These do not include “excepted benefits.”[[1]](#footnote-1) In addition to their inclusion in the PHSA, these provisions are incorporated by reference into section 715 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815 of the Internal Revenue Code (Code). The mandates for essential health benefits for grandfathered plans are as follows:

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| **Health Reform Rules That Apply to All Plans, Including Grandfathered Plans** |
| Pre-existing condition exclusions (PCE) prohibited.[[2]](#footnote-2) Grandfathered individual coverage can continue to apply these exclusions, but group health plans and group health insurance issuers cannot impose PCEs for plan years beginning on or after January 1, 2014. This prohibition took effect for plan years beginning on or after September 23, 2010, (i.e., January 1, 2011, for calendar-year plans) with respect to individuals enrolled in the plan who are younger than nineteen years of age. |
| Excessive waiting periods of more than ninety days are prohibited for plan years beginning in 2014.[[3]](#footnote-3) |
| Annual/lifetime limits are prohibited for plan years beginning in 2014.[[4]](#footnote-4) These rules apply to grandfathered plans, but the annual limit prohibition does not apply to grandfathered individual coverage. For benefits that are not “essential health benefits,” both lifetime and annual limits are allowed if not prohibited by other federal and state laws.[[5]](#footnote-5) Failure to provide any services for a condition is allowed, but if any benefits are provided for a condition, these prohibitions apply.[[6]](#footnote-6) While grandfathered health plans are not required to offer essential health benefits, they cannot impose either annual or lifetime dollar limits on the essential health benefits they do offer. Individual grandfathered policies may continue annual limits but not lifetime limits. |
| Rescission of policies is prohibited except for fraud or misrepresentation beginning in 2014.[[7]](#footnote-7) |
| Dependent coverage for children under age twenty-six must be offered until 2014, except for adults eligible for coverage through their own employer.[[8]](#footnote-8) |
| SBC Requirement. The requirement to provide at least a four-page summary of benefits and coverage to plan participants applies to grandfathered plans.[[9]](#footnote-9) This is discussed in more detail in Part VII of this publication. |
| Medical Loss Ratio (MLR) reporting and rebates, designed to lower health insurance costs apply to grandfathered plans.[[10]](#footnote-10) |

171. What health reform coverage mandates apply to new plans or plans that lose grandfathered status?

The following thirteen requirements do not apply to grandfathered plans but apply to new and nongrandfathered plans.

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| **Additional Rules Applicable to New and Nongrandfathered Health Plans** |
| Fair health insurance premiums.[[11]](#footnote-11) These are the rules that limit insurers in the individual or small group market as to allowable factors to alter premiums:   * coverage category (e.g., whether the coverage is individual versus family coverage) * rating area (as established by states); * age (may not vary by more than 3 to 1 for adults); and * tobacco use (may not vary more than 1.5 to 1)[[12]](#footnote-12) |
| Guaranteed-Availability Rules Applicable to Small and Large Group Markets.[[13]](#footnote-13) Healthcare reform makes changes to these requirements.  Through December 31, 2013, the guaranteed-availability rules apply to health insurance issuers in the small group market, but not to issuers in the large group market. These rules require a health insurance issuer that actively markets coverage in the small group market to accept every small employer that applies for coverage and to make all products that it actively markets in the small group market available to all small employers. The issuer also must accept for enrollment every eligible individual who applies for coverage when first eligible. Insurers are permitted to impose employer contribution and minimum participation requirements (to the extent consistent with applicable state law), within certain limitations.  As of January 1, 2014, the guaranteed-availability rules are significantly expanded. The statutory changes amended and restructured the guaranteed-availability provisions, making these rules applicable to health insurance issuers in the large and small group markets and effecting certain other changes.[[14]](#footnote-14) Each health insurance issuer that offers health insurance coverage in the individual or group market (regardless of whether the coverage is offered in the large or small group market) is required to accept every employer and individual in the state that applies for such coverage. Enrollment may, however, be restricted to open or special enrollment periods.[[15]](#footnote-15) |
| Guaranteed renewability, which means that an insurer must renew coverage if requested by the plan sponsor..[[16]](#footnote-16) Prior to January 1, 2014, these rules apply to both the small and large group market. They require group insurance issuers in both the small and large group market to renew coverage at the option of the plan sponsor subject to specified exceptions and restrictions (such as nonpayment of premiums, fraud, or violation of certain employer contribution or group participation requirements). |
| Nondiscrimination based on health status. Group health plans and health insurance issuers offering health insurance coverage are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health status factor.[[17]](#footnote-17) Health reform extended these rules, effective January 1, 2014, to health insurance issuers offering individual health insurance coverage.[[18]](#footnote-18) |
| Nondiscrimination against healthcare providers, beginning in 2014 if they act within the scope of their license or certification.[[19]](#footnote-19) |
| Comprehensive health insurance coverage. Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes the “essential health benefits package.”[[20]](#footnote-20) A plan must provide essential health benefits,[[21]](#footnote-21) limit cost-sharing,[[22]](#footnote-22) and provide either bronze, silver, gold, or platinum level coverage (benefits that are actuarially equivalent to 60 percent, 70 percent, 80 percent, or 90 percent of the full actuarial benefits provided under the plan), or a catastrophic plan (also known as “young invincibles” coverage).[[23]](#footnote-23) An insurer that offers bronze, silver, gold, or platinum coverage must offer the same level of coverage in a “child-only plan” designed for persons under age twenty-one.[[24]](#footnote-24) |
| No denial of coverage for individuals participating in approved clinical trials.[[25]](#footnote-25) |
| No cost-sharing (copayments) for preventive and wellness services.[[26]](#footnote-26) |
| Transparency in coverage.[[27]](#footnote-27) A health plan seeking Qualified Health Plan (QHP) certification from an exchange must disclose certain information to the exchange, HHS, and the state insurance commissioner, and make the information available to the public as well as cost-sharing disclosures to participants. |
| Nondiscrimination is prohibited in favor of highly compensated employees by nongrandfathered insured group plans.[[28]](#footnote-28) Those rules are discussed in detail in Part VII of this book. |
| Quality of care reporting requires group health plans and health insurance issuers annually to report to HHS about plan or coverage benefits and provider “reimbursement structures” that may affect the quality of care.[[29]](#footnote-29) |
| Claims appeals[[30]](#footnote-30) and external review[[31]](#footnote-31) rules.[[32]](#footnote-32) These rules apply in addition to the ERISA claims procedures. Insurers will handle this duty for insured plans. Plan documents, summary plan descriptions (SPDs), existing claims procedures, any forms and notices used to communicate benefit determinations, and service contracts with TPAs and insurers will need to be updated. Non-ERISA self-insured plans not previously subject to the ERISA claims procedure requirement must adopt the existing DOL claims procedures and comply with these new requirements, such as governmental and church plans that have not elected to be subject to ERISA. In March 2011, a grace period for some requirements was extended until plan years beginning on or after January 1, 2012, (with one exception).[[33]](#footnote-33) |
| Patient protections[[34]](#footnote-34) for women to select an OB-GYN and parents to select a pediatrician as their child’s primary care provider. Additionally, for group health plans providing for emergency services, the plan:   * may not require preauthorization, including for emergency services provided out-of-network; * must provide coverage regardless of whether the provider is in- or out-of-network; * may not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and * must comply with cost-sharing requirements.[[35]](#footnote-35) |

172. How are these coverage mandates enforced?

The health reform requirements discussed in Q#171, i.e., the coverage mandates incorporated into the PHSA, are enforceable by:

* the IRS or the Department of Labor (DOL)
* participants, beneficiaries and plan fiduciaries, and
* the states and HHS, for state and local government plans

Although the mandates applicable to group health plans and insurers are virtually identical, the consequences of noncompliance differ depending on type of entity and plan because of the different enforcement mechanisms under the Internal Revenue Code (Code), ERISA, the Fair Labor Standards Act (FLSA), and the PHSA.

The PHSA mandates are directly applicable to (and therefore enforceable against) state and local governmental employer group health plans. Insurers in the group and individual markets are subject to the PHSA.[[36]](#footnote-36) Due to incorporation of the mandates into ERISA, they are also applicable to private-sector employer group health plans. Private-sector group health plans are also subject to the mandates incorporated into the Code. While the group health plans of church employers are generally not subject to ERISA (unless they opt in to ERISA coverage), they are subject to the mandates as incorporated into the Code.

Litigation due to violation of these mandates to enforce them could be brought against employers, plan sponsors, and fiduciaries under the PHSA, ERISA, and the FLSA. In addition, there could be other litigation, for example, when an employer moves employees to part-time status (fewer than thirty hours per week) to eliminate or soften the impact of the employer mandate tax penalty. Any such workforce realignment inherently carries with it risks of litigation under ERISA section 510, which prohibits interference with a participant’s benefits or rights under ERISA, as well as potential claims under other antidiscrimination statutes, such as the Age Discrimination in Employment Act and Title VII of the Civil Rights Act.

Internal Revenue Code. The IRS can assess excise taxes upon group health plans that do not comply with the coverage mandates. For group health plans, the penalty tax upon a non-complying plan sponsor is $100 per day of noncompliance per affected individual,[[37]](#footnote-37) and the violations must be self-reported on IRS Form 8928. The tax may be higher where violations occurred or continued during a period under IRS examination or where the violations are more than *de minimis.* The tax does not apply where the failure was based on reasonable cause and not on willful neglect,[[38]](#footnote-38) and the failure is corrected within thirty days after the person knew or should have known that the failure existed.[[39]](#footnote-39) If the plan (other than a church plan)[[40]](#footnote-40) is audited by the IRS, the minimum excise tax for a compliance failure discovered after a notice of examination generally is $2,500.[[41]](#footnote-41) The minimum excise tax is increased to $15,000 if violations are “more than de minimis.” [[42]](#footnote-42) If not corrected and if the failure was due to reasonable cause and not willful neglect (an unintentional failure), the tax imposed may not exceed the lesser of 10 percent of the amount paid to provide medical care during the taxable year or $500,000. In the case of a multiemployer plan, the tax is levied upon the plan.

The PHSA also imposes an additional new penalty of up to $1,000 per day per affected individual for willful violations of the Summary of Benefits and Coverage (SBC) rules for group health plans.[[43]](#footnote-43) For an insured plan, the insurer and plan administrator are potentially subject to this penalty.[[44]](#footnote-44)

There is an exception for small employers with between two and fifty employees. This exception seems limited to failures by an insurer to comply with the mandates and not because an insured plan violates the rules, for example, the health insurance nondiscrimination rules, discussed at Q 306 to Q 310.

ERISA. Using ERISA’s enforcement mechanisms, health reform imposes substantial, complex, and plan-wide coverage mandates on employers. ERISA did this for pension benefits, and health reform has now extended this to the complex world of health benefits. It is quite likely that the plaintiffs’ bar, or perhaps even DOL, will test the limits of grandfathered status, as well as of the employers’ and plan fiduciaries’ good faith efforts to comply with the many coverage mandates.

Health reform allows health plans that were in effect on March 23, 2010, to continue as “grandfathered” plans without having to comply with many of the law’s coverage mandates. Under the DOL’s regulations, grandfathered plans must include a statement, in any plan materials provided to participants, noting the plan’s grandfathered status, describing the plan’s benefits, and providing contact information for questions and complaints.[[45]](#footnote-45) When there is more than one grandfathered option or “package,” the notice must be given for each grandfathered option.

It is unclear whether technical notice failures, such as being thirty days late, will forfeit grandfathered status, and good faith or substantial compliance on notice and changes in benefits may prevent loss of such status.[[46]](#footnote-46) Because the loss of grandfathered status triggers compliance with certain of the law’s coverage mandates on preventative care, it is likely that plaintiffs will often look to challenge grandfathering on a class basis. Plaintiffs also will be expected to contend that the “appropriate equitable relief” section of ERISA allows them to seek recovery of benefits that otherwise would have been provided from the date that such status elapsed.

The DOL may enforce the coverage mandates against group health plans by bringing a civil action to enjoin a noncompliant act or practice or for appropriate equitable relief under Part 7 of ERISA.[[47]](#footnote-47) In addition, participants, beneficiaries, and fiduciaries can sue under ERISA, either individually or through class actions, to enforce the PHSA mandates against private-sector group health plans and their insurers.[[48]](#footnote-48) Such lawsuits might include claims for payment of benefits alleged to be due under the plan, and the affected party could seek damages for unpaid benefits, interest, and attorney’s fees.

The coverage mandates result in litigation exposure because of their complexity and the uncertainty that surrounds implementation. In addition, many of these mandates will upset existing practices (e.g., the potential lifting of annual limits on durable medical equipment or therapy services), and will impose substantial costs on employers. For example, plaintiffs may be expected to test whether limits on doctor visits, mental health sessions, and the like (which are often imposed by plans) are permitted, or instead constitute impermissible forms of annual limits. Finally, if a court later determines that the benefit at issue was required, the employer or plan fiduciary may face plan-wide exposure, with plaintiffs seeking to use ERISA’s remedial provisions to acquire these benefits, including payment of money for any lost benefits.

Beginning in 2014, no essential health benefits (EHB) may have annual or lifetime limits, so plaintiffs may challenge annual or lifetime limits on certain items and services as violating the prohibition on such limits for EHBs. Health plans should be able to show compliance with the “good faith” implementation standard set forth in the regulations[[49]](#footnote-49) until more specific EHB criteria are issued.

ERISA’s fee-shifting provision,[[50]](#footnote-50) giving courts the power to award legal fees to plaintiffs who show “some success on the merits”[[51]](#footnote-51)may also increase the likelihood of class litigation. Previous ERISA litigation has resulted in large “common fund” fee awards for class actions,[[52]](#footnote-52) as well as large lodestar fee awards,[[53]](#footnote-53) making ERISA class litigation attractive to plaintiffs.

PHSA. Non-federal (state and local) governmental plans and health insurance issuers are subject to penalties for violations of the PHSA mandates by HHS (but only if the state takes no enforcement action).[[54]](#footnote-54)The PHSA civil money penalties of up to $100 per day may be assessed against the issuer, the sponsoring employer of a non-federal governmental plan, and the plan itself if it is sponsored by more than one employer.[[55]](#footnote-55) Like the tax penalty, there are exceptions if the failure was not discovered with the exercise of reasonable diligence.[[56]](#footnote-56) Failures due to reasonable cause that are self-corrected within thirty days of the date the entity knew or should have known of the failure have no penalty.[[57]](#footnote-57) Like the tax penalty, this penalty is capped at 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for the group health plan or $500,000, whichever is less.[[58]](#footnote-58)

FLSA. The Department of Labor and individuals denied their rights may sue to enforce the FLSA. Health reform amended the FLSA to protect employees reporting or otherwise opposing violations of the healthcare reform law. That amendment prohibits an employer from discharging or otherwise discriminating against an employee who:

* has received a premium tax credit or subsidy for a qualified health plan
* provided information or is about to provide information to the employer, the federal government, or the state attorney general about any violation of significant portions of the PPACA
* testified or is about to testify in a proceeding concerning such a violation
* has otherwise participated or is about to assist or participate in such a proceeding; or
* has objected to, or refused to participate in, any activity, policy, practice, or task that the employee reasonably believes to be such a violation[[59]](#footnote-59)

This amendment adopts the complaint procedures of the already existing whistleblower protection provision of the federal Consumer Product Safety Improvement Act. Under that provision, an employee who believes that he or she has been retaliated against may file a complaint with the U.S. Department of Labor.

The employee may also file suit in federal court within 90 days after receiving a written determination or within 210 days of the filing of the complaint, if the DOL has not issued a final decision.

**172.01 Who are ERISA health plan participants who can bring anti-discrimination claims due to part-time status being used to deny health plan participation?**

In one case, the term “participant” under ERISA was defined very broadly. A part-time pharmacist who desired full-time status and health benefits but resigned while still part-time was allowed to bring an ERISA anti-discrimination claim despite never having been a health plan participant. [*Sanders v. Amerimed* [No. 1:13-cv-813 (S.D. Ohio April 25, 2014)](http://scholar.google.com/scholar_case?case=10823565817445104883&hl=en&as_sdt=6&as_vis=1&oi=scholarr)] involves a defendant’s motion to dismiss numerous claims. This case could have significance for employees who are hired for less than 30 hours a week (1560 hours a year) and never offered health coverage under the applicable large employer mandate rules for healthcare reform. This case was not a decision on the merits but merely a ruling that plaintiff’s lawsuit can go forward.

Defendant Amerimed employs part-time and full-time pharmacists. On November 5, 2010, Amerimed employed Plaintiff as a part-time pharmacist. Plaintiff was not entitled to participate in Amerimed's group health plan. Plaintiff allegedly sought a full-time position because he wanted to participate in Amerimed's group health plan and receive other benefits. However, Plaintiff was never hired as a full-time pharmacist, despite trying, and eventually voluntarily resigned from his position in or around January 2013.

ERISA Discrimination (Count III). Plaintiff alleges that Defendant violated ERISA section 510 by refusing to hire him for a full-time position because Defendant was concerned that it would incur substantial medical expenses that would have to be paid by its group health insurance plan. Defendant argues that Plaintiff does not state a claim for ERISA discrimination because Plaintiff was not a "participant" in the group health plan.

Section 510 of ERISA states in relevant part: "[i]t shall be unlawful for any person to . . . discriminate against a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the provisions of an employee benefit plan." 29 U.S.C. § 1140. ERISA defines "participant" as "any employee or former employee of an employer, or any member or former member of an employee organization, ***who is or may become eligible to receive a benefit of any type*** from an employee benefit plan." 29 U.S.C. § 1002(7). [Emphasis added.] The "may become eligible" language means "a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or (2) eligibility requirements will be fulfilled in the future." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 117 (1989). The court followed *Fleming v. Ayers & Assoc*., 948 F.2d 993 (6th Cir. 1991), which affirmed liability under ERISA where the employer had discharged the plaintiff because of high medical expenses it expected would be incurred by her infant child, and for which the employer's health insurance plan could have been responsible. Like the instant case, the plaintiff in Fleming was originally hired to work in a part-time position without benefits, but there was a reasonable expectation she would ultimately obtain a full-time position and become eligible for benefits. However, she was discharged before she was ever employed in a full-time position. Under those circumstances, the Fleming Court held that the plaintiff met ERISA's definition of a "participant" in the defendant's health insurance plan, and therefore had standing to bring an action under section 510.

172.02 What is the status of cancelled policies not compliant with healthcare reform?

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They have been allowed to continue in 2014. A part of the basis of the federal healthcare reform was that when individuals are required to have health insurance (or pay a penalty), the insurance must be worth buying, meaning (1) important benefits must be covered, and (2) older and unhealthier people should not be charged amounts dramatically larger than young, healthy individuals. On November 14, 2013,[[60]](#footnote-60) HHS announced a one year retreat and now allows policies that do not comply with certain healthcare reform requirements to continue to be sold if the insurance companies wish to do so and if the state insurance regulators allow them to do so. The Obama administration has announced through this HHS letter that it will allow insurance companies to renew individual and small group market policies that do not meet health law standards through the end of 2013 and 2014 for policy years starting between January 1 and October 1 if that coverage was in effect for the insured or small group on October 1, 2013. Such policies may be renewed for one policy year beginning between January 1, 2014 through October 1, 2014 if insurers decide to do so and if the state insurance regulators permit..

As discussed at the end of this item, there is also legislation pending that would change the law in different ways than announced by HHS. The new administration policy seems designed, at least in part, to deflect blame for the current cancellations to insurers (those elect not to continue the old policies or cannot due so due to the short time available) and to reduce the likelihood that Democrats would vote for one of these pending legislative proposals discussed below. This is another example of the administration changing the law administratively (like the delay in the employer mandate) without a legislative change to the law or its effective dates. No mention has been made yet about the individual mandate and whether it is suspended for those buying these policies that otherwise would have been cancelled.

This HHS action was in response to the complaints that millions of individuals who have received notices that the insurance they had in 2013 would be cancelled, thus meaning that those people would not be able to keep their insurance, even if they liked it. Under this HHS change, a person with a policy that ends in June 2014 would have the option to renew that same plan for one more year, but only if their insurance company decides to continue the policy and the state allows it to be sold. Experts have indicated that many policies that have been cancelled or will be cancelled will not be profitable after the implementation of healthcare reform, meaning that many insurers may not continue to offer noncompliant policies to those who had them on October 1, 2013. This abrupt change of administration policy may be aimed at causing those unhappy with the policy cancellations to be upset with insurers who choose not to continue the cancelled policies rather than Congress and the administration. Had the website HealthCare.Gov been working properly, many people getting cancellations could see if they could get a better deal in an exchange (better coverage, lower cost due to subsidies, or both).

Insurers who use this new option must notify policyholders (1) of the various health law benefits missing from the plan[[61]](#footnote-61) and (2) about the other options they would have on the health law's state exchanges (marketplaces), including the possibility of financial assistance, and outside the exchanges that comply with healthcare reform requirements. Such notices must be sent as soon as possible to those who have received cancellation notices or when a cancellation notice would have otherwise in the future been sent. The administration’s change will only allow people who are already signed up for these pre-Obamacare plans to keep buying them.

State insurance regulators must react to this new federal policy, and initially the state of Washington and Washington, D.C. announced[[62]](#footnote-62) that it would not allow the noncompliant policies to be sold by insurers. Additionally, insurance companies who decide to continue existing and otherwise noncompliant policies must, before January 1, 2014, (1) reprogram their computer systems for cancelled policies, rates, and eligibility, (2) send notices to the policyholders of policy holders who have received cancellation notices via US Mail describing the differences are between specific policies and Obamacare compliant plans, (3) ask the person for their decision, and (4) enter those decisions into their systems without creating mistakes regarding billing, claim payment, and provider (hospital and physician) panel lists. Additionally, if insurers want rate changes to these otherwise discontinued policies, that will be difficult to run through the state insurance department and have a result in place by January 1, 2014.

Anyone remaining in one of these pre-Obamacare plans will be in a separate risk pool, meaning that their premiums are set based on those in their group. Everyone who buys an Obamacare-compliant plan will be in a different risk pool. If many insurers continue these pre-Obamacare plans, many if not most persons who have them may be willing to have their lesser benefit package. These individuals would tend to be healthier, which would drive up premiums sold on the state exchanges.

172.03 Is a hardship exemption from the individual mandate and catastrophic policies available in 2014 for those with cancelled health insurance policies?

Yes. The Obama administration announced December 19, 2013 that individuals whose insurance plans have been canceled will be eligible for “hardship exemptions” from the individual mandate requirement to have coverage in 2014 or pay a penalty. HHS Secretary Kathleen Sebelius outlined the policy in a letter[[63]](#footnote-63) to Sen. Mark Warner and five other senators who had raised concerns about the issue. “I agree with you that these consumers should qualify for this temporary hardship exemption, and I can assure that the exemption will be available to them,” Sebelius said. However, she made it clear that the exemption is limited to persons who have difficulty purchasing exchange coverage.

Sebelius also announced that individuals with canceled policies will be allowed to purchase catastrophic coverage. Previously, only individuals under the age of 30 could avoid incurring a financial penalty after March 312014 by purchasing such plans. However, there are no federal subsidies available for those buying catastrophic coverage.

Thus, the application of the hardship exemption to consumers whose plans were canceled does not appear to be a change in policy. The form[[64]](#footnote-64) for the application for a waiver from the individual mandate already includes such a category: “You received a notice saying that your current health insurance plan is being canceled, and you consider the other plans available unaffordable.”

Thus, the announcement by the administration is largely symbolic and a political response to the criticism that healthcare reform is causing people to lose the policies and physicians they liked and wanted to keep, as they were told generically that they could keep.

In fact, some argue that the hardship definition is so broad that it undermines the individual mandate.

Annual Limits on Essential Health Benefits Limited, Then Eliminated

173. What changes has health reform imposed on annual limits in health plans?

Health reform prohibits health plans from putting an annual dollar limit on essential health benefits for individual insurance and insurance issued in the small group market.[[65]](#footnote-65) Essential health benefits do not include “excepted benefits,” which are not subject to health reform provisions. (See Part I, Q 12 to Q 22, for more information on “excepted benefits.”) Self-funded, large group market, and grandfathered health plans are not required to offer essential health benefits.

The law restricts and phases out the annual dollar limits a health plan, other than a grandfathered plan, can place on essential health benefits.[[66]](#footnote-66) Annual limits are prohibited completely in 2014 for essential health benefits. While grandfathered plans are exempt from the essential health benefit requirement, they are subject to the prohibition on annual limits for any essential health benefit they offer.[[67]](#footnote-67) Beginning in 2014, all insurance coverage available on the exchanges will provide essential health benefits.

Before the healthcare law, many health plans set an annual limit — a dollar limit on their yearly spending for covered benefits. Many plans also set a lifetime limit — a dollar limit on what they would spend for covered benefits during the entire time a participant was enrolled in that plan.

Under the law, lifetime limits on most benefits are prohibited in any health plan or insurance policy issued or renewed on or after September 23, 2010.

The law restricts and phases out the annual dollar limits that all employment-related plans, and individual health insurance plans issued after March 23, 2010, can put on most covered health benefits. Specifically, the law says that none of these plans can set an annual dollar limit lower than:

* $750,000: for a plan year or policy year starting on or after September 23, 2010, but before September 23, 2011
* $1.25 million: for a plan year or policy year starting on or after September 23, 2011, but before September 23, 2012
* $2 million: for a plan year or policy year starting on or after September 23, 2012, but before January 1, 2014

No annual dollar limits are allowed on most covered benefits beginning January 1, 2014. The ban on lifetime dollar limits for most covered benefits applies to *every* health plan, whether individual or group coverage.

173.01. How does healthcare reform apply to self-insured (self-funded) health plans?

The Department of Health and Human Services (HHS) has addressed[[68]](#footnote-68) amendments by the PPACA to the law permitting self-funded nonfederal governmental plans to opt out of compliance with certain federal benefit mandates. Except for a narrow band of requirements, these group health plans will no longer be permitted to opt out of HIPAA rules regarding the preexisting condition exclusion, enrollment periods, and the prohibition on discriminating against persons due to preexisting conditions. Plan sponsors may continue to opt out of requirements under the Newborns’ and Mothers’ Health Protection Act, Mental Health Parity and Addiction Equity Act, Women’s Health and Cancer Rights Act, and Michelle’s Law.

Self-funded plans generally are treated the same as insured plans under the PPACA. Analysis of the application of PPACA (the 2010 healthcare reform law) to self-insured plans begins with section 1562, which adds section 715 to ERISA and section 9815 to the IRC. These provisions state that all of the provisions of Part A of Title XXVII of the Public Health Service Act (PHSA), as amended by the PPACA, apply to both ERISA group health plans and health insurance issuers that insure group health plans. ERISA group health plans include both self-insured and insured plans.

The section further provides that if anything in ERISA’s group plan requirements conflicts with Part A of the PHSA, the PHSA shall govern. The fact that this section refers both to group health plans and to insured group health plans makes it clear that the provision is meant to apply to self-insured plans. This is reinforced by subsection (b) of this section adding new section 715 to ERISA and IRC section 9815 to the IRC, both of which state that section 2716 and section 2718 of the PHSA do not apply to self-insured plans, indicating that the remaining provisions do.

The definition of group health plan under PPACA section 1301(b)(3), which incorporates the definition of section 2791 of the PHSA,[[69]](#footnote-69) states that group health plan means an employee welfare benefit plan as defined in ERISA section 3(1).[[70]](#footnote-70) section 1551 of the PPACA also provides that the definitions of PHSA section 2791 apply to the PPACA.

Several sections of the PPACA refer specifically to self-insured plans:

* Section 2701(a)(5), applying the health status underwriting provisions to large group plans in an exchange, does not apply to self-insured plans. section 2715 requires a plan sponsor or designated administrator to make disclosures required by that section for self-insured plans.
* Section 2716, discrimination in favor of highly-compensated employees, expressly states that it does not apply to self-insured plans, which already are covered by a similar requirement under IRC section 105(h).
* Self-insured plans expressly are subject to the external review requirements, that is, the appeal requirements, of section 2719 to be established by HHS.
* The reinsurance provisions of section 1341 expressly apply to self-insured plans; the risk-pooling provisions of section 1343 expressly do not.
* Self-insured plans expressly are subject to a per-member fee to fund patient centered outcomes research under recently added IRC section 4376.

These changes are effective beginning on or after September 23, 2010, for non-collectively bargained self-funded nonfederal governmental plans. For example, self-insured nonfederal governmental plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, have a different compliance effective date. These have been exempted from any of the relevant HIPAA requirements, limits on preexisting condition exclusions, special enrollment periods, and health status nondiscrimination requirements. They will not have to come into compliance with those requirements until the first day of the first plan year following the expiration of the last plan year governed by a collective bargaining agreement.

174. What are essential health benefits?[[71]](#footnote-71)

Insurance policies must cover these benefits in order to be certified and offered in exchanges, and all Medicaid state plans must cover these services by 2014. A definition and list of essential health benefits is found in Part I, Q 2.

175. What exceptions to the annual limit rules are there?

The annual limit rules do not apply to “excepted benefits.” The rules are not specific as to whether there can be non-dollar limits, such as limits on certain types of visits to providers. As noted, self-funded, large group market, and grandfathered health plans are not required to offer essential health benefits, but they are not subject to the prohibition on annual limits on the essential health benefits they do offer.[[72]](#footnote-72) The rule does not apply to health flexible spending arrangements, medical savings accounts, or health savings accounts. If a health reimbursement arrangement (HRA) is integrated with other coverage as part of a group health plan, and the other coverage standing alone would comply with this rule, then the HRA will not be subject to the rule.[[73]](#footnote-73)

The rule generally does not apply to retiree-only stand-alone HRAs. The tri-agency task force (HHS, DOL, and Treasury) has requested comments regarding the application of the rule to non-retiree-only stand-alone HRAs.

The regulations clarify that the rule does not preclude a plan from excluding all benefits with respect to a particular condition. If the plan provides any benefits for a condition, however, the rule applies.

176. Are any waivers to the annual limit rule available?

Yes. Some plans (typically “mini-med” plans offering restricted benefits) were eligible for a waiver from the rules concerning annual dollar limits, if complying with the limit would mean a significant decrease in benefits coverage or a significant increase in premiums. On June 17, 2011, the Centers for Medicare & Medicaid Services (CMS) introduced a process for plans that have already received waivers and want to renew those waivers for plan or policy years beginning before January 1, 2014. Revised guidance extends the duration of waivers that have been granted through 2013, if applicants submitted annual information about their plan and comply with requirements to ensure that their enrollees understand the limits of their coverage.

As a condition of receiving a waiver, a plan must provide a notice explaining to participants that the plan does not meet the annual limit requirements.[[74]](#footnote-74)

Lifetime Limits on Essential Health Benefits Eliminated

177. When are the rules against lifetime limits effective?

Unlike the rules for annual limits, there is no waiver procedure for the rules against lifetime limits. Effective for plan years beginning on or after September 23, 2010, group health plans and insurers, other than grandfathered plans, may not impose any lifetime limit on the dollar amount of essential health benefits for any individual.[[75]](#footnote-75) As noted, self-funded, large group market, and grandfathered health plans are not required to offer essential health benefits but are subject to the prohibition on lifetime limits on the essential health benefits they do offer.[[76]](#footnote-76)As noted above in Q 173, plans are not prohibited, however, from placing lifetime dollar limits on specific covered benefits that are not essential health benefits to the extent such limits are otherwise permitted under applicable federal or state law.[[77]](#footnote-77) The rules against lifetime limits apply to both in-network and out-of-network benefits.[[78]](#footnote-78) All coverages offered on the exchanges will offer essential health benefits.

The applicable essential health benefits benchmark for the state in which the insurance policy is issued would determine the essential health benefits for all participants, regardless of the employee’s state of residence or domicile.[[79]](#footnote-79) The preventive services described in section 2713 of the PHS Act are part of essential health benefits.[[80]](#footnote-80) Beginning January 1, 2014, all Medicaid benchmark and benchmark-equivalent plans must include at least the ten statutory categories of EHBs.[[81]](#footnote-81)

Dependent Coverage Extended to Children until Age Twenty-six

178. What are the rules that require extending coverage to children of the insured until the child reaches age twenty-six?

The until age 26 adult child coverage requirement is the following:

A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.[[82]](#footnote-82)

Thus, coverage is available until the day before the child’s twenty-sixth birthday. Therefore, unless extended by the plan until the end of the year, coverage terminates at age twenty-six.

Like all of health reform, the age twenty-six rules do not apply to “excepted benefits,” but only to major medical coverage.

179. When was the until age twenty-six coverage requirement effective?

The until age twenty-six rule is effective for plan years beginning on or after September 23, 2010.[[83]](#footnote-83) For policies in the individual market, the mandate is applicable for the initial period of coverage beginning on or after September 23, 2010, regardless of what the policy year is.[[84]](#footnote-84) Grandfathered plans only need to cover children not eligible for coverage from their own employer’s health plan (other than coverage as a dependent child) until the plan year beginning in 2014.[[85]](#footnote-85)

For income tax purposes, the change is effective March 30, 2010.[[86]](#footnote-86)

180. What about adult children who were previously ineligible for coverage who became eligible for the first plan year beginning on or after September 23, 2010?

The regulations required a notice to these newly eligible adult children and an enrollment period for plans meeting specified conditions.[[87]](#footnote-87)

181. What is the definition of a child for this purpose?

There is no statutory or regulatory definition of the term “child” for this purpose as there is for income tax purposes. The plan and summary plan description (SPD) should provide a clear definition of “child” that accurately reflects the plan sponsor’s intent as to the categories of individuals for whom coverage is intended to be extended until age twenty-six.

In defining which children under age twenty-six are eligible for coverage, the interim final regulations prohibit a plan from requiring a child to satisfy any conditions other than “a relationship between a child and the participant.”[[88]](#footnote-88) No further guidance was offered as to the meaning of “child.”

Relatives such as nephews and nieces are not required to be covered to age twenty-six, even if the plan grants them eligibility.[[89]](#footnote-89) Thus, it is permissible for a plan that covers them to impose a lower age limit with respect to coverage for them.

However, some plans permit or prohibit coverage of stepchildren, grandchildren, foster children, or other categories of children. If a plan provides coverage to children in these categories, it is not clear whether the plan can impose satisfaction of additional conditions before providing coverage. For example, if a plan provides coverage for stepchildren, is it required to cover all stepchildren, or can it limit coverage to those stepchildren who reside with or are financially dependent on a plan participant?

182. Must all health plans now offer the until age twenty-six coverage?

No. Plans are not required to offer any dependent care coverage. However, if a group health plan or insurer provides coverage of children, the plan must make such coverage available for a child until age twenty-six. In addition, a “uniformity rule” requires that coverage for children under age twenty-six cannot vary based on age.[[90]](#footnote-90) So a copay can be charged (so long as it is not for preventive services) for all persons age nineteen and over.

183. If adult child coverage is provided, must it eliminate prohibitions against preexisting conditions for adult children before 2014?

While this is not specifically addressed, it seems that the answer is “no.” Health reform prohibits preexisting condition exclusions for children under age nineteen, effective for the first plan year beginning on or after September 23, 2010.[[91]](#footnote-91)

184. Does this rule require the elimination of preexisting condition exclusions for all Code section 152(f)(1) children up to age twenty-six?

The IRS has informally indicated that HHS, DOL, and Treasury agree that the prohibition on benefit variance does not mandate an elimination of preexisting condition exclusions up to age twenty-six.[[92]](#footnote-92)

185. May a plan exclude, for the up to age twenty-six rule, children based on tax-dependent status, residency, age, income, employment, marital, or tax-filing status?

If a plan covers dependents, then the answer is no, at least not for children who are Code section 152(f) children, i.e., dependents.[[93]](#footnote-93) These factors cannot be used whether the child is a minor or an adult. The statute itself makes clear that marriage is not a disqualification.[[94]](#footnote-94) However, coverage need not be offered to the child’s spouse.[[95]](#footnote-95)

Generally, a plan cannot deny eligibility to a Code section 152(f) child because that child is eligible for other coverage.[[96]](#footnote-96) Thus, if a plan offers dependent coverage to Code section 152(f) children of employees, it must extend coverage even to Code section 152(f) children who are eligible for coverage through another parent’s employer or a spouse’s employer. As discussed at Q 179, for a limited time, grandfathered plans need not offer dependent coverage to a child under age twenty-six who is eligible to enroll in another employer-sponsored group health plan, other than that of the other parent’s employer.[[97]](#footnote-97)

186. Given the uncertain definition of a child, what should an employer or other health plan sponsor do?

Given the potential for litigation and liability for medical care for someone who should have been covered but was not, the plan sponsor should not impose conditions beyond the relationship with the participant on any child within the Code section 152(f)(1) dependent definition. This means, for example, that a plan should treat all stepchildren and foster children equally. i.e., cover all or none until they turn twenty-six.

187. May a plan allow a choice of coverage as an employee or dependent coverage as a child, but not both?

This provision would seem permissible, since the child could choose whether to enroll for dependent coverage (through an employed parent) or for the child’s own employee coverage. Again, absent a clear answer, the prudent course would be not to use this plan provision.

188. What about the children of a person’s same-sex partner?

Stepchildren are the children of an individual’s spouse, and in states that recognize same-sex marriage, the child of an employee’s same-sex spouse would likely be treated as a stepchild. It is unclear whether the stepchild status under state law would carry over for federal law purposes given the Defense of Marriage Act (DOMA) and its prohibition on treating same-sex couples as spouses for purposes of federal law. Arguably, DOMA’s effect should be confined to determining who is a spouse for federal law purposes and not who is a stepchild; however, the issue is uncertain.

189. What if a plan covers grandchildren? Does the until age twenty-six requirement apply to them?

No. The coverage mandate does not require coverage to be offered to a grandchild of an employee.[[98]](#footnote-98) Some plans previously extended eligibility to an employee’s grandchild if the grandchild was the employee’s tax dependent. A plan may place eligibility conditions on grandchildren (e.g., requiring that they be qualifying children or qualifying relatives of the employee), since they are not within the definition of Code section 152(f) children.[[99]](#footnote-99)

190. Who is a child for income tax purposes and what is the tax treatment of the until age twenty-six coverage?

Health reform revised IRC section 105(b) now makes excludable from an employee’s income employer and health plan reimbursements for medical care attributable to the employee’s child to the extent such child is not yet age twenty-seven during the taxable year. The 2010 law also included numerous conforming changes to the IRC regarding voluntary employees beneficiary associations (VEBAs), IRC section 401(h) transfer accounts, and the deduction for medical insurance for self-employed persons under IRC section 162(l). As discussed in Q 194, health reform inadvertently failed to amend IRC section 106, but the IRS is treating that provision as if it were amended.

IRS Notice 2010-38 addresses these tax changes in connection with the adult child coverage provisions of the PHSA. Employer-provided coverage for an employee’s Code section 152(f) children under age twenty-seven is now nontaxable[[100]](#footnote-100) for the “taxable year” (see discussion in Q 192 for meaning of “taxable year”) in addition to coverage for an employee’s Code section 105(b) dependents. For income tax purposes, a “child” is “a son, daughter, stepson, or stepdaughter of the taxpayer, or . . . an eligible foster child of the taxpayer.”[[101]](#footnote-101) This definition is used when determining the taxability of employer-provided coverage for children under age twenty-seven.[[102]](#footnote-102) So children who have their twenty-sixth birthday mid-year still enjoy favorable income tax treatment, as does the plan, until the end of the plan year or the policy year for individual policies.

191. Do the Internal Revenue Code’s dependency tests apply in determining qualifying adult child status?

No. Notice 2010-38 makes clear that the age, limit, residency, and support tests applicable to IRC section 152 dependents do not apply in determining whether an individual qualifies as an adult child for purposes of tax-free employer-paid coverage. Thus, to qualify, an adult child need only be younger than twenty-seven for the taxable year at issue and be a legal child, stepchild, or eligible foster child of the employee in order to qualify.

192. What is a “taxable year” for employees?

The law amended IRC section 105(b) to make excludable from an employee’s income any employer-paid coverage attributable to the employee’s child to the extent such child is not yet age twenty-seven during the “taxable year” at issue. Notice 2010-38 makes clear that “taxable year” means the employee’s taxable year and that employers may assume that an employee’s taxable year is the calendar year.[[103]](#footnote-103)

193. How does a plan sponsor know the age of adult children?

Employers may rely on employees’ representations regarding their children’s date of birth.[[104]](#footnote-104) The guidance is silent as to whether such representations must be in writing, but requiring a written statement would be prudent for employers.

194. Will the employer’s payments to a health plan for adult children also be given favorable tax treatment?

Yes, although health reform inadvertently failed to amend IRC section 106. Nevertheless, the IRS will issue regulations for IRC section 106 that make excludable the employer-paid coverage itself.[[105]](#footnote-105) “On and after March 30, 2010, both coverage under an employer-provided accident or health plan and amounts paid or reimbursed under such a plan for medical care expenses of … an employee’s [qualifying adult] child … are excluded from the employee’s gross income.”[[106]](#footnote-106)

195. Can mid-year election changes be made to cafeteria plans due to the new adult child until age twenty-six rules?

Yes, such changes can be made on and after March 30, 2010. Although existing rules[[107]](#footnote-107) do not permit mid-year changes to cafeteria plan elections when a coverage change results from an individual either qualifying or no longer qualifying as an adult child (because such election changes may only apply with respect to an employee, spouse, and dependents based on a modified IRC section 152 definition), the IRS will provide relief. Notice 2010-38 expressly states that “IRS and Treasury intend to amend the regulations under §1.125-4, effective retroactively to March 30, 2010, to include change in status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.”

196. What was the deadline for amending a cafeteria plan for the until age twenty-six law change?

If an employer wanted to permit adult children’s coverage to be offered in its cafeteria plan in 2010, the plan could have been operated to do so as long as it was amended by December 31, 2010, and retroactively effective to the date when this provision was implemented, but no earlier than March 30, 2010.

Notice 2010-38 provides a transition rule for cafeteria plan amendments. Generally, cafeteria plan amendments must be made prior to a change becoming effective.[[108]](#footnote-108) Nevertheless, Notice 2010-38 states as follows:

Notwithstanding this general rule, as of March 30, 2010, employers may permit employees to immediately make pre-tax salary reduction contributions for accident or health benefits under a cafeteria plan (including a health FSA) for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. However, a retroactive amendment to a cafeteria plan to cover children under age 27 must be made no later than December 31, 2010, and must be effective retroactively to the first date in 2010 when employees are permitted to make pre-tax salary reduction contributions to cover children under age 27 (but in no event before March 30, 2010).

197. What other changes were made for HRAs, FICA, FUTA, VEBAs, and Section 401(h) accounts?

Notice 2010-38 states the following:

* Its principles apply to health reimbursement arrangements (HRAs)
* Adult Child coverage is excepted from wages for FICA/FUTA purposes
* Its principles apply to VEBAs,[[109]](#footnote-109) IRC section 401(h) transfer accounts, and deductions for self-employed individuals under IRC section 162(l)

Regarding VEBAs, for purposes of providing for the payment of sick and accident benefits to members of a VEBA and their dependents, the term “dependent” includes any qualifying adult child (i.e., a child who has not attained age twenty-seven by the close of the calendar year).

As amended by the health reform law, IRC section 401(h) “provides that the term dependent includes any individual who is a retired employee’s [qualifying adult] child” (i.e., a child who has not attained age twenty-seven by the close of the calendar year).

IRC section 162(l), as amended, covers expenses associated with medical insurance attributable to a qualifying adult child (i.e., a child who has not attained age twenty-seven by the close of the calendar year).

198. Do the until age twenty-six adult child rules apply to HSAs?

No. Health savings accounts (HSAs) are not group health plans. However, the law does apply to an underlying high deductible health plan (HDHP) offered in conjunction with the HSA. The HSA rules were not amended by healthcare reform to allow medical expenses of nondependent children under age twenty-seven to be reimbursed tax-free from a parent’s HSA.[[110]](#footnote-110)

**Example:** A parent has coverage under her employer’s HDHP and enrolls her twenty-four-year-old daughter, in the coverage. The coverage provided by the HDHP is not taxable to the employee, because it is a group health plan. However, distributions from the parent’s HSA are not taxed only if they reimburse or pay medical expenses of the HSA account holder, spouse, or dependents. If the daughter incurs medical expenses that are not paid by the HDHP, any distributions that the parent takes from the HSA to cover those expenses will be taxable because the daughter does not qualify as her dependent for HSA purposes. She is not a qualifying child, nor a qualifying relative unless she is disabled or the parent provides more than 50 percent of the daughter’s support.[[111]](#footnote-111) However, the daughter could create an HSA and the parent could fund it.

Civil Rights Discrimination by Health Programs Prohibited

199. What existing anti-discrimination laws were affected by health reform?

Health reform[[112]](#footnote-112) prohibits discrimination by any health program or activity. A plan may not exclude persons from participation in, or deny benefits under, any health program or activity for a reason that is discriminatory under the Civil Rights Act (race, color, or national origin), the Education Amendments Act (sex), the Age Discrimination in Employment Act (age), or the Rehabilitation Act (disability).

200. What guidance has been issued on these rules?

Although health programs and activities are subject to these nondiscrimination requirements, the terms are undefined in the statute. On August 6, 2012, HHS issued seven questions and answers (Q&As) addressing nondiscrimination rules under healthcare reform that apply to health programs and activities receiving federal financial assistance.[[113]](#footnote-113)

Examples of these, HHS clarified that people who claim that they are not getting health care because of how they look can file a complaint. There will be no section 1557 regulation on the definition of what is masculine or feminine,[[114]](#footnote-114) and sex-change surgery need not be covered.[[115]](#footnote-115)

The Office for Civil Rights (OCR) has enforcement authority for health programs and activities that receive federal financial assistance from HHS.[[116]](#footnote-116)

Preventive Health Services Required

201. What does health reform do to encourage preventive care?

To encourage people to be treated as early as possible, health reform added section 2713 of the Public Health Service Act (PHSA). It provides that a group health and a health insurance issuer (as to both group and individual coverage) must provide benefits for, and may not impose cost-sharing (with certain out-of-network exceptions) with respect to, preventive care and screening.

This rule is effective for plan years (policy years in the individual market) beginning on or after September 23, 2010, and it affects all health plans that are not grandfathered health plans or that provide “excepted benefits.”

Women’s preventive service rules are generally effective August 1, 2012, although, as discussed in Q 204, there is an exemption for contraception and sterilization for religious organizations and a one-year delay for social organizations sponsored by religious organizations.

Health plans that violate section 2713 could be subject to the assessment of penalties of $100 per day per affected employee as long as the violation continues.[[117]](#footnote-117)

202. What guidance has been issued by the agencies regarding the preventive care coverage requirements?

The Departments of Health and Human Services (HHS), Treasury and Labor (collectively the agencies) issued interim final regulations regarding the new preventive care coverage requirements.[[118]](#footnote-118) As discussed in Q 208, they were later amended as to contraceptive services.

203. What preventive services are covered?

Generally, group health plans that are not “grandfathered health plans” must cover and waive all cost-sharing requirements for the following “recommended preventive services”:

* Evidence-based items or services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF)[[119]](#footnote-119)
* Immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention[[120]](#footnote-120)
* Evidence-informed preventive care screenings for infants, children, and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA)[[121]](#footnote-121) and
* Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF[[122]](#footnote-122)

The complete list of recommendations and guidelines that must be covered by plans is at http://www.healthcare.gov/law/resources/regulations/prevention/recommendations.html (the List) and will be continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Plans are not required to provide coverage (or waive cost-sharing) for any item or service that ceases to be a recommended preventive service, for example, if the USPSTF downgrades a recommended preventive service from a rating of “B” to a rating of “C” or “D.” Likewise, plans may provide coverage for items and services in addition to those included in the recommendations and guidelines (and such services may be subject to cost sharing).

204. Are there any limits on the frequency, method, treatment, or setting for preventive services to prevent patients from abusing this rule?

Yes. Reasonable medical management techniques can be used when the applicable recommendations and guidelines do not specify the frequency, method, treatment, or setting for a particular preventive service. Plans and insurers may use reasonable medical management techniques to determine any coverage limitations.[[123]](#footnote-123)

205. What are the requirements as to the prohibition on patient payment, i.e., cost-sharing requirements?

Generally, cost sharing for network providers with respect to “recommended preventive services” is prohibited. “Cost sharing” for these rules includes deductibles, copayments, and coinsurance. Cost sharing is permitted for any item or service that ceases to be a recommended preventive service or for services or treatments in addition to those included in the specified recommendations.

Cost-sharing is permitted for office visits when preventive services are billed or tracked as individual encounter data separately or are not the primary purpose of an office visit. Conversely, cost-sharing cannot be imposed when preventive services are not billed or not tracked as individual encounter data separately and are the primary purpose of an office visit.

**Example:** A child visits an in-network pediatrician for a preventive care screening. As a result of the screening, the pediatrician recommends that the child undergo surgery for a heart disorder. Because the preventive care screening is a recommended preventive service, the plan cannot impose a cost-sharing requirement. However, the plan may impose a cost-sharing requirement for the child’s heart surgery, which resulted from the preventive care screening.

**Example:** A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam that is a recommended preventive service. During the office visit, the child receives additional services that are not recommended preventive services. The provider bills the plan for the office visit. Because the primary purpose for the office visit was to provide recommended preventive services, and the plan was not billed separately for the additional services, the plan may not impose a cost-sharing requirement with respect to the office visit.

**Example:** A patient is covered by a group health plan and visits an in-network healthcare provider. While visiting the provider, the patient is screened for cholesterol abnormalities with a rating of A or B (which are recommended preventive services). The provider bills the plan separately for the office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the separately billed laboratory work of the cholesterol screening test. However, the plan may impose cost-sharing requirements for the office visit since it was billed separately from the recommended preventive service.

**Example:** A patient visits his network provider for abdominal pain. During the visit, he has a blood pressure screening that is a recommended preventive service. The provider bills the plan for the office visit, and there is no separate bill for the blood pressure screening. The plan may impose cost sharing on the office visit because the primary purpose of the office visit was not the delivery of a recommended preventive service.

206. How do these rules deal with in-network and out-of-network providers?

The regulations clarify that a network-based plan is not required to provide coverage for recommended preventive services delivered by an out-of-network provider and may impose cost-sharing requirements for any such out-of-network services that are offered.[[124]](#footnote-124)

207. What rules apply for women’s preventive services?

New rules went into effect for women’s preventive health benefits on August 1, 2012, and for health plans, other than grandfathered plans, for the first plan year beginning on or after August 1, 2012, except for contraception and sterilization services for women employed by certain religious organizations or social organizations operated by religious organizations, which are exempt or have a delayed effective date, respectively.

In addition to previously discussed mandated preventive services the enhanced services mandate requires no cost sharing for women for:

* Well-woman visits
* Screening for gestational diabetes
* HPV and DNA testing for women thirty years and older
* Sexually transmitted infection counseling
* HIV screening and counseling
* FDA-approved contraceptive methods and contraceptive counseling. (Some religious groups may qualify for a complete or temporary exemption from covering contraceptive counseling and methods as discussed in Q 208.)
* Breastfeeding support, supplies, and counseling
* Domestic violence screening and counseling

As changes occur, an updated list can be found at http://www.hrsa.gov/womensguidelines.

208. How does health reform deal with contraception and sterilization services for employees of religious organizations and social organizations sponsored by religious groups?

Section 2713(a)(4) of the PHS Act requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide benefits for certain women's preventive health services without cost sharing, as provided by Health Resources and Services Administration (HRSA) guidelines. The August 1, 2011, HRSA Guidelines include all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services). The HRSA guidelines do not cover men.

The final contraception regulations promote two goals. First, they provide women with access to contraceptive coverage without cost sharing, thereby advancing the compelling government interests in safeguarding public health and ensuring that women have equal access to health care. Second, they protect certain not-for-profit religious organizations with religious objections to providing contraceptive coverage from having to contract, arrange, pay, or refer for such coverage.

In July 2013, the agencies (DOL, HHS, and IRS) issued revised final regulations, changing how the previous 2012 regulations applied the contraceptive coverage mandate to not-for-profit religious organizations. Under the 2013 final regulations, a religious employer includes (1) churches, their integrated auxiliaries, and conventions or associations of churches[[125]](#footnote-125) or (2) the exclusively religious activities of any religious order[[126]](#footnote-126) and is exempt from the mandate.[[127]](#footnote-127) With the exception of the amendments to the religious employer exemption, which apply to group health plans and health insurance issuers for plan years beginning on or after August 1, 2013, these 2013 final regulations apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2014.

The prior exemption requirements that the organization had to have as its purpose the inculcation of religious values and had to primarily employ and serve persons who share its religious tenets were removed. Under the 2013 final regulation, an eligible organization is an organization that (1) opposes providing coverage for some or all of the contraceptive services required to be covered under section 2713 of the PHSA on account of religious objections; (2) is organized and operates as a not-for-profit entity; (3) holds itself out as a religious organization; and (4) certifies that it satisfies the first three criteria. An eligible organization also includes student health insurance coverage arranged by eligible organizations that are institutions of higher learning.

Therefore, group health plans of not-for-profit houses of worship that provide educational, charitable, or social services to their communities qualify for the exemption. An employer that is a not-for-profit entity is not limited to any particular form of entity under state law, and it is not necessary to determine the federal tax-exempt status of a not-for-profit entity in determining whether the religious employer exemption applies.

The accommodation for eligible organizations with nongrandfathered insured plans requires the insurer to assume sole responsibility for providing separate payment for contraceptive services directly to participants and beneficiaries, without cost-sharing, premium, fee, or other charge to plan participants, beneficiaries, or to the religious organization or its plan. The payments are not individual health insurance policies.

For eligible organizations with self-insured plans, the TPA becomes an ERISA plan administrator and claims administrator solely for the purpose of providing payments for contraceptive services for participants and beneficiaries at no cost to plan participants or beneficiaries or to the eligible organization. The TPA must provide or arrange separate payments for contraceptive services for participants and beneficiaries in the plan without cost-sharing, premium, fee, or other charge to plan participants, beneficiaries, the eligible religious organization, or its plan. The TPA can provide the payments on its own, or it can arrange for an insurer or other entity to provide the payments. Like the payments for contraceptive services under the accommodation for insured plans, the payments are not health insurance policies.[[128]](#footnote-128)

Any organization seeking accommodation as an eligible organization certifies to its insurer or TPA that it meets the definition of an eligible organization. In turn, insurers or TPAs provide an annual notice of the availability of the coverage to participants and beneficiaries.[[129]](#footnote-129)

Employers participating in a multiple employer plan are required to independently qualify as religious employers or eligible organizations to take advantage of the exemption or accommodations.[[130]](#footnote-130)

Not-for-profit employers that do not fit within the previously outlined exemption and do not currently cover contraceptive services are not required to provide contraception coverage until plan years beginning on or after January 1, 2014.[[131]](#footnote-131)

* The safe harbor is also available to not-for-profit organizations with religious objections to some but not all contraceptive coverage;
* Group health plans will not be ineligible for the safe harbor merely because an attempt made before February 10, 2012, to exclude or limit contraceptive coverage proved unsuccessful; and
* The safe harbor may be invoked without prejudice by not-for-profit organizations that are uncertain whether they qualify for the religious employer exemption (i.e., doing so will not preclude an otherwise-eligible employer from later invoking the exemption).[[132]](#footnote-132)

The HHS bulletin requires specific notice and certification requirements that these organizations must meet in order to qualify. Specific language must be used to satisfy these requirements. The notice must be distributed “in connection with enrollment (or re-enrollment)” for coverage that is effective beginning each plan year before January 1, 2014. Thus, for a calendar-year plan with an open enrollment period beginning November 1, the notice must be provided to participants on or after November 1, 2013. The notice is required to be provided by the plan, although the plan may delegate this responsibility to its insurer or TPA. With respect to insured coverage, unless it accepts in writing the responsibility to provide the notice, an insurer does not lose protection under the temporary enforcement safe harbor solely because the notice is not distributed by the plan or because the insurer relies in good faith on a representation by the plan that turns out to be incorrect.

209. Are there any other options for religious organizations that object to these rules?

Employers that do not intend to comply with section 2713 could terminate their group health plan and encourage their employees to obtain individual policies. As of January 1, 2014, such individual policies must be offered on state health insurance exchanges on a guaranteed issue, guaranteed renewability basis. However, employers with at least fifty full-time equivalent employees or with at least thirty-one full-time employees that do not offer health coverage are subject to penalties.[[133]](#footnote-133)

209.01 How the Supreme Court *Hobby Lobby* decision affect the ACA contraception mandate for for profit businesses?

The U.S. Supreme Court in *Burwell v. Hobby Lobby Stores, Inc*.[[134]](#footnote-134) created a new exemption to the Affordable Care Act provision requiring that for-profit companies offer birth control coverage to their employees. The Court ruled that closely-held for-profit corporations are entitled to statutory religious freedom protections where their owners’ sincere religious beliefs are violated, at least as to birth control. Religious nonprofit employers, such as churches, are already exempt from the contraceptive mandate.[[135]](#footnote-135) The Court rules that “persons” protected under the Religious Freedom Restoration Act of 1993 (“RFRA”) include the owners of closely-held corporations. This decision does not address the free exercise of religion clause under the First Amendment to the Constitution. It also does not affect state law, which as discussed below, may require all forms of contraception to be provided by insured health plans.

The RFRA provides that the federal government shall not “substantially burden a person’s exercise of religion” unless that burden is the least restrictive means to further a compelling governmental interest. The Court noted that for the government to prevail, it needed to demonstrate a compelling state interest and to show that its application was the least restrictive means to achieving its objectives. While the Court assumed a compelling governmental interest, it concluded that there were less restrictive alternatives available to the government for achieving its objectives as to the healthcare reform rules regarding contraception. The Court noted that the government could itself simply provide these benefits to all without charge.

The Supreme Court’s decision in effect allows for-profit business corporation owners to impose their religious choices about contraception on its employees’ health plan, even where those employees follow different religions or no religion. In many cases, closely-held businesses employ many more people than they have owners. As the dissent notes, “the family-owned candy giant Mars, Inc., takes in $33 billion in revenues and has some 72,000 employees, and closely-held Cargill, Inc., takes in more than $136 billion in revenues and employs some 140,000 persons.”[[136]](#footnote-136)

The RFRA does not apply to state laws.[[137]](#footnote-137) Therefore, the *Hobby Lobby* decision has no impact on state laws. Twenty-eight states, including California and New York, require insurers to provide coverage of contraceptive drugs and devices.[[138]](#footnote-138) Twenty two states have no contraception mandate. Seventeen states also require coverage of correlated outpatient services.[[139]](#footnote-139)

For example, California's law includes a provision permitting a "religious employer" to opt out of providing such coverage. However, the California law's definition of "religious employer" is narrower than that of the *Hobby Lobby* decision. California's law defines a "religious employer" as a nonprofit entity whose primary purpose is to inculcate religious values, and which primarily serves and employs people who share the entity's religious beliefs.[[140]](#footnote-140) The plaintiffs in *Hobby Lobby*, for-profit retailers specializing in crafts and furniture, do not meet this definition. Thus, in states with law like California’s, a closely-held for-profit corporation, such as the retailers in *Hobby Lobby*, would need to comply with state law. Unlike California, a few states have enacted RFRA statutes and there the *Hobby Lobby* rationale could succeed. However, the majority of states mandating contraceptive drug and device coverage appear to be similarly insulated from court challenge.

The majority decision was limited only to four of the twenty contraception mandates (those that work after fertilization) and not to other health care mandates that might violate other religious beliefs. The Court said that there was no proof to the government’s claim that vaccinations and blood transfusions violated any religious beliefs. The Court stated: “In any event, our decision in these cases is concerned solely with the contraceptive mandate. Our decision should not be understood to hold that an insurance coverage mandate must necessarily fall if it conflicts with an employer’s religious beliefs. Other coverage requirements, such as immunizations, may be supported by different interests (for example, the need to combat the spread of infectious diseases) and may involve different arguments about the least restrictive means of providing them.”[[141]](#footnote-141)

In terms of business entity law, the *Hobby Lobby* decision seems seriously flawed. The Court does not (i) define a closely-held business (the corporations in the *Hobby Lobby* case were each owned by members of one family); (ii) recognize that the closely-held concept has varying meanings in different contexts, depending on the purpose the law in that context is supposed to serve (closely-held businesses comprise 50-90 percent of US businesses, depending on which definition is used); (iii) mention the entity versus aggregation of owners distinction and that distinction's ramifications, where the law previously sometimes looked, in the case of partnerships, to the partners, not the entity; (iv) recognize that the decision is a type of piercing of the corporate veil, looking through the entity to its owners; which typically is only done where there is some type of fraud, fault, or wrongdoing; and (v) reconcile its holding with its *Citizens United* decision[[142]](#footnote-142), where it held that corporations are themselves persons and have free speech rights to spend money in political campaigns. Had the Court looked to the corporations in *Hobby Lobby* and not their owners, the result seemingly would have been different. As the dissent notes, “the exercise of religion is characteristic of natural persons, not artificial legal entities.”[[143]](#footnote-143)

209.02 How the Hobby Lobby decision affect disclosure and notice requirements for employers who cease providing contraceptive services?

DOL FAQ Part XX[[144]](#footnote-144) addresses the notice requirements for employers who cease providing contraceptive services in a single Q&A. It states that where a closely held for-profit corporation’s health plan will cease providing coverage for some or all contraceptive services mid-plan year, this reduction in coverage triggers a notice requirements to plan participants and beneficiaries. Remember that the employers in the Supreme Court’s *Hobby Lobby[[145]](#footnote-145)* decision were owned by family members, but it is not clear if that is required to be closely held, as the Supreme Court did not define that term and it has many meanings in different contexts.

The DOL states that ERISA’s requirements for welfare benefit plans, such as health plans, require disclosure of information relevant to coverage of preventive services, including contraceptive coverage. DOL regulations provide that the summary plan description (SPD) must include a description of the extent to which preventive services (which includes contraceptive services) are covered under the plan.[[146]](#footnote-146) Accordingly, if an ERISA plan excludes all or a subset of contraceptive services from coverage under its group health plan, the plan’s SPD must describe the extent of the limitation or exclusion of coverage.

For plans that reduce or eliminate coverage of contraceptive services after having provided such coverage, expedited disclosure requirements for material reductions in covered services or benefits apply and generally require disclosure at least 60 days after the date of adoption of a modification or change to the plan that is a material reduction in covered services or benefits.[[147]](#footnote-147) The notice of the material modification must be provided no later than 60 days prior to the date on which such change will become effective. Alternatively, plan sponsors may provide an SMM in health plan coverage at regular intervals of not more than 90 days.[[148]](#footnote-148) Other disclosure requirements may apply, for example, under State insurance law applicable to health insurance issuers.”

Rescissions Limited

210. How does health reform limit insurers’ ability to terminate coverage?

Before enactment of health reform in 2010, the Public Health Service Act (PHSA) included some protections regarding cancellation of coverage. Additional protections were also provided in the HIPAA nondiscrimination rules. This new rescission regulation builds on the existing protections, and sets a federal floor on rescissions.

The restriction limiting rescissions is effective for plan years (for individual policies in the individual market, policy years) beginning on or after September 23, 2010.

States may limit rescissions beyond the limits of the federal health reform law.[[149]](#footnote-149) The federal law prohibiting rescissions does not apply to “excepted benefits.”

211. What is a rescission?

A “rescission” is a retroactive cancellation or discontinuance of coverage of an “enrollee,” i.e., a person who is covered by the policy. Whether an individual or group policy, the statute indicates that a rescission can only apply to the individual who committed the fraud or intentional misrepresentation of a material fact.[[150]](#footnote-150) However, the regulations contemplate that a group policy can be rescinded as well.[[151]](#footnote-151) A cancellation or discontinuation of coverage is not a rescission if it:

* has only a prospective effect; or
* is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.[[152]](#footnote-152)

A rescission is an adverse benefit determination that is subject to the healthcare reform internal claims and appeals and external review requirements discussed at Q 216 to Q 226.

212. When is an insurer allowed to rescind or terminate an individual or group policy retroactively?

An insurer may retroactively terminate a policy for fraud or an intentional misrepresentation of a material fact with notice.[[153]](#footnote-153) Misrepresentations that are inadvertent are not intentional.[[154]](#footnote-154)

The regulations require a group health plan or an issuer offering group coverage to provide at least thirty days’ advance written notice to each participant who would be affected before coverage may be rescinded—regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group (same rules apply with respect to a rescission of individual coverage).[[155]](#footnote-155) The purpose of the waiting period is to provide individuals and plan sponsors with an opportunity to explore their rights to contest the rescission, or look for alternative coverage, as appropriate.”[[156]](#footnote-156)

213. If an employer with an insured group plan covering employees working thirty hours or more a week forgets to advise the insurer that a covered employee’s hours are reduced below thirty, can this individual’s policy be rescinded?

No because there is no fraud or intentional material misrepresentation. However, the insurer could cancel the employee’s coverage prospectively, subject to requirements of state and federal laws.[[157]](#footnote-157)

214. What should the sponsor of an insured group plan do if the plan wants to be able to rescind coverage retroactively?

If a plan wants to be able to cancel coverage retroactively, the plan document and summary plan description (SPD) should define what constitutes fraud and what will be considered an intentional misrepresentation of material fact, consistent with the statute that will trigger the plan’s right to rescind coverage. A frequent reason for retroactive cancellation of coverage is the enrollment of an ineligible dependent or adult child. In order to retain the right to rescind coverage of ineligible children and dependents, the SPD should clearly describe who is eligible for coverage and the requirements for documenting eligibility. The SPD should state that intentionally enrolling or continuing coverage for an ineligible individual constitutes fraud and an intentional misrepresentation of a material fact that will trigger rescission. In addition, the SPD should describe the results of rescission, including but not limited to liability for improper benefits paid.

215. Has the government declared any coverage terminations not to be rescissions?

Yes. An FAQ clarified several eligibility matters. For example, some employers’ human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the agencies do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission.

Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions), the plan is not notified of a divorce, and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the agencies do not consider a plan’s termination of coverage retroactive to the divorce to be a rescission of coverage.[[158]](#footnote-158)

New Claims and Appeals Procedures

216. What are health reform’s required claims and appeals procedures?

Nongrandfathered group health plans (excluding those for “excepted benefits”) are required to have internal claims and external appeals procedures in place for plan years beginning on and after September 23, 2010.[[159]](#footnote-159) PPACA in the Public Health Service Act (PHSA) section 2719 set forth standards for non-grandfathered group health plans, insured and self-insured, and for internal claims and appeals and external reviews. The Employee Benefits Security Administration (EBSA), IRS, and Department of Health and Human Services (HHS) published the interim final regulations implementing PHSA section 2719 on July 23, 2010.[[160]](#footnote-160) The regulations were updated and revised in June 2011.[[161]](#footnote-161)

217. Were any of the requirements postponed?

Yes. The DOL’s Employee Benefits Security Administration (EBSA) in Technical Release 2010-02 initially provided group health plans and self-funded nonfederal governmental health plans relief until July 1, 2011, from enforcement actions by IRS (including the otherwise applicable excise tax for noncompliance) and by EBSA for plans that work in good faith to implement the new regulatory internal claims and appeals rules. EBSA extended this grace period until January 1, 2012, in Technical Release 2011-01. The original grace period and new extension are, however, only for three minor new standards, less than 1 percent of the entire PPACA Claims Regulations, and have no effect on the PPACA statutory effective date of September 23, 2010, for the bulk of the PPACA Claims Regulations. Specifically, Technical Release 2011-01 extends the enforcement grace period until plan years beginning on or after January 1, 2012, with respect to standard #2 (regarding the timeframe for making urgent care claims decisions), standard #5 (regarding providing notices in a culturally and linguistically appropriate manner), and standard #7 (regarding substantial compliance).

Plans of a private-sector or church employer and those health plans subject to the Internal Revenue Code did not have to report any excise tax liability on Form 8928 for the rules extended by the grace period.[[162]](#footnote-162)

Many state insurance departments offer claims assistance.[[163]](#footnote-163)

218. Is there a minimum claim threshold under these new claim and appeal rules?

No. There is no *de minimis* exception for small claims eligible for external review, including some HRAs and dental and vision plans that do not qualify as excepted benefits. The appeals regulations specifically provide that the “state process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review.”[[164]](#footnote-164) Thus, there can be no minimum claims threshold. Although the appeals regulations and guidance are silent on this point for federal standards for external review, plans subject to the federal standards similarly are likely not permitted to impose minimum thresholds for claims.

219. How are health reimbursement account claims handled?

For many HRAs, the claim decision simply is whether the expense meets the definition of “medical expense” under Code section 213(d). As a result, HRA claims are simpler and less urgent than many other health plan claims. As a practical matter, there are fewer appeals for HRAs than other types of plans.

220. How do these claims and appeal rules relate to the ERISA claims and appeal rules?

The ERISA claims procedure continues to apply.[[165]](#footnote-165) Non-ERISA self-insured plans, such as church plans, while not subject to ERISA (assuming they have not affirmatively made themselves subject to ERISA), are subject to these new health reform rules. The health reform regulations expand on the 2000 DOL claims regulations, add several new requirements, and extend application of the requirements to non-ERISA group plans and to issuers of individual health insurance.

The health law claims and appeal regulations apply to group health plans and group and individual health insurance issuers for plan or policy years beginning after September 23, 2010. For nongrandfathered ERISA plans, these new requirements are in addition to existing claims procedures in the ERISA internal claim procedure rules at 29 CFR 2560.503-1. Where applicable, if an internal appeal is denied, patients may choose to have the claim reviewed by an independent reviewer. The regulations do not require the plan to provide continued coverage during the claim and any internal appeal, other than the coverage for an ongoing course of treatment. Plans are generally prohibited from reducing or terminating an ongoing course of treatment without notice and an opportunity to review. Individuals in urgent care situations and those receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process. However, the regulations do not make it clear whether this continued coverage requirement applies to appeals of eligibility claims and rescissions.

221. Can state versus federal standards apply?

Yes. Group health plans must determine whether they are subject to state standards or federal standards. For health insurance coverage (i.e., fully insured group health plans), if a state’s external review process is binding on an insurer and includes the consumer protections in the NAIC Uniform Model Act in place as of July 23, 2010, the insurer must comply with the applicable state standards. This requirement is imposed on the insurer and not the plan. If a state’s process does not meet such requirements, then the federal process will apply. The federal external review process generally will apply to ERISA-covered, self-insured plans. However, the preamble to the final regulations also notes that this would not preclude a state from applying its external review process to self-insured group health plans not covered by ERISA or subject to other state insurance law (i.e., nonfederal governmental plans, church plans and multiple employer welfare arrangements).

222. Which external review process (state or federal) applies to plans?

|  |  |  |
| --- | --- | --- |
| **Type of Plan** | **What Process Applies?** | **Who Is Liable?** |
| Insured Plan | State process (if state process applies and is binding) | Insurer (not plan) |
| Federal process (if no state process applies and is binding) | Insurer or plan**\*\*** |
| Self-Insured ERISA Plan | Federal process (unless plan voluntarily complies with an applicable state process, if available) | Plan |
| Self-Insured Non-ERISA Plan (e.g., nonfederal governmental plans and church plans) | State process (if state process applies and is binding) | Plan |
| Federal process (if no state process applies and is binding) | Plan |
| **\*\*** Although the federal external review requirement applies by its terms to plans or insurers, as a practical reality, insured plan sponsors will use the process used by their insurers to comply with this requirement. | | |

223. What are the requirements of the new claims and appeals rules?

These regulations amended ERISA claims procedures applicable to group health plans, and made the new standards applicable to both group health plans and health insurance issuers. Specifically, the regulations provide the following new rules for internal claims and appeals processes:

* The appeals process provision under the law imposes obligations owed to health plan “enrollees.”[[166]](#footnote-166) The appeals regulations, however, generally use the term “claimant.” A claimant is an individual (participant or beneficiary) who makes a claim under the rules for internal claims and appeals and external review procedures, which may include a claimant’s authorized representative.[[167]](#footnote-167) This is the same definition as under the DOL claims procedure regulations.[[168]](#footnote-168)
* As part of full and fair review, a claimant must be permitted to review his or her claim file.[[169]](#footnote-169) This is in addition to the right under the DOL claims procedures to have access to and copies of “documents, records, and other information relevant” to the claim.[[170]](#footnote-170) Existing DOL regulations permit claimants to present written comments, records, and information relating to a benefits claim.[[171]](#footnote-171) Claimants also must be permitted to present evidence and testimony;[[172]](#footnote-172) however, the law and regulations do not define testimony. The term “testimony” likely includes personal and written testimony from a witness, for example, by affidavit.[[173]](#footnote-173) It generally is made by oath or affirmation under penalty of perjury.[[174]](#footnote-174) Informally, the DOL has indicated that the appeals regulations were not intended to add a new rule requiring plans to hold hearings and allow claimants to make oral statements.[[175]](#footnote-175)
* An adverse benefit determination eligible for internal claims and appeals was expanded to include a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time.[[176]](#footnote-176)
* A final internal adverse benefit determination is either an adverse benefit determination that has been upheld by a plan or insurer at completion of the plan’s internal appeals procedures or an adverse benefit determination for which the internal appeals procedures have been exhausted.[[177]](#footnote-177) Typically, most plans a claim and one internal appeal.
* A plan or issuer must notify a claimant of a benefit determination, whether or not adverse, for a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than seventy-two hours after the receipt of the claim by the plan or issuer. The original standard of twenty-four hours was amended to seventy-two hours.[[178]](#footnote-178)
* The appeals regulations require plans or insurers to provide claimants, free of charge, and without any requirement of a claimant’s request, with “any new or additional evidence considered, relied upon, or generated by” the plan or insurer (or at the direction of the plan or insurer) in connection with a claim.[[179]](#footnote-179) This evidence must be provided as soon as possible and soon enough so the claimant can respond.[[180]](#footnote-180) These rules must be followed at each stage of the process.
* Decisions regarding hiring, compensation, termination, promotion, or other similar matters by decision-makers, such as claims adjudicators and medical experts, must avoid any conflict of interest and not be based upon the likelihood that the individual will support the denial of benefits.[[181]](#footnote-181)
* Notices must be provided in a culturally and linguistically appropriate manner,[[182]](#footnote-182) including notices in a non-English language if 25 percent of all participants are literate in the same non-English language. For plans with 100 or more participants, the notices must be provided in a non-English language if the lesser of 500 participants or 10 percent of all participants are literate in the same non-English language.[[183]](#footnote-183)
* Notices to claimants must comply with certain content requirements:
* Any notice of an adverse benefit determination or a final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
* The plan or issuer must ensure that the reasons for an adverse benefit determination or final internal adverse benefit determination include the denial code and its corresponding meaning, as well as a description of the plan’s or issuer’s standard, if any, that was used in denying the claim; and in the case of a final internal adverse benefit determination, this description must also include a discussion of the decision
* The plan or issuer must provide a description of the available internal appeals and external review processes, including information regarding how to initiate an appeal; and
* The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793

224. What if a plan fails to follow these claims and external review rules?

Prior to filing a lawsuit, a claimant must exhaust the appeals process. If a plan or issuer fails to adhere strictly to all requirements of the interim final regulations, the claimant is deemed to have exhausted the plan’s or issuer’s internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied. The claimant may initiate any available external review process and remedies available under ERISA and state law.

The claimant may request a written explanation of a violation of the procedures from the plan or insurer, and the plan or insurer must provide such explanation within ten days, including a specific description of its bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.[[184]](#footnote-184)

If an external reviewer or court rejects a claimant’s request for immediate review on the basis that the plan met the standards for the exception described above, the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the plan must provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim begin to run when the claimant receives the notice.[[185]](#footnote-185)

225. Have model notices been issued?

Yes. Three model notices have been issued by the Labor Department[[186]](#footnote-186) and are reproduced in Appendix B.

226. What are the requirements for SPDs to incorporate the new claims and appeals rules?

The enhanced internal claims and appeals requirements and external review procedures will require that existing SPDs and other plan communications that describe the plan’s claims procedures be updated. In March 2011, the agencies modified and extended the enforcement grace period for certain internal claims and appeals requirements.[[187]](#footnote-187) SPDs and plan communications should provide participants and beneficiaries with information relating to internal claims and appeals requirements and external review procedures, as updated in June 2011.[[188]](#footnote-188)

Wellness Program Rules

227. What are wellness programs?

Some wellness programs are stand-alone programs and others are offered as part of or in conjunction with a group health plan. Wellness programs encourage good health and healthy lifestyles. Additionally, some may provide physical examinations, cholesterol screening, flu shots, nutrition counseling and education, and similar benefits. To the extent that a wellness program provides such medical benefits, it will likely be treated as a group health plan subject to the PHSA mandates in ERISA and the Internal Revenue Code for private employers or in the PHSA for state and local government employers.

The 2014 prohibition against discriminating based on a health status-related factor means, among other things, that plans and insurers may not charge individuals different premiums or impose different costs based on the presence or absence of a health status-related factor. However, nondiscrimination provisions were not meant to prevent a group health plan or insurer from establishing premium discounts or reduced copayments or deductibles in return for “adherence to programs of health promotion and disease prevention.”[[189]](#footnote-189) Thus, certain programs of health promotion or disease prevention (referred to as “wellness programs”) are an exception to the general prohibition on discrimination based on a health status-related factor.

228. How are stand-alone wellness programs treated?

Stand-alone wellness programs are not subject to the PHSA mandates if they are not group health plans. A wellness plan is not a group health plan if it does not provide or pay for health or medical benefits. Examples of types of stand-alone wellness programs that are not group health plans include programs that pay for health or weight-loss club dues, award prizes to persons who walk a certain number of miles, or provide health information. Even when a wellness plan offers incentives, this does not make it a group health plan if the incentives are unrelated to the group health plan, such as a plan offering extra vacation days or bonuses to those who do not smoke or have a good cholesterol level, for example.

On the other hand, stand-alone wellness programs that provide or pay for medical benefits (such as a physical exam program) are group health plans[[190]](#footnote-190) and are subject to the PHSA mandates unless they qualify for an exception.

229. How are wellness programs that relate to group health plans regulated?

A wellness program that relates to, or is a part of, a larger group health plan is subject to the PHSA mandates, if the group health plan to which it is connected is subject to the mandates and is not an excepted benefit, such as a stand-alone vision or dental plan.

A wellness program is related to a group health plan if it is actually one of the benefits under the larger group health plan or if any of the incentives or rewards that it offers affect the benefits or contributions under the larger group plan. For example, an employer-sponsored wellness program that offers, as an incentive for undergoing certain testing, a discount on the amount that an employee must pay for major medical coverage is subject to the PHSA mandates.

The permissible reward under a health-contingent wellness program—from 20 percent to 30 percent of the cost of individual coverage under the group health plan, and up to 50 percent for programs designed to prevent or reduce tobacco use. The codified rules are effective for plan years beginning on or after January 1, 2014.[[191]](#footnote-191) The regulations apply the same standards to both grandfathered and nongrandfathered plans, except grandfathered plans in the individual market.[[192]](#footnote-192)

Additional rules apply to certain wellness programs under HIPAA’s health status nondiscrimination rules. Employers offering wellness programs must also comply with the Americans with Disabilities Act (ADA). Wellness programs or discounts may violate the ADA if the discounts or other rewards are not available to individuals with disabilities. A wellness program could also violate the ADA provisions limiting an employer’s ability to make disability related inquiries and to require medical examinations during employment.

Bringing Down the Cost of Coverage

Medical Loss Ratio (MLR) Rules; PHSA, ERISA and Tax Ramifications

230. What are the health reform provisions relating to reducing the cost of health insurance?

Health reform added PHSA section 2718 entitled “Bringing Down Cost Of Health Care Coverage.” The purpose of the law is to limit the amount insurers can spend on administrative costs. If an insurer exceeds the limit, it is required to rebate the excess. The medical loss ratio (MLR) is the cost of claims plus amounts expended on health care quality improvement as a percentage of total premiums, excluding taxes, fees, and adjustments for risk adjustments and risk corridors, as well as reinsurance.[[193]](#footnote-193)

Health care reform’s Medical Loss Ratio rules became effective January 1, 2011, and the first rebates were required to be issued on August 1, 2012. These rules apply to individual insurance policies and insured group plans but not self-insured health plans. Insurers must provide rebates (refunds)[[194]](#footnote-194) if their percentage of premiums spent on medical claims (and quality improvement) for policies issued in a state is less than 80 percent in the small group and individual markets or 85 percent in the large group market.[[195]](#footnote-195)

Until 2014, the rebate is to be calculated using the figures for the reporting year. Beginning on January 1, 2014, the calculation to determine rebate amounts will be based on the average ratio over the previous three years.[[196]](#footnote-196) Notices of rebates must be sent to both plan sponsors and participants in the plan to which the rebate relates.

Rebates must be paid by August 1 of the year following the year for which the medical loss ratio (MLR) data are calculated.[[197]](#footnote-197) Insurers must also report how the rebate was calculated. Insurers who fail to comply with the law are subject to civil fines to be assessed by HHS up to $100 per day per individual affected by the violation.

231. When were the final MLR regulations issued?

In December 2011, HHS issued final MLR regulations,[[198]](#footnote-198) and the DOL has issued related guidance on healthcare reform’s MLR rules, making changes for employer-sponsored group health plans, including who receives the rebates and how such amounts may be applied.[[199]](#footnote-199) Insurers must provide the rebates for individuals covered by group health plans subject to ERISA or the PHSA to the policyholder, which is generally the employer for a group plan. The effective date of this final regulation was January 3, 2012.

232. How may the insurance company rebates be paid to persons (“enrollees”) purchasing individual policies in the individual market?

For current individual policy owners, insurers may issue rebates in the form of either a premium credit, a reduction in the premium, or a lump-sum payment.[[200]](#footnote-200) For former individual policy owners, only a lump-sum payment is permitted.[[201]](#footnote-201) If an insurer finds that its MLR is lower than the standard required during an MLR reporting year, it may also institute a premium holiday to avoid paying rebates, but only if permitted under state law.[[202]](#footnote-202) An insurer seeking to suspend or reduce premiums must obtain permission from the governing state agency and do so in a non-discriminatory manner. An “enrollee” for rebate purposes is the policyholder or government entity that paid the premium for healthcare coverage received by an individual during the respective MLR reporting year.[[203]](#footnote-203)

In addition to a premium credit or a lump-sum payment, if the premium is paid using a credit or debit card, an insurer is permitted to return the entire rebate to the account used to pay the premium[[204]](#footnote-204) and no additional fees are charged.[[205]](#footnote-205)

233. How are insurers to pay rebates in connection with employer health insurance plans?

If an employer selects the insurer and administers the health insurance plan, it is an employee welfare benefit plan and subject to ERISA. Section 3(l) of ERISA describes an employee welfare plan as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits. . .” [[206]](#footnote-206)

Insurers must provide rebates for group health plans subject to ERISA (private employers) or the PHSA (state and local governments) to the policyholder, which is generally the employer sponsoring the plan.[[207]](#footnote-207) For these plans, the rebates can have both ERISA and income tax ramifications, both of which are discussed in more detail below, in Q 247 and Q 248.

234. What if the plan has been terminated when the rebate is due?

If a group health plan, regardless of whether it is subject to ERISA, has been terminated at the time of rebate payment and the insurer cannot, despite reasonable efforts, locate the policyholder (the employer), the insurer must distribute the entire rebate, including the employer’s share, to the participants who were enrolled in the terminated plan during the MLR reporting year on which the rebate was calculated by dividing the rebate equally among the individuals entitled to a rebate.[[208]](#footnote-208) If an insurer is able to locate the policyholder with respect to a terminated ERISA plan, the policyholder would need to comply with ERISA’s fiduciary provisions when handling any rebate. Despite the fact that the plan has been terminated, the plan document should be consulted and its terms followed. If the plan document does not provide direction, the employer must pay the employees’ portion to them unless it is not cost effective.[[209]](#footnote-209)

235. What if the MLR limits on insurers cause financial problems for insurers?

HHS may “adjust” (but not waive) the MLR target[[210]](#footnote-210) in individual states where enforcement of the 80 percent target would “destabilize” the individual market.[[211]](#footnote-211) HHS must provide detailed, public information as to its conclusions and the public may comment. HHS may elect to hold a hearing and must respond promptly to state requests.

236. Do the MLR rules limit commissions paid to brokers and agents?

Brokers and agents commissions reportedly may account for 5 percent or more of premiums as of this writing. The statute requires that sales commissions be counted as administrative costs, although HHS could consider such compensation in assessing market destabilization.[[212]](#footnote-212)

237. How is the MLR computed?

The numerator of the MLR formula includes reimbursement of claims for clinical services and expenditures for quality improvement activities. Clinical services reimbursement includes direct payments for services and supplies as well as changes in contract reserves (where an issuer holds reserves for later years when claims are expected to rise as experience deteriorates) and reserves for contingent benefits and lawsuits. Payments under capitation contracts with providers may be counted fully as claims, but insurers must count as administrative costs rather than claims costs payments made to third party vendors (such as behavioral health or pharmacy benefit managers) that are attributable to administrative services.

The definition of quality improvement activities found in section 2717 of the health reform law is used for the MLR rules. Quality improvement activities include activities that:

* improve health care outcomes,
* reduce medical errors,
* improve patient safety,
* encourage wellness and prevention, and
* reduce re-hospitalizations.
* MLR quality improvement costs also include:
* related IT expenses,
* the cost of healthcare hotlines,
* the cost of collecting and reporting quality data for accreditation purposes, and
* expenditures for facilitating the “meaningful use” of certified electronic health record technologies.

Prospective utilization review may be considered quality improvement to the extent it is intended to ensure appropriate treatment, but concurrent and retrospective utilization review activities are administrative costs.

The regulations provide that the MLR is calculated as follows:

|  |
| --- |
| medical care claims + quality improvement expenses |
| premiums – (federal and state taxes + licensing and regulatory fees)[[213]](#footnote-213) |

Fraud Prevention. PPACA does not allow insurers to count fraud prevention costs in the numerator as quality improvement expenses. However, the rule allows insurers to offset their fraud detection and recovery expenses against successful fraud recoveries.

Quality Improvement Expenses Must Be Verifiable and Objective. The HHS rule states that only activities “capable of being objectively measured and of producing verifiable results and achievements” can be counted as quality improvement. The preface to the HHS rule states: “While an issuer does not have to present initial evidence proving the effectiveness of a quality improvement activity, the issuer will have to show measurable results stemming from the executed quality improvement activity.”

238. What if an insurer has several entities licensed in a state?

MLRs are calculated separately for each licensed entity within a state by market segment (individual, small, or large group). Experience can be aggregated to the state in which the contract is located for employers with employees in multiple states. Affiliated insurers can also aggregate their experience where they combine to offer an employer in- and out-of-network coverage. No national reporting is allowed. Association health plans selling individual coverage must report their experience in the state in which individual certificates of coverage are issued.[[214]](#footnote-214)

239. What are the rules for MLR rebates for state and local government (non-federal) group health plans?

Group health plans maintained by non-federal governmental employers, including state and local governments, are not subject to ERISA. HHS issued separate interim final regulations for these plans.[[215]](#footnote-215) The plan policyholder is required to use the portion of rebates attributable to the amount of premium paid by plan subscribers for the benefit of subscribers. At the option of the policyholder, this portion of the rebate must be used either to reduce employee premium contributions or to provide cash refunds to employees covered by the group health policy on which the rebate is based. In either case, however, the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year, i.e., the prior year, on which the rebate was calculated).

240. What are the rules for group insured health plans sponsored by employers and subject to ERISA?

Most employer-provided health plans are subject to ERISA. The exceptions for state and local governments and church plans are discussed in Q 220.

Where the health plan is funded by a trust, the rebate is paid to that trust. If the plan is not funded by a trust, DOL Technical Release 2011-04, excuses insured group health plans from the obligations to hold participant contributions in trust and to file Form 5500 *if* the MLR rebates are used within three months of receipt to make employee refunds (the preferred option, as discussed in Q 234) or to pay the employees’ share of premiums, in each case to the extent premiums were paid by employees.[[216]](#footnote-216)

241. How does an employer comply with the three-month rule?

To be safe under the three-month rule, rebates belonging to participants must be used to benefit plan participants within three months. An employer that decides to distribute the rebate to plan participants must issue checks, by regular payroll or special checks, within three months of the employer’s receipt of the rebate. If the employer decides to use the portion of the rebate belonging to employees to reduce required participant contributions, it must adjust payroll deductions for affected participants within three months of the rebate’s receipt. Thus, a plan that receives a rebate on August 1 cannot wait until the next plan year begins to reduce employee contributions if the beginning of the next year is more than three months after receipt of the rebate.

242. How does an employer decide whether an MLR belongs to the employer or the employees when the health plan is not funded through a trust?

DOL Technical Release 2011-04[[217]](#footnote-217) discusses MLR payments relating to ERISA health insurance plans and explains the fiduciary and plan asset rules that apply. As noted in Q 240, plans without a trust need to dispose of the rebates belonging to participants within three months of receipt. Plan sponsors should review plan documents to determine if they address how the plan assets portion of a rebate is determined and to verify whether such provisions are consistent with the final regulation.

The DOL states that MLR rebates may be ERISA plan assets in whole or part, depending on various factors, including the terms of the insurance contract and plan documents. Quite often, there will be no specific provisions in either the insurance contract or the employer’s health insurance plan. In that case, the 2011 Technical Release offers guidance on how to deal with the MLR refunds.

Assuming the plan documents, the insurance contract, and other extrinsic evidence do not resolve the allocation issue, the DOL says the portion of a rebate that is attributable to employee contributions belongs to the participants. Any portion of a rebate that constitutes ERISA plan assets must be used for the exclusive benefit of plan participants and beneficiaries.

For an ERISA plan, the employer may never retain more than the amount of premiums and plan expenses paid by the employer. Otherwise, this would be a breach of fiduciary duty and a prohibited transaction under ERISA. The DOL guidance directs employers to look to who paid the premiums for the health plan for the year to which the MLR rebate relates to determine whether the rebate is owned by the plan if a trust, the employer, or the employees.

* If the employer paid entire premium, the employer may retain the entire rebate.
* If a trust or the employees paid the entire premium, the entire rebate belongs to the trust or employees.
* If the employer and employees each paid a specified percentage of the premium, they each are entitled to the rebate based on those percentages.
* If the employer was required to pay a fixed amount and participants were responsible for paying any additional costs, then the portion of the rebate under such a policy that does not exceed the participants’ total amount of prior contributions during the relevant period would be attributable to participant contributions.
* If participants paid a fixed amount and the employer was responsible for paying any additional costs, then the portion of the rebate under such a policy that did not exceed the employer’s total amount of prior contributions during the relevant period would not be attributable to participant contributions.

243. How does an employer decide how amounts belonging to employees are used?

The preferred option for participant rebate funds is to return them to the participants. If that is not cost effective, then the employee’s share of the rebate can be used to reduce participant contributions due within the three months after the rebate is received, or to enhance benefits. DOL Technical Release 2011-04 states that if a fiduciary finds that the cost of distributing shares of a rebate to former participants (terminated employees who participated in the program during the year for which the rebates are paid), approximates the amount of those proceeds, the fiduciary may properly decide to allocate the proceeds to current participants based upon a reasonable, fair and objective allocation method If there are former participants who cannot be located after use of a locator service, then the plan should be followed. If the plan is silent, it would seem reasonable to add those funds to the amounts being distributed to current and former participants.

Making Payment to Employees Is Fail-Safe. As a practical matter, employers may return 100 percent of the MLR rebate to participants, even when the employers legally could retain all or a portion of the rebate as the employer’s share under the rules discussed in Q 242. This approach assures compliance with ERISA’s fiduciary requirements and allows the employer to communicate positive news to employees. When there are terminated employees who were participants during the year to which the rebate is attributable, they too are entitled to their share of the rebate unless they cannot be located with reasonable effort (a locator service should be used) or the refund is not cost-effective, as discussed above in Q 234.

244. What are the special considerations when an employer has a plan with several insurance options?

Where an employer has several health insurance plans, such as an HMO, PPO, and high deductible options, those employers must distribute the rebates only to participants that were covered by the specific policy for which the rebate is issued. The DOL states that using rebates to benefit non-participants is a breach of ERISA fiduciary duties.[[218]](#footnote-218)

245. What are the special issues if insurance is paid in part by employee pre-tax cafeteria plan payments?

With respect to an MLR rebate to a cafeteria plan under Code section 125, refunding part or all of the rebate to participants should not be a violation of the “use it or lose it” rule of the regulations because that rule applies to healthcare and dependent care flexible spending accounts, not to premium conversion amounts that are plan assets. The rebate should not be used to reduce the employees’ contribution for the next three months. That would be an impermissible election change unless this is done by virtue of the fact that the employee’s share of the premiums are reduced, and the plan allows for changing payroll deductions based on changes in the insurance premiums.

246. How do the rebate rules differ for non-ERISA plans?

Plans of state and local governments and churches are exempt from ERISA unless their plan documents make them subject to ERISA. If not subject to ERISA, they are not bound by the three-month rule and can apply the rebates to reduce the costs for the upcoming plan year.

247. What is the income tax treatment for rebates paid to owners of individual health insurance policies issued in the individual market?

For individual market coverage (non-group individual policies), the rebate is not taxed if the individual did not deduct the premiums for that year to which the rebate relates.[[219]](#footnote-219) If the individual did deduct the premium, the rebate is taxable,[[220]](#footnote-220) including a premium deducted by a sole proprietor or partner.[[221]](#footnote-221)

248. What are the income tax rules for rebates paid to employees in employer-sponsored group health insurance plans?

For those participating in insured group plans, the concepts are the same: the rebates are not taxable if paid with after-tax (no deduction taken) dollars, whether paid directly to the employee by the insurer or by the insurer to the employer and in turn by the employer to the employee.[[222]](#footnote-222) However, if the employee deducted the premium on the employee’s personal income tax return, the rebate is taxable income.[[223]](#footnote-223) If a person participates in the plan in the year in which the rebate is paid, but not the prior year, and receives a share of the rebate, the rebate is not taxed.[[224]](#footnote-224)

Where the insurance policy is a group policy, and the employee paid the employee’s share of the premium with pre-tax dollars (amounts not taxed to an employee, such as a salary reduction payment through a cafeteria plan that is not reported as taxable income to the employee) in the plan year to which the rebate relates, the following rules apply:

* If the employer applies the employee’s share of the rebate to reduce the employee’s share of the premium, this is taxed to the employee.[[225]](#footnote-225)
* The rebate is also taxable in the year paid if it is paid to the employee and is “wages” subject to payroll and employment taxes.[[226]](#footnote-226)

Where the insurance policy is a group policy, the rebate is paid to participants regardless of whether they participated in the plan in the year generating the rebate, and the employee pays the employee’s share of the premium in the current plan year with pre-tax dollars:

* If the employee’s share of the rebate is allocated to reduce the cost of insurance for the year in which the rebate was received, the rebate is taxable and is wages in the year paid subject to employment taxes.[[227]](#footnote-227)
* If the rebate is paid to the employee, who participated in the plan in the year for which the rebated is paid, the rebate is taxable and is wages in the year paid subject to employment taxes.[[228]](#footnote-228)

If the rebate is paid to the employee, who did not participate in the plan in the year for which the rebated is paid, the rebate is taxable and is wages in the year paid subject to employment taxes.[[229]](#footnote-229)

Summary of Benefits and Coverage (SBC) Requirement for Insurers and Employers

249. Are insurance companies and health plans required to prepare and distribute to participants/insureds a Summary of Benefits and Coverage (SBC)?

Yes, for those providing essential health benefits, and they also must provide a Uniform Glossary, a list of important defined terms. This health reform requirement[[230]](#footnote-230) applies to essential health benefits and not “excepted benefits.” Where a plan is insured, the insurer is required to prepare the SBC, and the employer or other plan sponsor is required to distribute it annually in a timely manner. A self-funded plan must prepare its own SBC. Where an employer has several health benefit package options, this requirement will require coordination.

250. What guidance has been provided for the SBC requirement?

The DOL, HHS, and IRS issued on April 23, 2013 (1) FAQs, Part XIV,[[231]](#footnote-231) addressing changes to the summary of benefits and coverage (SBC) effective for coverage beginning on or after January 1, 2014, and before January 1, 2015, (2) an updated SBC template,[[232]](#footnote-232) and (3) sample completed SBC.[[233]](#footnote-233)

251. What is new in the updated SBC template (beginning on or after January 1, 2014, and before January 1, 2015?

The updated sample SBC template (and sample completed SBC) require information about whether the plan or coverage provides “minimum essential coverage” and satisfies the “minimum value” standard. The SBC template for the first year of applicability did not require this information. A copy of a completed updated sample SBC template is located in Appendix A.

To the extent that it would be administratively burdensome for a plan or insurer to modify its SBCs to add this new information, the agencies indicate that no enforcement action will be taken for using the previous template, provided that the necessary minimum essential coverage and minimum value information is set forth in a cover letter or other disclosure furnished with the SBC. Model language is provided for this purpose.

The SBC disclosures of minimum essential coverage and minimum value is important for employees. Enrollment in minimum essential coverage is required to avoid individual mandate penalties. Additionally, information about minimum value is needed for determining potential eligibility for subsidized Exchange coverage. An employee is not eligible for subsidies for health insurance purchased on an Exchange if he or she is offered employer minimum essential coverage that provides minimum value and is affordable.

It is notable that the SBC does not require any information about affordability. The draft Individual Exchange Application by HHS includes an “Employer Coverage Form” to request information from an employer on how much an employee would have to pay under the employer’s lowest cost self-only health plan providing minimum value.

252. Are there any changes to the Glossary, Instructions, or Coverage Examples as a result of the April 23, 2013, guidance?

The agencies have indicated that no changes have been made to the uniform glossary (a separate document that is a companion to the SBC) or to the instructions for completing the SBC. Also, no additional coverage examples are required with this guidance. The same two coverage examples previously provided—relating to having a baby and managing diabetes—must be included. See Q 263.

253. What impact do the SBC changes have on annual limits?

While no changes have been made to the SBC template or the sample completed SBC regarding annual limits, there is recognition that, for plan years beginning on or after January 1, 2014, the prohibition on imposing annual limits on the dollar value of essential health benefits will take effect. Thus, the agencies have indicated that no enforcement action will be taken against a plan or insurer that modifies its SBC for the second year of applicability by removing the entire row containing the question “Is there an overall annual limit on what the plan pays?”

254. What other issues does the April 23, 2013, guidance address?

The agencies have extended existing enforcement relief relating to various facets of SBC compliance (e.g., the circumstances in which the SBC may be provided electronically, penalties for failure to provide the SBC or uniform glossary) through the end of the second year of applicability, i.e., coverage beginning on or after January 1, 2014, and before January 1, 2015.

255. What if there is more than one benefit package for essential health benefits?

A plan sponsor may offer more than one essential health benefits benefit package, such as a choice among an HMO, a PPO, and a self-insured option, or a high deductible option paired with an HSA. In such a case, for a newly eligible participant, SBCs for each benefit package must be distributed. For those already enrolled, the SBC for the option previously selected must be distributed.[[234]](#footnote-234) In addition, the SBC for any benefit package must be provided within seven days of a participant or insured’s request.[[235]](#footnote-235)

256. Does the SBC/Uniform Glossary requirement apply to grandfathered plans?

Yes.[[236]](#footnote-236)

257. What plans are exempt from the SBC and Uniform Glossary requirements? What about HSAs, HRAs, MERPs, health FSAs, EAPs, and wellness programs?

Any plan or policy that is not an essential health benefit need not comply with these rules.[[237]](#footnote-237) Thus, policies and plans that provide “excepted benefits” need not comply. Generally, health savings accounts, health reimbursement accounts (medical expense reimbursement accounts), and health flexible spending accounts are “excepted benefits.” Where the employer provides a high deductible health plan (HDHP) that funds HSAs, the role of the HSA is mentioned when discussing the HDHP.[[238]](#footnote-238) When stand-alone HRAs and health FSAs are not excepted benefits, they must comply with the SBC/Uniform Glossary rules.[[239]](#footnote-239) Plans in which HRAs are integrated with other coverage may use one SBC.[[240]](#footnote-240) In this case, the HRA plan administrator is responsible for the SBC’s description of the HRA’s coverage.[[241]](#footnote-241)

The SBC rules do not discuss employee assistance programs (EAPs). Whether the SBC requirements apply depends on whether the EAP is a group health plan. EAPs offer a range of benefits, such as counseling for alcohol and substance abuse, marital, family, and personal problems, stress, anxiety, grief, finances, retirement as well as childcare and elder care. These benefits are not included in the model SBC. Thus, EAPs are governed by the rule that where a plan’s terms cannot reasonably be described in a manner consistent with the template and instructions, the plan or insurer must describe the terms using its best efforts to do so in accordance with the instructions and prescribed format.[[242]](#footnote-242) Where an EAP is offered to employees, whether or not they are covered in the plan providing essential health benefits, it should seem that the SBC would not mention the EAP.

A wellness program may or may not be part of a group health plan. The FAQs refer to a wellness program that is an “add on” to major medical coverage that could affect the individual’s cost-sharing and other information on the SBC. In such circumstances, the agencies explain that the coverage examples (discussed in Q 263) should note the assumptions used in creating them.[[243]](#footnote-243) The sample SBC provides an example of how to describe a diabetes wellness program.[[244]](#footnote-244)

258. What is the reason for the SBC requirement?

The SBC and a Uniform Glossary[[245]](#footnote-245) of commonly used terms are to be distributed to all persons with essential health benefits in an individual policy or group plan. It applies to grandfathered policies and plans. The purpose is to provide a uniform summary of important provisions to assist individuals in understanding their coverage and provide the ability to compare it to other available options on an “apples to apples” basis.

259. Who must distribute the SBC and Glossary, and what happens if they fail to do so?

For insured plans, the insurer must distribute them to the plan administrator, which is often the employer. The plan administrator must distribute them to the participants. For a self-insured plan, the plan administrator, unless the plan says otherwise, is responsible to prepare and distribute the SBC and glossary.[[246]](#footnote-246) Thus, employers with insured plans should seek contractual protection by requiring the insurer to deliver the SBC with sufficient lead time that the plan’s plan administrator can timely deliver the SBC and Glossary to participants. Alternatively, the employer contractually can require the insurer to distribute the SBC to participants, which eliminates the employer and plan administrator for any penalty liability.[[247]](#footnote-247)

Those responsible for preparation and delivery of the SBC and glossary are subject to substantial penalties for failure timely to do so. As discussed earlier in Q 172 as to the enforcement of the health reform coverage mandates, the law imposes a penalty of up to $1,000 per day per affected individual (per participant) for willful violations of the SBC rules for group health plans. For an insured plan, the insurer and plan administrator are each potentially subject to this penalty because the insurer must distribute the SBC to the plan administrator, and the plan administrator must distribute it to the participants. Additionally, the penalty tax upon a non-complying plan sponsor is $100 per day of noncompliance per affected individual,[[248]](#footnote-248) and the violations must be self-reported on IRS Form 8928. The tax may be higher where violations occurred or continued during a period under IRS examination or where the violations are more than minimal. The tax does not apply where the failure was based on reasonable cause and not on willful neglect,[[249]](#footnote-249) and the failure is corrected within thirty days after the person knew or should have known that the failure existed.[[250]](#footnote-250)

260. When is the SBC required to be distributed?

Insurers must distribute SBCs to holders of individual market coverage and to insured group health plans beginning September 23, 2012. ***For group health plans, the requirement applies beginning with the first open enrollment period beginning on or after September 23, 2012,*** for participants and beneficiaries enrolling or re-enrolling through open enrollment. For individuals enrolling other than through open enrollment (such as newly eligible individuals or special enrollees), the requirement applies beginning on the first day of the first plan year that begins on or after September 23, 2012.[[251]](#footnote-251) Thus, when an open enrollment period begins prior to September 23, 2012, the SBC and Uniform Glossary would only need to be distributed on and after September 23, 2012, to newly eligible persons. All others would receive the SBC and Uniform Glossary in 2013 at the open enrollment.[[252]](#footnote-252)

Enrollment and Re-Enrollment. All health plans and insurers will provide an SBC to enrollees at important points in the enrollment process, including application and renewal. The SBC requirements apply to disclosures made to those enrolling or re-enrolling in group health plan coverage through an open enrollment period beginning on or after September 23, 2012. For enrollments occurring outside of open enrollment, the requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012.

SBC and Glossary on Demand. Whether shopping for health insurance or already enrolled in coverage, consumers will be able to request the SBC at any time, and health plans will have to provide it within seven business days. Consumers will also be able to request and receive the Uniform Glossary within seven business days.[[253]](#footnote-253)

Material Modification: Mid-Year Change. To the extent a plan or policy implements a mid-year change that is a material modification that affects the content of the SBC, and that occurs other than in connection with a renewal or reissuance of coverage, a notice of modification must be provided sixty days in advance of the effective date of the change.[[254]](#footnote-254)

A group health plan or insurer must provide notice of a plan change if it makes a material modification in any of the terms of the plan that is not reflected in the most recently provided SBC. A material modification[[255]](#footnote-255) is any modification to the coverage offered under a plan that alone or in conjunction with other modifications is an important change in benefits or other terms of coverage to an average plan participant, including diminished or enriched benefits, coverage of previously excluded benefits, changes to cost sharing (copays or deductibles), premiums, or referrals requirements. However, only material modifications that would affect SBC content require plans and insurers to provide this notice. The notice may be provided in paper or electronic form, in accordance with the requirements discussed previously for providing the SBC.[[256]](#footnote-256)

This requirement can be satisfied either by a separate notice describing the material modification or an updated SBC containing it. For ERISA-covered group health plans, this will satisfy the requirement to provide a Summary of Material Modification under ERISA. [Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8677 (February 14, 2012)]

COBRA Continuation Notice. As discussed in Q 265, the SBC must contain a verbatim statement about state and COBRA continuation options.

261. To whom must an SBC be provided?

The SBC requirement applies to all health insurance plans, individual and group, and all employer sponsored plans, both insured and self-insured, grandfathered and non-grandfathered. Persons in any such plan or arrangement must receive an SBC.

262. May the SBC be distributed electronically?

Yes. The SBC can be distributed electronically to participants in an ERISA welfare benefit plan if the Department of Labor’s requirements are met.[[257]](#footnote-257) See Q 254.

263. What is the required format for the SBC?

A specified format is required, and detailed instructions for the format are provided.[[258]](#footnote-258) Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise provided, the plan or insurance company must use 12-point font, and replicate all symbols, formatting, bolding, and shading on the specimen formats, which are provided later in this question. While the law requires four pages, the agencies (HHS, DOL, and Treasury) have interpreted this to be eight pages because the pages have a front and back side. Surprisingly, the size of the paper that one can use is not specified.

To the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or insurance company must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example:

* if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template,
* if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient),
* in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or
* if a plan provides different cost sharing based on participation in a wellness program.

Plans and insurance companies must customize all identifiable company information throughout the document, including Web sites and telephone numbers.

The items shown on pages 1 and 2 must always appear on pages 1 and 2, and the rows of the chart must always appear in the same order. However, the chart rows shown on page 2 may extend to page 3 if space requires, and the chart rows on page 3 may extend to the beginning of page 4 if space requires. The Excluded Services and Other Covered Services section may appear on page 3 or page 4, but must always immediately follow the chart starting on page 2. The Excluded Services and Other Covered Services section must be followed by the Your Rights to Continue Coverage section, the Your Grievance and Appeals Rights section, and the Coverage Examples section, in that order.

A footer must appear at the bottom left of every page with the appropriate telephone number and Web site information.

The language used must be plain language and present the information in a culturally and linguistically appropriate manner, utilizing terminology understandable by the average individual.

Plans and insurance companies with questions about completing the SBC may contact the Department of Health and Human Services at SBC@cms.hhs.gov or the Department of Labor at 866-444-EBSA(3272).

Two coverage examples are required. CMS provides the information necessary to perform the two coverage example calculations for having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition).[[259]](#footnote-259)

The SBC for a group health plan need not be a standalone document. Plans or insurance companies may provide the SBC as a separate document or in combination with other summary materials, such as a summary plan description (SPD), so long as the SBC information is “intact and prominently displayed at the beginning of the materials,” such as after the Table of Contents in a SPD. However, SBCs issued for a plan in the individual market must be provided as a standalone document.[[260]](#footnote-260)

A model SBC[[261]](#footnote-261) and Uniform Glossary[[262]](#footnote-262) of health coverage and medical terms has also been provided by CMS. These are provided in English, Chinese, Navajo, Spanish, and Tagalog.[[263]](#footnote-263) An updated model SBC and Uniform Glossary are provided in Appendix A.

264. Can a state impose its own requirements on the SBC or Uniform Glossary?

No. Any state law that requires less information is preempted.[[264]](#footnote-264) However, a state can impose additional disclosure requirements unless the plan is subject to ERISA, which preempts any contrary state law.[[265]](#footnote-265) Private employer plans will be welfare benefit plans governed by ERISA. Government plans, church plans, and insurance policies purchased by individuals without significant employer involvement are not subject to ERISA.

265. Is the SBC used in connection with COBRA continuation coverage?

Yes. The exact language in the SBC template must be used without change.[[266]](#footnote-266) The SBC template includes a section called “Your Rights to Continue Coverage.” The instructions to this section of the template provide different required language for group and for individual coverage. For group coverage, the language provides a general statement about state and federal continuation coverage rights that “must appear without alteration,” as follows:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continuation coverage may also apply. For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.[[267]](#footnote-267)

This section must be placed, as indicated in the template and instructions, after the section entitled “Other Covered Services” and before the section entitled “Your Grievance and Appeals Rights.”

Exchange Notice Required

266. What is the Exchange notice requirement for employers?

FAQ guidance[[268]](#footnote-268) provides that Exchange notices will not be required until after regulations on this requirement are issued and become applicable, which is by October 1, 2013, and each year thereafter. Employers of all sizes, whether or not they have health plans, that are subject to the Fair Labor Standards Act must provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.[[269]](#footnote-269) (Regulations implementing the Notice of Exchange requirement will be issued by the Secretary of Labor; the FLSA is enforced by the DOL).

267. When must employers give employees this Exchange Notice?

This disclosure requirement was to go into effect for employers beginning on March 1, 2013. In January 2013, the DOL announced a delay in the statutorily prescribed March 1, 2013 effective date.[[270]](#footnote-270) The effective date is now October 1, 2013, and each year thereafter. See Q 266.

The Exchange Notice will inform the employees about the existence of the health benefit exchange and give a description of the services provided by the exchange. Additionally, it will explain how the employee may be eligible for a premium tax credit or a cost-sharing reduction if the employer’s plan does not meet certain requirements. The Exchange Notice must inform employees that if they purchase a qualified health plan through the exchange, then they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of the employer contribution to employer-provided coverage may be excludable for federal income tax purposes. Finally, the Exchange Notice will include contact information for customer service resources within the exchange and an explanation of appeal rights.

268. Which employers are subject to the Exchange Notice requirement?

The Exchange Notice requirement applies to employers that are subject to the FLSA. Although the FLSA’s minimum wage and maximum hour provisions are generally limited to entities that are engaged in interstate commerce and have a gross annual volume of sales that is not less than $500,000[[271]](#footnote-271) it is not clear that the Exchange Notice has this same limitation. As a result, its scope appears to be determined by the FLSA’s definition of “employer,” which generally includes “any person acting directly or indirectly in the interest of an employer in relation to an employee.”[[272]](#footnote-272)

269. What is the penalty for failing to give the Exchange Notice?

The law provides no specific penalty for noncompliance.

HIPAA Electronic Transactions and Operating Rules

270. How has health reform expanded HIPAA’s electronic transaction requirements?

HIPAA’s provisions include standards for electronic transactions to reduce healthcare costs by encouraging the use of electronic data interchange (EDI), standardize the electronic processing of health care claims, and improve overall communication in the health care industry. Health reform[[273]](#footnote-273) includes an expansion of HIPAA’s electronic transaction requirements and requires HHS to adopt uniform standards and operating rules governing transactions with health plans. HHS issued regulations[[274]](#footnote-274) adopting operating rules for two HIPAA electronic transactions: (1) eligibility for a health plan and (2) healthcare claim status.

271. When is compliance required with these expanded requirements?

Compliance is required by January 1, 2013, for (1) eligibility for a health plan and (2) healthcare claim status.[[275]](#footnote-275) Additional regulations will be issued for other electronic requirements with their own due dates from 2014 through 2016.[[276]](#footnote-276)

272. What should group health plan sponsors do to comply with these expanded requirements?

Most health plans do not process their own electronic transactions but instead engage a third party (called a “business associate”) to process them. In this case, plan sponsors should ensure the relevant documents (such as a business associate agreement, a trading partner agreement, and policies and procedures) are consistent with these rules. Plan sponsors’ business associate agreements should require that the business associates as well as their agents and contractors comply with the rules.

273. What requirements are there for electronic funds transfer and health claims attachment transactions?

HHS must establish standards for electronic funds transfer and health claims attachment transactions. HHS has issued regulations called “health care electronic funds transfers (EFT) and remittance advice.”[[277]](#footnote-277) These new standards deal with EFT payments made through the Automated Clearing House (ACH) Network, and the remittance advice that explains the payment, the explanation of benefits (EOB).

274. What are the rules relating to HPIDs and OEIDs?

As required by health reform,[[278]](#footnote-278) HHS issued regulations[[279]](#footnote-279) establishing standards for a national unique health plan identifier (HPID) and implementation of the HPID. The regulations also establish another entity identifier (OEID) for non-health plan entities that may need to be identified in standard transactions.[[280]](#footnote-280) The standards are based on recommendations from the National Committee on Vital and Health Statistics (NCVHS).

Large health plans must use the HPID in standard transactions beginning October 1, 2014, and small health plans must the HPID in standard transactions no later than October 1, 2015.[[281]](#footnote-281)

275. What are the HPID rules for a controlling health plan (CHP) and a subhealth plan (SHP)?

A CHP is a health plan that controls its own business activities, actions, or policies, or is controlled by an entity that is not a health plan. Additionally, a CHP is an entity that directs the business activities, actions, or policies of one or more SHPs. All CHPs must obtain an HPID. An SHP is defined as a health plan whose business activities, actions, or policies are directed by a CHP. Health plans include group health plans, health insurance issuers, and HMOs.[[282]](#footnote-282)

A controlling health plan (CHP), which includes a self-insured CHP, would be required to obtain an HPID. A subhealth plan (SHP) would not be required to obtain an HPID but could obtain an HPID at the direction of its CHP or on its own initiative. A CHP also would be able to obtain HPIDs for its SHPs.[[283]](#footnote-283)

If a CHP uses a single data processing center for all of its SHPs, the CHP may use one HPID for itself and its SHPs. Alternatively, if an SHP has its own processing center, the CHP could obtain a separate HPID for such SHPs or ask them to do so.

276. How are HPIDs and OEIDs used?

A covered entity is required to use an HPID when it identifies a health plan in a standard transaction. If a covered entity uses one or more business associates to conduct standard transactions, the covered entity would require them to use an HPID to identify the health plan in the standard transactions.[[284]](#footnote-284)

Other uses for the HPID that are permitted, including in internal files, are to facilitate processing of healthcare transactions; on an enrollee’s health insurance card; as a cross-reference in healthcare fraud and abuse files and other program integrity files; in patient medical records to identify patients’ healthcare benefit packages; and for reporting purposes.[[285]](#footnote-285)

The OEID is a voluntary identifier for entities that are not health plans but need to be identified in standard transactions. HHS asked for comments as to whether use of an OEID should be required.[[286]](#footnote-286)

277. What are the penalties for failure to comply with the requirements and operating rules?

Through the Social Security Act (SSA) HHS will conduct audits to ensure that health plans (including third parties, such as business associates) comply with requirements and operating rules.[[287]](#footnote-287) HHS can assess a penalty against a health plan for failing to meet the certification and documentation requirements.[[288]](#footnote-288) HHS will assess a penalty of $1 per covered life up to a ceiling until the certification is complete.[[289]](#footnote-289) The penalty doubles for any health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance.[[290]](#footnote-290) The annual penalty against a health plan may not exceed $20 per covered life and $40 per covered life if the plan knowingly has provided inaccurate or incomplete information.[[291]](#footnote-291)

Automatic Enrollment

278. When are employers required to enroll employees automatically in their health benefits plan?

Whenever the agencies issue final regulations,[[292]](#footnote-292) specified employers will be required to enroll new full-time employees automatically in one of the “health benefits plans”[[293]](#footnote-293) offered through the employer and must continue the enrollment of current employees in such plans.[[294]](#footnote-294) This provision applies to employers that have more than 200 full-time employees and that offer employees enrollment in one or more health benefit plans.[[295]](#footnote-295) Automatic enrollment may be subject to the plan’s waiting period. The automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of coverage.[[296]](#footnote-296) Employers may ask employees to provide proof of alternative coverage, but the legislation does not require employees to provide this documentation.

The Fair Labor Standards Act (FLSA) does not define “full-time employee.” For purposes of the FLSA, the employer makes that determination. It is likely that DOL regulations[[297]](#footnote-297) will adopt the employer mandate definition of a full-time employee, which is a person who, for any month, is employed on average for at least thirty hours of service per week.[[298]](#footnote-298)

The general FLSA preemption rule supersedes those state laws that are less beneficial to workers than the FLSA, but requires compliance with state laws that are more beneficial to workers than the FLSA.[[299]](#footnote-299) Employers that have 200 or fewer employees and require employees to pay a portion of the health insurance premium must have employees authorize the payroll deduction in writing and cannot automatically enroll their employees in their group health plan without this authorization. Employers that have 200 or fewer employees and pay 100 percent of the health insurance premium may follow their policy or practice for automatic enrollment, including requiring the necessary information to be provided by employees for coverage.

New Health Insurance Nondiscrimination Provisions

279. What are the new health insurance income tax nondiscrimination rules?

Prior to the health reform law, the Internal Revenue Code only imposed nondiscrimination rules on self-insured health plans. No benefits-related nondiscrimination rules applied to an insured health plan. Thus, an insured group health plan could cover management and other highly paid employees under terms that were more favorable than those applicable to other employees, or not even cover the other employees.

Self-insured plans and employers’ medical expense reimbursement plans are subject to the nondiscrimination provisions of Code section 105(h), in effect since 1980. Congress originally believed that insurance underwriting considerations limited abuses favoring the highly paid in insured plans. However, underwriting practices in fact allowed plans to favor the highly compensated.

Health reform imposes similar rules to those that apply to self-insured plans or insured group health plans, other than grandfathered plans. The law does this in a very circular way. Health reform law[[300]](#footnote-300) added new ERISA section 715 and Code section 9815, respectively. Both ERISA section 715 and Code section 9815 incorporate by reference Public Health Service Act (PHSA) section 2716, which incorporates by reference the concepts of Code section 105(h). The law leaves the details of the insured plan nondiscrimination rules to the regulations. It merely requires “rules similar to” those in Code section 105(h), regarding nondiscrimination eligibility, nondiscriminatory benefits, and controlled groups.[[301]](#footnote-301) These rules prohibit discrimination in favor of highly compensated individuals (HCIs), who are generally the highest paid 25 percent of the employer’s workforce.

279.01 How do the health insurance income tax nondiscrimination rules apply to retiree medical?

There is an exception for retirees under the section 105(h) self-insured nondiscrimination rules. It is not clear how the rule applies when the only retirees are highly compensated individuals, although it could be read that the exception to the nondiscrimination rule does apply when all of the retirees are HCIs.

Here is the regulation as relates to applying the nondiscrimination rule for retirees (1.105-11(c)(3)(iii)):

(iii) Retired employees. To the extent that an employer provides benefits under a self-insured medical reimbursement plan to a retired employee that would otherwise be excludible from gross income under section 105(b), determined without regard to section 105(h), such benefits shall not be considered a discriminatory benefit under this paragraph (c). The preceding sentence shall not apply to a retired employee who was a highly compensated individual unless the type, and the dollar limitations, of benefits provided retired employees who were highly compensated individuals are the same for all other retired participants. If this subdivision applies to a retired participant, that individual is not considered an employee for purposes of determining the highest paid 25 percent of all employees under paragraph (d) of this section solely by reason of receiving such plan benefits.

Retiree-only plans are excepted from the ACA rules.

280. When are the income tax nondiscrimination rules for nongrandfathered group health insurance plans applicable?

The law provides that these nondiscrimination rules were to be effective for nongrandfathered plans for plan years beginning on or after September 23, 2010. However, the IRS postponed the effective date until regulations are issued and the IRS announces a new effective date.[[302]](#footnote-302) This had not yet occurred.

281. What is the consequence of violating the new health insurance nondiscrimination rules?

As a result of incorporating the HIPAA penalty, the excise tax that applies in the event of a violation of the HIPAA requirements also applies in the event of a violation of these new nondiscrimination requirements.[[303]](#footnote-303) The health insurance nondiscrimination rules for nongrandfathered plans have different and potentially much harsher sanctions than for self-insured plans that fall under Code section 105(h). For discriminatory self-insured plans, the highly compensated employees have taxable income based on the benefits paid by the employer. However, with respect to the new health insurance nondiscrimination requirements, the sanction is a $100 per day excise tax[[304]](#footnote-304) on the “affected employees” and is paid by the employer or the plan in the case of a multiemployer plan. While the IRS has not yet issued any regulations on the penalty, its request for comments indicates that the term “affected employees” means all those who are not highly compensated. Thus, if an employer has an insured health plan that is not grandfathered and violates these new nondiscrimination rules for the plan year beginning on or after September 23, 2010, and if that employer has twenty non-highly compensated employees, the penalty will be $2,000 per day (20 employees X $100/day) as a result of having a discriminatory non-grandfathered health insurance plan.

282. What is the small employer exception to the application of the excise tax, and does it apply to avoid the nondiscrimination tax penalty?

Code section 4980(D)(d)(1) contains an exception to the excise tax for small employers, but the language is somewhat ambiguous. It states:

In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure (other than a failure attributable to §9811) *which is solely because of the health insurance coverage offered by such issuer.* (Emphasis added.)

It is not clear whether this exception applies to the new nondiscrimination rules or simply to a health insurance policy that does not meet federal requirements. The italicized language may mean that the exception will apply only if the insurance policy is discriminatory as opposed to the employer’s plan being discriminatory. In other words, the small business exception may not apply if the plan, rather than the insurance policy, is nondiscriminatory. For the purpose of this exception, a small employer is defined as one with two to fifty employees.[[305]](#footnote-305)

283. What are the issues involved in applying the nondiscrimination excise tax?

Code section 4980D(a) imposes an excise tax on the failure of a group health plan to meet the requirements of Chapter 100 relating to group health plans. The amount of tax is $100 for each day in the noncompliance period with respect to each individual to whom such failure relates.[[306]](#footnote-306) As noted in Q 280, Notice 2011-1 deferred the effective date of the insured plan nondiscrimination rules and indicates that the penalty will apply to nonhighly compensated individuals (“NHCIs”). Notice 2011-1 states:

[I]f an insured group health plan fails to comply with Code Sec. 105(h), it is subject to a civil action to compel it to provide nondiscriminatory benefits and the plan or plan sponsor is subject to an excise tax or civil money penalty of $100 per day ***per individual discriminated against***. [Emphasis added.][[307]](#footnote-307)

The noncompliance period is the period beginning on the date on which the failure occurs,[[308]](#footnote-308) and ends on the date the failure is corrected.[[309]](#footnote-309) A failure is treated as corrected if it is retroactively undone to the extent possible,[[310]](#footnote-310) and the person to whom the failure relates is placed in a financial position that is as good as the position such person would have been in had the failure not occurred.[[311]](#footnote-311)

284. What are the limits or exceptions to the application of the nondiscrimination excise tax on nongrandfathered insured plans?

There are a number of limitations on the amount of the tax. First, no tax is imposed on any failure during any period for which it is established to the satisfaction of the IRS that the person liable for the tax did not know, and, exercising reasonable diligence, would not have known that such failure existed.[[312]](#footnote-312) For church plans,[[313]](#footnote-313) no tax is imposed if the failure is corrected before the end of the correction period.[[314]](#footnote-314) For most plans, no tax is imposed if the failure was due to reasonable cause and not to willful neglect,[[315]](#footnote-315) and such failure is corrected during the thirty-day period beginning on the first date the person otherwise liable for such loss knew, or exercising reasonable diligence would have known, that such failure existed.[[316]](#footnote-316)

Notwithstanding these limits on the Code section 4980D excise tax, in the case of one or more failures for an individual before the date a notice of examination of income tax liability is sent to the employer, and when such failure occurred or continued during the period under examination, there is a minimum tax with respect to such individual of not less than the lesser of $2,500, or the amount of tax that would have been imposed without regard to the limitations on tax.[[317]](#footnote-317) To the extent that the violations are more than *de minimis* (an undefined term), $15,000 is substituted for $2,500.[[318]](#footnote-318)

With respect to unintentional failures (i.e., those due to reasonable cause and not to willful neglect), the tax imposed on single employers for failures during the employer’s tax year cannot exceed the lesser of:

* 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding tax year for group health plans, or
* $500,000[[319]](#footnote-319)

With respect to specified multiple employer health plans,[[320]](#footnote-320) the excise tax cannot exceed the lesser of

* 10 percent of the amount paid or incurred by such trust during the tax year to provide medical care directly or through insurance, reimbursement, or otherwise, or
* $500,000[[321]](#footnote-321)

However, if an employer is assessed a tax by reason of failure with respect to a specified multiple employer health plan, the limit is determined in the same manner as for a single employer plan, rather than for a specified multiple employer health plan.[[322]](#footnote-322) For a failure due to reasonable cause and not to willful neglect, the IRS may waive all or a portion of the tax “to the extent that the payment of such tax would be excessive relative to the failure involved.”[[323]](#footnote-323)

The excise tax does not apply to a group health plan of a small employer[[324]](#footnote-324) that provides health insurance coverage[[325]](#footnote-325) solely through a contract with a health insurance issuer[[326]](#footnote-326) with respect to any failure[[327]](#footnote-327) that is solely because of the health insurance coverage offered by such issuer. The issues about the scope of this exception are discussed previously.

285. Who is liable to pay the excise tax?

Liability for the tax is generally imposed on the employer.[[328]](#footnote-328) However, with respect to a multiemployer plan[[329]](#footnote-329) or a failure under Code section 9803 relating to guaranteed renewability with respect to a multiple employer welfare arrangement,[[330]](#footnote-330) the tax is imposed on the plan.

286. How is the liability for the excise tax reported?

Employers subject to the excise tax must file Form 8928.[[331]](#footnote-331) For single employer plans, the employer must file the return on or before the due date for filing the employer’s income tax return, without any extensions unless a separate extension request is filed properly for Form 8928.[[332]](#footnote-332) It also must reflect the portion of the noncompliance period for each failure that occurs during the employer’s tax year.[[333]](#footnote-333) If the person liable for the excise tax is a specified multiple employer health plan, the return must be filed on or before the last day of the seventh month following the end of the plan’s plan year.[[334]](#footnote-334) The return is filed at the place specified in Form 8928 and the instructions, and the tax shown on the return is paid to the IRS office with which the return is filed, at the time and place for filing each return.

287. What is the penalty if an insured plan incorrectly believes that it is grandfathered, but it is not?

How should Code section 4980D be applied if a nongrandfathered health plan fails one of the technical requirements because the employer believes it to be grandfathered? For example, if a nongrandfathered plan provides coverage for obstetrical or gynecological care or both and requires the designation of an in-network primary care provider, the plan may not require authorization or referral by the plan or any person for a female participant who seeks gynecological or obstetrical care provided by an in-network specialist i.e., an obstetrician or a gynecologist. Additionally, the plan must advise each participant that the plan cannot require authorization or referral for gynecological care.

What if the employer believes that the plan is grandfathered but it is not grandfathered because it was unaware of the notice or recordkeeping requirements of the regulations or because it inadvertently failed to satisfy them? As a result, when Alice, a plan participant, requests a gynecological exam with Dr. Brady, an in-network OB-GYN, the plan requires prior authorization from Alice’s designated primary care provider, Dr. Colby, for the exam. Dr. Colby provides the authorization, and Alice sees Dr. Brady. This prior authorization for a woman to see an OB-GYN is not permitted for a nongrandfathered plan.

In the example in the preceding paragraph, when did the failure occur? A failure cannot occur until the status as a grandfathered health plan is lost, but the regulations do not specify when this occurs. No precise time is provided for the required notice, but presumably, it should have been provided during the open enrollment period, but it was not. Therefore, (1) every female participant and dependent (at least those above a certain age) was affected by the failure to receive the notice and (2) at least all individuals in that category who saw a gynecologist or obstetrician in that period and had requested an authorization from the primary care physician were affected by that failure.

However, the IRS could argue that the latter failure related to all female plan participants and dependents because they may not have sought to obtain authorization from their primary care physician for the OB-GYN treatment. It is not clear if, with respect to one individual, there can be multiple failures relating to one Code requirement.

Assuming there was a failure, when would it be corrected, if at all? The first requirement is that the failure be retroactively undone to the extent possible. The second requirement is that the person to whom the failure relates be placed in the same financial position in which he or she would have been had the failure not occurred. However, unless the primary care physician charged the participant for obtaining that authorization/referral, there was no financial detriment to the participant unless the referral process caused a delay in seeing the OB/GYN, and the OB/GYN increased its fees in the interim. If so, the detriment is the difference between those fees. Absent this, the failure arguably is self-correcting but it is unknown whether the IRS will recognize this concept.

288. What if the failure to meet the nondiscrimination rules is due to reasonable cause and not willful neglect?

As to whether the failure was due to reasonable cause and not to willful neglect, the issue in all likelihood will not be whether the plan sponsor had some reasonable basis for a position that it took, but rather a matter of inadvertence (in the example above about a plan that the employer thought was grandfathered but was not), whether a participant failed to receive an SPD or open enrollment material, or whether some documents relating to verification, or clarification of grandfathered health plan status were not maintained. In the context of an inadvertent error, it may not be clear that, by exercising reasonable diligence, the employer would have known if the failure occurred. If a participant fails to receive a summary plan description or a document is improperly discarded, it is unclear if reasonable diligence would have located the errors. The issue of what constitutes “reasonable diligence” is based on all relevant facts and circumstances.

If the failure to provide notice or retain records was due to erroneous advice from a plan’s advisor, many cases address what constitutes reasonable cause and not willful neglect.

A failure to give a notice or to maintain records is not as serious as a HIPAA violation, such as discrimination due to health status, which was the type of action that initially resulted in the imposition of this excise tax that was enacted with HIPAA. At a minimum, the amount of excise tax for the violation of the group health plan rules applicable only to non-grandfathered group health plans that do not violate HIPAA should depend on whether the plan administrator believed in good faith, albeit erroneously, that the plan had grandfathered status.

Waiting Period Limits and Eligibility Requirements

289. What is a waiting period?

A waiting period is the time that must pass before coverage for a person who is otherwise eligible for coverage under the terms of the plan is effective if the person applies for it. Being eligible for coverage means having met the plan’s eligibility conditions other than any waiting period, such as being in a job category that is covered by the plan’s terms).[[335]](#footnote-335)

290. What is the maximum waiting period for essential health benefits in 2014?

Eligibility conditions based solely on the lapse of time are permissible for ninety days and no more. Other eligibility conditions are permitted unless the condition is designed to avoid compliance with the ninety-day waiting period limitation. If an employee may elect coverage and be covered on a date that does not exceed a ninety-day waiting period, the ninety-day limit is met.

Group health plans and insurers offering group or individual coverage, including grandfathered plans or individual policies, are prohibited from applying a waiting period that exceeds ninety days for plan years beginning on or after January 1, 2014.[[336]](#footnote-336) The prohibition on excessive waiting periods does not apply to “excepted benefits.”[[337]](#footnote-337) The prohibition applies regardless of the size of the employer/plan sponsor.

Compliance guidance was issued by the IRS, DOL, and HHS. This guidance is effective at least through 2014.

291. When does a waiting period begin?

The ninety-day waiting period begins when an employee is otherwise eligible for coverage under the terms of the group health plan.[[338]](#footnote-338) If a plan provides that full-time employees are eligible for coverage without satisfying any other condition, and an employee was hired as a full-time employee, the waiting period for that employee would begin on the date of hire. Any eligibility condition based solely on the lapse of a time period is permitted for no more than ninety days.[[339]](#footnote-339)

292. Is the ninety-day limit extended if employees take additional time to elect coverage?

A plan or insurer does not violate the ninety-day limit if employees take additional time to elect coverage.[[340]](#footnote-340) Thus, if employees are eligible on the first day of the month following completion of enrollment forms, the fact that an employee hired on the first day of the month does not complete the forms that day does not violate the excessive waiting period rule.[[341]](#footnote-341) Thus, if employees are eligible on the first day of the month following completion of enrollment forms, the fact that an employee hired on the first day of the month does not complete the forms that day does not violate the excessive waiting period rule.[[342]](#footnote-342)

It is not permissible to allow eligibility on the first weekday, the first day of the month, or the beginning of the first pay period after a ninety-day waiting period ends even though the statute provides that a waiting period may not exceed ninety days. No guidance exists as to whether the ninety-day waiting period must be continuous.

293. What other eligibility requirements can an employer have?

The law permits other eligibility conditions unless the condition is designed to avoid compliance with the ninety-day waiting period rule. For example, eligibility conditions such as full-time status or a bona fide specified job category are permitted. While employers and other plan sponsors who are subject to the employer mandate,[[343]](#footnote-343) as discussed previously, may choose to base eligibility on full-time status (thirty hours or more), they are not required to do so.

In determining an eligibility requirement such as full-time status, a plan may use a reasonable measurement period of up to twelve months to determine whether a new employee with variable hours meets the condition. This period will not be considered to be designed to avoid compliance if coverage is available no later than thirteen months from the employee’s start date (plus, if applicable, the time between the start date and the first day of the next month). If a plan requires a cumulative number of hours to become eligible, that requirement will not be considered to be designed to avoid compliance if the required hours do not exceed 1,200.

294. What other prohibitions apply to the eligibility requirements?

It is not permissible to allow eligibility on the first weekday, the first day of the month, or the beginning of the first pay period after a ninety-day waiting period ends even though the statute provides that a waiting period may not exceed ninety days. No guidance exists as to whether the ninety-day waiting period must be continuous.

295. How are permissible eligibility requirements applied to part-time and variable hour employees?

If a plan conditions eligibility on an employee regularly working a specified number of hours per period or working full-time, and the employer cannot determine that a new employee is reasonably expected regularly to work that number of hours or work full-time, the plan may take a reasonable amount of time to determine whether the employee meets the plan’s eligibility condition. This may include a measurement period that is consistent with the timeframe used for purposes of the employer shared responsibility (employer mandate or “play or pay” penalty) provision.[[344]](#footnote-344)

A period is reasonable if coverage is effective no later than thirteen months from the employee’s start date, plus, if applicable, the time remaining until the first day of the next calendar month. Where cumulative hours of service are required for eligibility, up to 1,200 hours may be required; more than 1,200 hours would be considered designed to avoid compliance with the ninety-day waiting period limitation.

***Illustration 1: Going from Part-Time to Full-Time Employment.*** Employer’s plan limits eligibility for coverage to full-time employees. Coverage becomes effective on the first day of the calendar month following the date the employee becomes eligible. Employee begins working full-time on May 15. Prior to this date, employee worked part-time for employer. Employee enrolls in the plan, and coverage is effective June 1. The period while employee was working part-time is not part of the waiting period because employee was not in a class of employees eligible for coverage while working part-time. Full-time employment is a condition that is not designed to avoid compliance with the ninety-day waiting period rule.[[345]](#footnote-345)

***Illustration 2: Part-Time Employee Satisfies Cumulative Hours of Service Requirement.*** Employee begins working twenty-five hours per week for Employer on January 1 as a part-time employee for purposes of employer’s plan. Employer sponsors a plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. Employee satisfies the plan’s cumulative hours of service condition on December 15. The cumulative hours of service condition for part-time employees is not designed to avoid compliance with the ninety-day waiting period rule. Accordingly, coverage for employee under the plan must begin no later than the ninety-first day after employee works 1,200 hours. If the plan’s cumulative hours of service requirement were more than 1,200 hours, that requirement would be deemed designed to avoid compliance with the ninety-day waiting period limitation.[[346]](#footnote-346)

***Illustration 3: Variable Hour Employee to Full-Time Status***. Under employer’s group health plan, employees who work full-time (defined as regularly working thirty hours per week or more) are eligible for coverage. Employee begins work for employer on May 15 of Year 1. Employee’s hours are expected to vary between twenty and forty-five hours per week depending on work and employee’s availability. Thus, it cannot be determined at employee’s start date that employee is reasonably expected to work full-time. Under the terms of the plan, variable hour employees are eligible to enroll in the plan if they are determined to be full-time after a measurement period of twelve months. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received.

Employee’s twelve-month measurement period ends May 14 of Year 2. Employee is determined to be full-time and is notified of his plan eligibility. If employee then elects coverage, his first day of coverage will be July 1 of Year 2. Here, the measurement period is permissible and not considered to be designed to avoid compliance with the ninety-day waiting period limitation because the plan may use a reasonable period of time to determine whether a variable hour employee is full time if the period of time is consistent with the timeframe permitted for such determinations under the employer shared responsibility rules. In such circumstances, the time period for determining whether an employee is full time will not be considered to avoid the ninety-day waiting period limitation if coverage can become effective no later than thirteen months from employee’s start date, plus the time remaining until the first day of the next calendar month.[[347]](#footnote-347)

Guaranteed Coverage

No Preexisting Conditions or Health Status   
Discrimination for Essential Health Benefits

296. How does health reform affect the ability of a health insurance policy or plan covering essential health conditions not to deny coverage or reimbursement for preexisting conditions (PCEs)?

Health reform eliminated the ability of a health insurance policy or plan covering essential health conditions to deny coverage or reimbursement for preexisting conditions for plan years beginning on or after September 23, 2010, for persons under age nineteen.[[348]](#footnote-348) Group health plans and group health insurance companies, as well as individual policies cannot impose PCEs for plan years beginning on or after January 1, 2014.[[349]](#footnote-349)A PCE may still be imposed for excepted benefits.

297. What is a preexisting condition (PCE)?

A PCE is “a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).”[[350]](#footnote-350) Thus, the prohibition covers (1) denial of enrollment and (2) denial of specific benefits based on a preexisting condition. A preexisting condition can be a serious medical condition, such as cancer, diabetes, or high blood pressure, or something relatively minor, such as tendonitis.

A PCE includes any limitation or exclusion based on information relating to an individual’s health status, “such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.”[[351]](#footnote-351)

298. Are certificates of creditable coverage still required?

Under HIPAA rules relating to preexisting conditions coverage, group health plans and health plan issuers are required to issue certificates of creditable coverage. Beginning on or after January 1, 2014, PPACA's prohibition on preexisting condition exclusions applies and a certificate of creditable coverage need no longer be issued. However, the current regulations will continue to apply until December 31, 2014, so that individuals needing to offset a preexisting condition exclusion under a plan that operates with a plan year beginning later than January 1, 2014, would still have access to the certificate for proof of coverage.[[352]](#footnote-352)

Cost-Sharing Limits

299. What are the cost-sharing limits on out-of-pocket expenses and annual deductibles?

For plan years beginning in 2014, except as discussed subsequently, the cost sharing for self-only and coverage other than self-only coverage cannot exceed the maximum out-of-pocket expense limits for self-only and family coverage for HSA-compatible high deductible health plans (HDHPs) for taxable years beginning in 2014,[[353]](#footnote-353) namely $6,350 for individuals and $12,700 for families. The HDHP deductible amount is adjusted for increases in the cost of living. This sets the maximum out-of-pocket expense limit, i.e., the plan’s annual deductible and other annual out-of-pocket expenses (such as copayments) the insured is required to pay. In the case of a plan using a network of providers, cost sharing paid by, or on behalf of, an individual for benefits provided outside of such network does not count toward the annual limitation on cost sharing or the annual limitation on deductibles.[[354]](#footnote-354)

However, employer plans that have “separately administered” benefits, such as a primary package of health benefits and a different insurer or administrator for other benefits such as prescription drugs, need not comply until 2015.[[355]](#footnote-355) Employer plans with separately administered benefits that qualify for the delay must apply some out-of-pocket limits in 2014. These plans must ensure that their primary package of health benefits has an out-of-pocket limit of no more than $6,350 for individuals and $12,700 for families. A separately administered benefit, such as prescription drugs, that already has an existing limit on out-of-pocket costs must also comply with the limits of $6,350 for individuals and $12,700 for families in 2014.[[356]](#footnote-356)

For a plan year beginning in a calendar year after 2014, the cost-sharing limit for self-only coverage is the amount for self-only coverage for plan years beginning in 2014, increased by an index amount equal to the product of that amount and the “premium adjustment percentage” for the calendar year. For coverage other than self-only coverage, the cost-sharing limit for a plan year beginning in a calendar year after 2014 is twice the amount for self-only coverage.[[357]](#footnote-357) The premium adjustment percentage for a calendar year is determined by HHS and is the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2013.[[358]](#footnote-358)

300. What are the 2014 limits for annual deductibles?

There are none. The prior rule that for plans in the small group market, the deductible could not exceed $2,000 for a plan covering one individual and $4,000 for any other plan[[359]](#footnote-359) was repealed. Under the Protecting Access to Medicare Act of 2014,[[360]](#footnote-360) this annual deductible limit was eliminated retroactively. The repeal occurred due to the desire by small businesses to offer high deductible plans paired with HSAs, HRAs, or health FSAs.

Clinical Trials and Coverage

301. What patient protections does the law create for persons participating in clinical trials?

Specifically, a group health plan may not:

* deny any qualified individual the right to participate in a clinical trial as described below
* deny, limit, or impose additional conditions on the coverage of “routine patient costs” for items and services furnished in connection with participation in the clinical trial;[[361]](#footnote-361) or
* discriminate against any qualified individual who participates in a clinical trial[[362]](#footnote-362)

A plan can require a “qualified individual” to use an in-network provider participating in a clinical trial if the provider will accept the individual as a participant. A person participating in an approved clinical trial conducted outside the state of the individual’s residence is also protected if the plan otherwise provides out-of-network coverage for routine patient costs[[363]](#footnote-363)

“Routine patient costs” include items and services provided for a person not enrolled in a clinical trial. However, such items and services do not include:

* the investigational item, device or service itself
* items and services not included in the direct clinical management of the patient, but rather in connection with data collection and analysis; or
* a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis[[364]](#footnote-364)

A “qualified individual” is a group health plan participant or beneficiary who is eligible to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and:

* The referring healthcare professional is a participating provider and has concluded that the participant’s or beneficiary’s participation in the clinical trial would be appropriate, or
* The participant or beneficiary provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate[[365]](#footnote-365)

An “approved clinical trial” is a Phase I, Phase II, Phase III, or Phase IV clinical trial that:

* is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition[[366]](#footnote-366) and is federally funded through a variety of entities or departments of the federal government, including the National Institutes of Health, the CDC, the Centers for Medicare & Medicaid Services, a cooperative group or center of any of the previous entities or the Department of Defense or the Department of Veterans Affairs, a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants and, if certain conditions are met, the Department of Veterans Affairs, the Department of Defense, and the Department of Energy [[367]](#footnote-367)
* is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration;[[368]](#footnote-368) or
* is exempt from investigational new drug application requirements[[369]](#footnote-369)

Fair Insurance Premiums

Health Insurance Rating Rules

302. What are the health insurance rating rules imposed by health reform?

Effective in 2014, health reform imposes new federal rules on how health insurers may “rate” or price their products. Grandfathered plans and plans in the large group and self-insured markets are not subject to these rules. However, if large group market insurance plans are offered on an exchange, they will be subject to these rating rules.[[370]](#footnote-370)

Under the new rules, insurers will be allowed to vary premiums for coverage in the individual and small group markets using only four factors:

* Self-only versus family coverage
* Geographic “rating area,” established by each state[[371]](#footnote-371)
* Age, and
* Tobacco use

In the cases of age and tobacco use, the new rules also limit the extent of the permitted premium variations.[[372]](#footnote-372)

For tobacco use, the maximum allowed variation will be 1.5 to 1, meaning that a plan will not be allowed to charge a tobacco user more than one and a half times (or 50 percent above) the rate charged to a non-tobacco user. With respect to age rating, the maximum allowed variation for adults will be 3 to 1, meaning that a plan will not be allowed to charge a sixty-four-year-old more than three times the premium charged a twenty-one-year-old for the same coverage.

Under the law, premiums also may vary based only on self-only or family enrollment and rating area, as specified by the state.[[373]](#footnote-373) Factors such as gender and health status are not allowed.[[374]](#footnote-374)

Additionally, health reform[[375]](#footnote-375) prohibits employer-sponsored health plans and commercial health insurers from imposing a preexisting-condition exclusion on the coverage of any enrollee or applicant under any circumstances.[[376]](#footnote-376) This blanket prohibition took effect for children (under age nineteen) on September 23, 2010, and will take effect for adults on January 1, 2014.[[377]](#footnote-377) Under prior law, insurers and employer self-insured health plans are required to provide coverage to enrollees in employer-sponsored plans on a guaranteed-issue basis and are prohibited from varying premiums based on individual health status.[[378]](#footnote-378) sections 1201(2) and (4) of PPACA (the health reform law) extend those requirements to the individual market as well, effective January 1, 2014.[[379]](#footnote-379)

**Health Insurance Coverage Transparency Reporting   
and Cost-Sharing Disclosure**

303. What are the “transparency in coverage” reporting and cost-sharing disclosures?

Health reform requires each state to have a health insurance exchange for the purchase of qualified health plans (QHPs).[[380]](#footnote-380) A health plan seeking QHP certification must disclose certain information to the exchange, HHS, and the state insurance commissioner, and make the information available to the public (“transparency in coverage” reporting and cost-sharing disclosures).[[381]](#footnote-381) Both exchange QHPs and health plans and insurers outside an exchange must comply.[[382]](#footnote-382) The requirements for QHPs and plans and insurers outside of the exchange are identical to the requirements for QHPs on an exchange, except that with respect to transparency in coverage reporting, non-exchange plans and insurers are not required to provide the information to the exchange.

Grandfathered policies and group plans are not required to comply[[383]](#footnote-383) except for QHPs sold on an exchange.[[384]](#footnote-384)

304. What information must be provided for transparency in coverage reporting?

Health plans and insurers subject to the transparency in coverage reporting requirement must make accurate and timely disclosure of the following information to HHS, the state insurance commissioner, and the public:

* claims payment policies and practices
* periodic financial disclosures
* data on enrollment and disenrollment
* data on the number of claims denied
* data on rating practices
* information on cost-sharing and payments regarding any out-of-network coverage
* information on enrollee and participant rights under Title I of PPACA; and
* other information as determined by HHS[[385]](#footnote-385)

Additionally, exchange-based QHPs must disclose this information to the exchange.

The information must be disclosed using “plain language” that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.[[386]](#footnote-386)

305. What cost-sharing disclosures to individuals must be made?

Health plans and insurers subject to this requirement must provide certain cost-sharing (including deductibles, copayments, and coinsurance) information in a timely manner on request by an individual.[[387]](#footnote-387) At a minimum, the information must be made available to the individual through an Internet Web site. However, for those individuals who do not have access to the Internet, the information must be provided in some other means.[[388]](#footnote-388)

No Discrimination against Providers

306. How does health reform prohibit discrimination against healthcare providers, such as physicians?

A group health plan and a health insurance issuer offering group or individual health insurance coverage cannot discriminate as to participation under the plan or coverage against any healthcare provider acting within the scope of that provider’s license or certification under applicable state law. However, this rule does not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer.[[389]](#footnote-389)

In addition, this law does not prevent HHS, a group health plan, or a health insurance issuer, from establishing varying reimbursement rates based on quality or performance measures.[[390]](#footnote-390)

This law is the first federal provider non-discrimination law applicable to non-government and to self-insured ERISA plans. “Group health plans” and “health insurance issuers offering group or individual health insurance coverage” include self-insured employee health benefit plans, group health insurance, individual health insurance, and likely the federal employees health benefits program. This nondiscrimination requirement applies to products sold through the new health insurance exchanges starting in 2014.

307. What are some examples of prohibited discrimination against providers?

Possible prohibited activities could include the following:

* Health insurer requires that optometrists seeking to be participating providers in health plan provider network must also contract to be participating providers in free-standing vision plan, but does not impose same requirement on ophthalmologists or other physicians
* Health insurer maintains “closed” or “limited” network of podiatrists but has “open panel” approach to participation by qualified orthopedic physicians and primary care physicians.
* Could be vulnerable to charge of discrimination
* Could perhaps be defended on ground that law does not impose “any willing provider requirement” and plan has different needs for orthopedic surgeons than for podiatrists or achieves legitimate business objectives by varying contracting approach taking into account services provided by orthopedists compared to podiatrists, and is not discriminating based on license.
* Health insurer includes optometrists or nurse midwives in network only in rural areas but not in urban areas
* Health insurer has different fee schedule for same CPT code service based on whether service is performed by psychologist or M.D.
* Insurer has limited network for provision of certain eye exams for which it uses an RFP bid process to choose a vendor, but has a separate provider network for a different set of eye care services some of which are not performed in that state by optometrists, such as eye surgery. If optometrists are able to participate in bid activity for the former, but are not able to qualify for the second, is this federal law violated?
* What if insurer imposes new credentialing criteria that are hard for non-MDs to meet, and it grandfathers people in its existing network, which includes a few non-MDs?

308. What is the effective date of the provider nondiscrimination requirements?

This provision is effective January 1, 2014, or, for group plans, plan years beginning on or after January 1, 2014.[[391]](#footnote-391)

309. How will the nondiscrimination requirement be enforced?

HHS enforces the PHSA for government plans, and the states enforce the law for its private health insurance requirements.[[392]](#footnote-392) Sanction for insurers that violate the law would depend on state law. HHS enforces the PHSA for self-insured group health plans and, if the state does not enforce it, for health insurers.[[393]](#footnote-393)

For HHS enforcement, HHS may impose a civil monetary penalty on insurance issuers that fail to comply with the PHSA requirements. The maximum penalty imposed under the PHSA is $100 per day per individual with respect to which such a failure occurs.[[394]](#footnote-394) Similar to the Internal Revenue Code, certain minimum penalty amounts may apply to a plan or employer if the violation is not corrected within a specified period, or if a violation is considered to be more than *de minimis.* In determining the amount of the penalty, HHS must take into account the entity’s previous record of compliance with the PHSA provisions.

In addition, a penalty may not be imposed for a violation if it is established to the Secretary’s satisfaction that none of the entities knew (or if exercising reasonable diligence would have known) that the violation existed. If the violation was due to reasonable cause and not willful neglect, a penalty would not be imposed if the violation were corrected within thirty days of discovery.[[395]](#footnote-395) Entities found to violate the PHSA requirements may challenge the penalty in a hearing subject to a decision by an administrative law judge.[[396]](#footnote-396) Following this administrative hearing, entities may file an action for judicial review.[[397]](#footnote-397)

310. To what products or programs do these provider nondiscrimination rules not apply?

These provider nondiscrimination rules do not apply to Medicare, Medicare Advantage, Medicare Supplement or Medicaid. Medicare Advantage plans already are prohibited from discriminating, in terms of participation, reimbursement, or indemnification, against any healthcare professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Additionally, the requirement does not apply to “excepted benefits,” such as stand-alone dental and vision coverage, workers compensation, long-term-care insurance, insurance for a specific disease or illness, or hospital indemnity insurance, for example.

1. . Preamble to Grandfathered Health Plan Regulations, 75 Fed. Reg. 34537 (June 17, 2010) and HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part II, Q/A-6, at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-1)
2. . PHSA §2704(a), IRC Sec. 9815 and ERISA Sec. 715. [↑](#footnote-ref-2)
3. . PHSA §2708. [↑](#footnote-ref-3)
4. . PHSA §2711. [↑](#footnote-ref-4)
5. . Treas. Reg. §54.9815-2711T(b)(1); DOL Reg. §2590.715-2711(b)(1); HHS Reg. §147.126(b)(2). [↑](#footnote-ref-5)
6. . Treas. Reg. §54.9815-2711T(b)(2); DOL Reg. §2590.715-2711(b)(2); HHS Reg. §147.126(b)(2). [↑](#footnote-ref-6)
7. . PHSA §2712. [↑](#footnote-ref-7)
8. . PHSA §2714. [↑](#footnote-ref-8)
9. . PHSA §2715. [↑](#footnote-ref-9)
10. . PHSA §2718. [↑](#footnote-ref-10)
11. . PHSA §2701. [↑](#footnote-ref-11)
12. . PHSA §2701(a)(1)(A). [↑](#footnote-ref-12)
13. . PHSA §2702. [↑](#footnote-ref-13)
14. . PPACA renumbered PHSA §2711as PHSA §2731; PPACA §1105 included new PHSA §2702(a); and PPACA §1563(c)(8) made changes to PHSA §2731 and renumbered it as PHSA §2702. [↑](#footnote-ref-14)
15. . PHSA §2702(b). [↑](#footnote-ref-15)
16. . PHSA §2703. [↑](#footnote-ref-16)
17. . Health status factors are health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (EOI) (including conditions arising out of acts of domestic violence); disability; and any other health status-related factor determined appropriate by the Secretary of HHS. IRC Sec. 9802(a)(1); ERISA Sec. 702(a)(1); PHSA §2705(a). The last category was added by health reform. PHSA §2705(a). [↑](#footnote-ref-17)
18. . PHSA §2705. [↑](#footnote-ref-18)
19. . PHSA §2706. [↑](#footnote-ref-19)
20. . PHSA §2707(a). [↑](#footnote-ref-20)
21. . PPACA §1302(b). [↑](#footnote-ref-21)
22. . PPACA §1302(c). [↑](#footnote-ref-22)
23. . PPACA §1302(e). [↑](#footnote-ref-23)
24. . PHSA §2707(c). [↑](#footnote-ref-24)
25. . PHSA §2709. [↑](#footnote-ref-25)
26. . PHSA §2713. [↑](#footnote-ref-26)
27. . PHSA §2715A. [↑](#footnote-ref-27)
28. . PHSA §2716, IRC Sec. 9815 and ERISA Sec. 715. [↑](#footnote-ref-28)
29. . PHSA §2717. [↑](#footnote-ref-29)
30. . DOL Reg. §2590.715-2719(b)(2). [↑](#footnote-ref-30)
31. . DOL Reg. §2590.715-2719(a). [↑](#footnote-ref-31)
32. . PHSA §2719. [↑](#footnote-ref-32)
33. . DOL Technical Release 2011-02. [↑](#footnote-ref-33)
34. . PHSA §2719A. [↑](#footnote-ref-34)
35. . Treas. Reg. §54.9815-2719AT(b)(3)(i); DOL Reg. §2590.715-2719A(b)(3)(i); HHS Reg. §147.138(b)(3)(i). [↑](#footnote-ref-35)
36. . PHSA §2723. [↑](#footnote-ref-36)
37. . IRC Sec. 4980D, which does not apply to insurers. [↑](#footnote-ref-37)
38. . IRC Sec. 4980D(c)(1). [↑](#footnote-ref-38)
39. . IRC Sec. 4980D(c)(2). See IRC Sec. 4980D(c)(2)(B)(ii), which gives church plans 270 days after the date of mailing by the Secretary of a notice of default with respect to the plan’s failure. [↑](#footnote-ref-39)
40. . IRC Sec. 4980D(b)(3)(c). [↑](#footnote-ref-40)
41. . IRC Sec. 4980D(b)(3)(B). [↑](#footnote-ref-41)
42. . IRC Sec. 4980D(c)(3)(A). [↑](#footnote-ref-42)
43. . PHSA §2715(f). [↑](#footnote-ref-43)
44. . PHSA §2715(f); Treas. Regs. §54.9815-2715(e); DOL Regs. §2590.715-2715(e); 45 CFR §147.200(e). [↑](#footnote-ref-44)
45. . 75 Fed. Reg. 34538 (June 17, 2010). [↑](#footnote-ref-45)
46. . Participant notices are required to "maintain status as a grandfathered health plan." 75 Fed. Reg. 34538, 34541. A representative of the Treasury Department stated in nonbinding remarks that failing to provide the required notices will not automatically revoke a plan's grandfathered status, and that the facts and circumstances surrounding a notice failure will be determinative as to continued grandfathering. See http://www.employersgroup.com/Content.aspx?id=1675. [↑](#footnote-ref-46)
47. . ERISA Sec. 502(a). [↑](#footnote-ref-47)
48. . ERISA Sec. 502(a). [↑](#footnote-ref-48)
49. . Dep't of Labor's FAQs About the Affordable Care Act Implementation Part IV, available at http://www.dol.gov/ebsa/faqs/faq-aca4.html. [↑](#footnote-ref-49)
50. . ERISA Sec. 502(g), 29 U.S.C. §1132(g). [↑](#footnote-ref-50)
51. . See *Hardt v. Reliance Std. Life Ins. Co.,* 130 S. Ct. 2149, 2157-58 (2010). [↑](#footnote-ref-51)
52. . E.g., *IBM Personal Pension Plan v. Cooper*, 2005 WL 1981501 (S.D. Ill. August 16, 2005) (settling cash balance conversion case for $314.3 million, with attorney's fees of 29 percent of first $250 million, and 25 percent of remainder). [↑](#footnote-ref-52)
53. . *Continental Group v. McClendon*, 872 F. Supp. 142 (D.N.J. 1994) (ERISA 510 claim settled for $415 million, with $33.3 million fee award based on "enhanced" lodestar method). [↑](#footnote-ref-53)
54. . PHSA §§2723(a) and (b)(1). [↑](#footnote-ref-54)
55. . PHSA §2723(b)(2). [↑](#footnote-ref-55)
56. . PHSA §2723(b)(2)(C)(iii)(I). [↑](#footnote-ref-56)
57. . PHSA §2723(b)(2)(C)(iii)(II). [↑](#footnote-ref-57)
58. . PHSA §2723(b)(2)(D). [↑](#footnote-ref-58)
59. . FLSA §18C. [↑](#footnote-ref-59)
60. See HHS, CMS, Center for Consumer Information & Insurance Oversight (CCIIO) letter from CCIIO Director Gary Cohen to state insurance commissioners at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>. Footnote 2 of this letter indicates that the IRS and Department of Labor concur with this program [↑](#footnote-ref-60)
61. These could include any or all of the following requirements contained in the following sections of the Public Health Service Act, as amended by healthcare reform: 2701 (relating to fair health insurance premiums); 2702 (relating to guaranteed availability of coverage); 2703 (relating to guaranteed renewability of coverage); 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage; 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage; 2706 (relating to non-discrimination in health care); 2707 (relating to comprehensive health insurance coverage); and 2709 (relating to coverage for individuals participating in approved clinical trials). [↑](#footnote-ref-61)
62. “Insurers Caught off Guard by Policy Reversal,” Wall Street Journal, p.1 A-1 (November 15, 2013) and online as “Health Insurers Express Worries Over Obama Shift on Policy Cancellations” at <http://online.wsj.com/news/articles/SB10001424052702303289904579198053626111152?mod=ITP_pageone_0>. [↑](#footnote-ref-62)
63. At <http://www.scribd.com/doc/192619675/Sec-Sebelius-Response-to-Senator-Warner?wpisrc=nl_wonk>. [↑](#footnote-ref-63)
64. At <http://marketplace.cms.gov/getofficialresources/publications-and-articles/hardship-exemption.pdf>. [↑](#footnote-ref-64)
65. . Treas. Reg. §54.9815-2711T(b)(1); DOL Reg. §2590.715-2711(b)(1); HHS Reg. §147.126(b)(2). [↑](#footnote-ref-65)
66. . PHSA §2711. [↑](#footnote-ref-66)
67. PHSA § 2711. [↑](#footnote-ref-67)
68. See “Self-Funded Non-Federal Governmental Plans” at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html>. [↑](#footnote-ref-68)
69. 42 U.S.C. 30gg-91. [↑](#footnote-ref-69)
70. 29 U.S.C. 1002(1). [↑](#footnote-ref-70)
71. . See http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html. [↑](#footnote-ref-71)
72. . Frequently Asked Questions on Essential Health Benefits Bulletin, Q/A-10, at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. [↑](#footnote-ref-72)
73. . Preamble to Interim Final Rules Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections Under PPACA, 75 Fed. Reg. 37188, 37190 (June 28, 2010). [↑](#footnote-ref-73)
74. . OCIIO Sub-Regulatory Guidance (OCIIO 2010-1A): Supplemental Guidance, at http://cciio.cms.gov/resources/files/annual\_limits\_waiver\_guidance.pdf. [↑](#footnote-ref-74)
75. . PHSA §2711(a)(1)(A); Treas. Reg. §54.9815-2711T(a)(1); DOL Reg. §2590.715-2711(a)(1); HHS Reg. §147.126(a)(1). [↑](#footnote-ref-75)
76. . Frequently Asked Questions on Essential Health Benefits Bulletin, Q/A-10, at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. [↑](#footnote-ref-76)
77. . PHSA §2711(b); Treas. Reg. §54.9815-2711T(b); DOL Reg. §2590.715-2711(b); HHS Reg. §147.126(b). [↑](#footnote-ref-77)
78. . Nonbinding comments of James Mayhew, Office of Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services of HHS, Department of Labor Affordable Care Act Compliance Assistance Webcast Series: Part I(September 7, 2010). [↑](#footnote-ref-78)
79. . Frequently Asked Questions on Essential Health Benefits Bulletin, Q/A-11, at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. [↑](#footnote-ref-79)
80. . Frequently Asked Questions on Essential Health Benefits Bulletin, Q/A-12, at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. [↑](#footnote-ref-80)
81. . Frequently Asked Questions on Essential Health Benefits Bulletin, Q/A-20, at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. [↑](#footnote-ref-81)
82. . PHSA §2714. [↑](#footnote-ref-82)
83. . PPACA §1004(a). [↑](#footnote-ref-83)
84. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part II, Q/A-9, at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-84)
85. . PPACA, Pub. L. No. 111-148, §1251(a). [↑](#footnote-ref-85)
86. . IRS Notice 2010-38. [↑](#footnote-ref-86)
87. . DOL Reg. §2590.715-2714(f); Treas. Reg. §54.9815-2714T(f); HHS Reg. §147.120(f); Interim Final Rules Relating to Dependent Coverage of Children to Age 26 Under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147; 75 Fed. Reg. 27121 (May 13, 2010). [↑](#footnote-ref-87)
88. . Interim Final Rules Relating to Dependent Coverage of Children to Age 26 Under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR Parts 144, 146, and 147; 75 Fed. Reg. 27121, 27134 (May 13, 2010). [↑](#footnote-ref-88)
89. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part I, Q14, available at http://www.dol.gov/ebsa/faqs/faq-aca.html. [↑](#footnote-ref-89)
90. . DOL Reg. §2590.715-2714(a); Treas. Reg. §54.9815-2714T; HHS Reg. §147.120(a). [↑](#footnote-ref-90)
91. . PHSA §2704. [↑](#footnote-ref-91)
92. . Nonbinding comments of Russ Weinheimer, IRS Attorney, Department of Labor Affordable Care Act Compliance Assistance Webcast (September 7, 2010). [↑](#footnote-ref-92)
93. . DOL Reg. §2590.715-2714(b); Treas. Reg. §54.9815-2714T(b); HHS Reg. §147.120(b). [↑](#footnote-ref-93)
94. . PHSA §2714(b) because the phrase “who is not married” was removed. [↑](#footnote-ref-94)
95. . Interim Final Rules Relating to Dependent Coverage of Children to Age 26 Under PPACA, 26 CFR Parts 54 and 602; 29 CFR Part 2590.45 CFR Parts 144, 146, and 147, 75 Fed. Reg. 27121 (May 13, 2010). [↑](#footnote-ref-95)
96. . DOL Reg. §2590.715-2714(b); Treas. Reg. §54.9815-2714T(b); HHS Reg. §147.120(b). [↑](#footnote-ref-96)
97. . PPACA, Pub. L. No. 111-148, §1001(5). [↑](#footnote-ref-97)
98. . DOL Reg. §2590.715-2714(c); Treas. Reg. §54.9815-2714T(c); HHS Reg. §147.120(c). [↑](#footnote-ref-98)
99. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part I, Q14, at http://www.dol.gov/ebsa/faqs/faq-aca.html. [↑](#footnote-ref-99)
100. . IRS Notice 2010-38. [↑](#footnote-ref-100)
101. . IRC Sec. 152(f)(1). [↑](#footnote-ref-101)
102. . IRS Notice 2010-38. [↑](#footnote-ref-102)
103. . IRS Notice 2010-38. [↑](#footnote-ref-103)
104. . IRS Notice 2010-38. [↑](#footnote-ref-104)
105. . Notice 2010-38 addresses this issue and notes that “[t]here is no indication that Congress intended to provide a broader exclusion in Code section 105(b) than in Code section 106,” and that, therefore, “IRS and Treasury intend to amend the regulations under Code section 106, retroactively to March 30, 2010, to provide that coverage for an employee’s child under age 27 is excluded from gross income.” [↑](#footnote-ref-105)
106. . Notice 2010-38. [↑](#footnote-ref-106)
107. . Treas. Reg. §1.125-4(c). [↑](#footnote-ref-107)
108. . Prop. Treas. Reg. §1.125-1(c). [↑](#footnote-ref-108)
109. . Voluntary Employees Beneficiary Associations, which are governed by IRC Sec. 501(c)(9). [↑](#footnote-ref-109)
110. . IRC Sec. 223(d)(2)(A). [↑](#footnote-ref-110)
111. . IRC Sec. 223(d)(2)(A) (for HSA purposes, dependent is as defined in IRC Sec. 152 without regard to subsections (b)(1), (b)(2), and (d)(1)(B). [↑](#footnote-ref-111)
112. . PPACA §1557. [↑](#footnote-ref-112)
113. . http://www.hhs.gov/ocr/civilrights/resources/laws/section1557\_questions\_answers.html. [↑](#footnote-ref-113)
114. . http://www.hhs.gov/ocr/civilrights/resources/laws/section1557\_questions\_answers.html, Q/A-3. [↑](#footnote-ref-114)
115. . http://www.hhs.gov/ocr/civilrights/resources/laws/section1557\_questions\_answers.html, Q/A-4. [↑](#footnote-ref-115)
116. . http://www.hhs.gov/ocr/civilrights/resources/laws/section1557\_questions\_answers.html, Q/A-1. [↑](#footnote-ref-116)
117. . IRC Sec. 4980D, and the penalty must be self-reported on Form 8928. [↑](#footnote-ref-117)
118. . Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Health Services Under PPACA, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Part 147, 75 Fed. Reg. 41726 (July 19, 2010). [↑](#footnote-ref-118)
119. . PHSA §2713(a)(1); Treas. Reg. §54.9815-2713T(a)(1)(i); DOL Reg. §2590.715-2713(a)(1)(i); HHS Reg. §147.130(a)(1)(i). [↑](#footnote-ref-119)
120. . PHSA §2713(a)(2); Treas. Reg. §54.9815-2713T(a)(1)(ii); DOL Reg. §2590.715-2713(a)(1)(ii); HHS Reg. §147.130(a)(1)(ii). [↑](#footnote-ref-120)
121. . PHSA §2713(a)(3); Treas. Reg. §54.9815-2713T(a)(1)(iii); DOL Reg. §2590.715-2713(a)(1)(iii); HHS Reg. §147.130(a)(1)(iii). [↑](#footnote-ref-121)
122. . PHSA §2713(a)(4); Treas. Reg. §54.9815-2713T(a)(1)(iv); DOL Reg. §2590.715-2713(a)(1)(iv); HHS Reg. §147.130(a)(1)(iv). The regulations note that HHS is developing these. [↑](#footnote-ref-122)
123. . Treas. Reg. §54.9815-2713T(a)(4); DOL Reg. §2590.715-2713(a)(4); HHS Reg. §147.130(a)(4). [↑](#footnote-ref-123)
124. . Treas. Reg. §54.9815-2713T(a)(3); DOL Reg. §2590.715-2713(a)(3); HHS Reg. §147.130(a)(3). [↑](#footnote-ref-124)
125. . IRC Sec. 6033(a)(3)(A)(i). [↑](#footnote-ref-125)
126. . IRC Sec. 6033(a)(3)(A)(iii). [↑](#footnote-ref-126)
127. . The revised religious employer exemption applies to group health plans and health insurers for plan years beginning on or after August 1, 2013. HHS Reg. §147.131(a): Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Parts 147, 148, and 156; 78 Fed. Reg. 39869 (July 2, 2013). [↑](#footnote-ref-127)
128. . Treas. Reg. §54.9815-2713(b); DOL Reg. §2590.715-2713(b); Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Parts 147, 148, and 156; 78 Fed. Reg. 39869, 39879 (July 2, 2013). [↑](#footnote-ref-128)
129. . HHS Reg. §147.131(d); Treas. Reg. §54.9815-2713(d); DOL Reg. §2590.715-2713(d). [↑](#footnote-ref-129)
130. . Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Parts 147, 148, and 156; 78 Fed. Reg. 39869, 39886 (July 2, 2013). [↑](#footnote-ref-130)
131. . CCIIO Bulletin: Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under PHSA §2713, ERISA §715(a)(1), and Code §9815(a)(1) (June 28, 2013) at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/preventive-services-guidance-6-28-2013.pdf. [↑](#footnote-ref-131)
132. . Id. [↑](#footnote-ref-132)
133. . Employers with at least 50 full-time equivalent employees must offer insurance meeting specified requirements or pay a $2,000 penalty per full-time worker (in excess of 30 full-time workers) if any of its full-time employees receive a federal premium subsidy through a Health Care Exchange. IRC Sec. 4980H(c)(2)(D). A different penalty applies for employers of at least 50 full-time equivalent employees that offer insurance that does not meet federal requirements. IRC Sec. 4980H(b)(1). [↑](#footnote-ref-133)
134. 573 U.S. \_\_\_ (2014) at <http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf>. [↑](#footnote-ref-134)
135. In August, 2011, the HHS’s Health Resources and Services Administration (“HRSA”) released guidelines that mandated coverage for all FDA-approved contraceptives, but which include a narrow exemption for religious employers. To qualify for this exemption, a religious employer must (i) have the inculcation of religious values as its purpose, (ii) primarily employ persons who share its religious tenets, (iii) primarily serve persons who share its religious tenets, and (iv) be a non-profit organization. Thus, the exemption applied primarily to group health plans established or maintained by churches, synagogues, mosques, and other houses of worship, and religious orders. The religious exemption was subsequently expanded to accommodate religious nonprofit organizations with religious objections to providing coverage for contraceptive services. Under this accommodation, an insurance issuer must exclude contraceptive coverage from the employer’s plan and provide plan participants with separate payments for contraceptive services without imposing any cost sharing requirements on the employer, its insurance plan, or its employee beneficiaries. [↑](#footnote-ref-135)
136. Dissent Slip Op. at 20, fn. 19. [↑](#footnote-ref-136)
137. *City of Boerne v. Flores*, 521 U.S. 507 (1997). [↑](#footnote-ref-137)
138. See Guttmacher Institute, State Policies In Brief, Insurance Coverage of Contraceptives (July 1, 2014); and <http://www.ncsl.org/research/health/insurance-coverage-for-contraception-state-laws.aspx>; [↑](#footnote-ref-138)
139. For example, California Health and Safety Code § 1367.25 is part of the state's managed care law. California law requires all individual and group health plans (though not employer self-funded plans) that include prescription drug benefits to cover "a variety of federal Food and Drug Administration approved prescription contraceptive methods designated by the plan." California Insurance Code § 10123.196 imposes similar requirements on health insurance. [↑](#footnote-ref-139)
140. Cal. Health & Safety Code § 1367.25(b)(1). [↑](#footnote-ref-140)
141. Slip Op. at 46. [↑](#footnote-ref-141)
142. *Citizens United v. Federal Election Commission*, 558 U.S. 310 (2010). [↑](#footnote-ref-142)
143. Dissent Slip Op. at 14. [↑](#footnote-ref-143)
144. See DOL FAQs about Affordable Care Act Implementation (Part XX) at <http://www.dol.gov/ebsa/faqs/faq-aca20.html>. [↑](#footnote-ref-144)
145. *Burwell v. Hobby Lobby Stores, Inc*., 573 U.S. \_\_\_ (June 30, 2014), available at <http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf>. [↑](#footnote-ref-145)
146. 29 CFR 2520.102-3(j)(3). [↑](#footnote-ref-146)
147. See ERISA section 104(b)(1) and 29 CFR 2520.104b-3(d)(1). [↑](#footnote-ref-147)
148. Id. [↑](#footnote-ref-148)
149. . Preamble, 75 Fed. Reg. 37188, 37192 (June 28, 2010). [↑](#footnote-ref-149)
150. . PHSA §2712. [↑](#footnote-ref-150)
151. . Preamble, 75 Fed. Reg. 37188, 37192 (June 28, 2010). [↑](#footnote-ref-151)
152. . Treas. Reg. §54.9815-2712T(a)(2); DOL Reg. §2590.715-2712(a)(2); HHS Reg. §147.128(a)(2). [↑](#footnote-ref-152)
153. . PHSA §2712. [↑](#footnote-ref-153)
154. . Treas. Reg. §54.9815-2712T(a)(3), Example 1; DOL Reg. §2590.715-2712(a)(3), Example 1; HHS Reg. §147.128(a)(3), Example 1. [↑](#footnote-ref-154)
155. . Treas. Reg. §54.9815-2712T(a)(1); DOL Reg. §2590.715-2712(a)(1); HHS Reg. §147.128(a)(1). [↑](#footnote-ref-155)
156. . Preamble, 75 Fed. Reg. 37188, 37193 (June 28, 2010). [↑](#footnote-ref-156)
157. . Treas. Reg. §54.9815-2712T(a)(3), Example 2; DOL Reg. §2590.715-2712(a)(3), Example 2; HHS Reg. §147.128(a)(3), Example 2. [↑](#footnote-ref-157)
158. . See FAQs About the Affordable Care Act Implementation Part II, Q/A-7, at http://www.dol.gov/ebsa/faqs/faq-aca2.html. [↑](#footnote-ref-158)
159. . Appeals Regulations, 75 Fed. Reg. 43329, 43337–38 (July 23, 2010). [↑](#footnote-ref-159)
160. . Interim Final Rule on Internal Claims and Appeals and External Review Processes, 75 Fed. Reg. 43329 (July 23, 2010). [↑](#footnote-ref-160)
161. . Amendment to Interim Final Rule on Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208 (June 24, 2011). [↑](#footnote-ref-161)
162. . See DOL Technical Release 2011-01. [↑](#footnote-ref-162)
163. . See Technical Release 2011-01, Appendix, at http://www.dol.gov/ebsa/newsroom/tr11-01.html. [↑](#footnote-ref-163)
164. . Treas. Reg. §54.9815–2719T(c)(2)(v); DOL Reg. §2590.715–2719(c)(2)(v); HHS Reg. §147.136(c)(2)(v). [↑](#footnote-ref-164)
165. . DOL Reg. §2560.503-1. [↑](#footnote-ref-165)
166. . PHSA §2719(a). [↑](#footnote-ref-166)
167. . DOL Reg. §2590.715-2719(a)(2)(iii). [↑](#footnote-ref-167)
168. . DOL Reg. §2560.503-1(a). [↑](#footnote-ref-168)
169. . PHSA §2719(a)(1)(C). [↑](#footnote-ref-169)
170. . DOL Reg. §2560.503-1(h)(2)(iii). [↑](#footnote-ref-170)
171. . DOL Reg. §2560.503-1(h)(2)(ii). [↑](#footnote-ref-171)
172. . PHSA §2719(a)(1)(C). [↑](#footnote-ref-172)
173. . Black’s Law Dictionary (9th ed. 2009) (“testimony”). [↑](#footnote-ref-173)
174. . Black's Law Dictionary Free Online 2nd Ed. at http://thelawdictionary.org/testimony. [↑](#footnote-ref-174)
175. . Nonbinding comments, Amy Turner, EBSA, ABA Joint Committee on Employee Benefits teleconference, “Health Plans: Compliance with PPACA’s Health Claims and Appeals Process” (November 17, 2010). [↑](#footnote-ref-175)
176. . DOL Reg. §2590.715-2719(b)(2)(ii)(A). [↑](#footnote-ref-176)
177. . DOL Reg. §2590.715-2719(a)(2)(v). [↑](#footnote-ref-177)
178. . Preamble to amended Appeals Regulations, 76 Fed. Reg. 37208, 37212 (June 24, 2011). [↑](#footnote-ref-178)
179. . DOL Reg. §2590.715-2719(b)(2)(ii)(C)(1). [↑](#footnote-ref-179)
180. . DOL Reg. §2560.503-1(i). [↑](#footnote-ref-180)
181. . DOL Reg. §§2560.503-1(b) and (h). [↑](#footnote-ref-181)
182. . PHSA §2719(a)(1)(B); Reg. §54.9815-2719T(e); 2012 Culturally and Linguistically Appropriate Services (CLAS) County Data, at http://www.cciio.cms.gov/resources/factsheets/clas-data.html. [↑](#footnote-ref-182)
183. . HHS Reg. §147.136(e)(3). [↑](#footnote-ref-183)
184. . DOL Reg. §2590.715-2719(b)(2)(ii)(F)(2). [↑](#footnote-ref-184)
185. . DOL Reg. §2590.715-2719(b)(2)(ii)(F)(2). [↑](#footnote-ref-185)
186. . Technical Release No. 2011-02 at http://www.dol.gov/ebsa/newsroom/tr11-02.html. [↑](#footnote-ref-186)
187. . DOL Technical Release 2011-01 (March 18, 2011). [↑](#footnote-ref-187)
188. . Amendment to Interim Final Rule on Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37208 (June 24, 2011). [↑](#footnote-ref-188)
189. . IRC Sec. 9802(b)(2); ERISA Sec. 702(b)(2); PHSA §2705(b)(2). [↑](#footnote-ref-189)
190. . See, e.g., DOL Information Letter to Joseph S. Dunn (November 17, 1993). [↑](#footnote-ref-190)
191. . Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147, 78 Fed. Reg. 33158 (June 3, 2013). [↑](#footnote-ref-191)
192. . HHS Reg. §147.110(b). [↑](#footnote-ref-192)
193. . PHSA §2718(a) and (b)(1)(A). [↑](#footnote-ref-193)
194. . PHSA §2718(b)(1)(A). [↑](#footnote-ref-194)
195. . PHSA §§2718(b)(1)(A)(i) and (ii). This ratio is determined on a state-by-state basis and it is measured in the state in which the policy is issued. States can require higher minimum MLR percentages, but HHS can also adjust state MLR requirements downward where necessary to prevent destabilization of the individual market. State MLR targets tend to be lower than the health reform law targets. [↑](#footnote-ref-195)
196. . PHSA §2791(e)(4). [↑](#footnote-ref-196)
197. . 45 CFR §158.240(d). [↑](#footnote-ref-197)
198. . On November 22, 2010, the Department of Health and Human Services (HHS) issued its interim final regulations implementing the MLR requirements of section 2718 of the Public Health Services Act (PHSA) entitled “Bringing Down the Cost of Health Care Coverage.” The term “medical loss ratio” does not appear in section 2718. [↑](#footnote-ref-198)
199. . Medical Loss Ratio Requirements under PPACA, 45 CFR Part 158, 76 Fed. Reg. 76574 (December 7, 2011); Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans, 45 CFR Part 158, 76 Fed Reg. 76596 (December 7, 2011); DOL Technical Release 2011-04 (December 2, 2011); HHS Fact Sheet: Medical Loss Ratio: Getting Your Money's Worth on Health Insurance (December 2, 2011). [↑](#footnote-ref-199)
200. . 45 CFR §158.241(a). [↑](#footnote-ref-200)
201. . 45 CFR §158.241(b). [↑](#footnote-ref-201)
202. . CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation, Q/A-30, at http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf. [↑](#footnote-ref-202)
203. . 45 CFR §158.240(b). [↑](#footnote-ref-203)
204. . 45 CFR §158.241. [↑](#footnote-ref-204)
205. . CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation, Q/A-37, at http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf. [↑](#footnote-ref-205)
206. . ERISA Sec. 3(1), 29 U.S.C. §1002(1). [↑](#footnote-ref-206)
207. . 45 CFR §158.242(b). ERISA generally applies to private employer plans, while the PHSA applies to non-federal governmental employer plans. [↑](#footnote-ref-207)
208. . 45 CFR §158.242(b)(4). [↑](#footnote-ref-208)
209. . DOL Technical Release No. 2011-04, Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act (December 2, 2011), at http://www.dol.gov/ebsa/newsroom/tr11-04.html. [↑](#footnote-ref-209)
210. . CCIIO Technical Guidance (CCIIO 2011-002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule, Q/A-17, at http://cciio.cms.gov/resources/files/2011\_05\_13\_mlr\_q\_and\_a\_guidance.pdf. [↑](#footnote-ref-210)
211. . OCIIO Technical Guidance (OCIIO 2010-2A): Process for a State to Submit a Request for Adjustment to the Medical Loss Ratio Standard of PHS Act section 2718, at http://cciio.cms.gov/resources/files/12-17-2010ociio\_2010-2a\_guidance.pdf. [↑](#footnote-ref-211)
212. . 75 Fed. Reg. 74863, 74877 (December 1, 2010). [↑](#footnote-ref-212)
213. . 103 45 CFR §158.140, 104 45 CFR §158.150.105, 45 CFR §§158.161 and 158.162, 106 45 CFR §158.240(c); see also http://www.gao.gov/new.items/d1290r.pdf, page 4. [↑](#footnote-ref-213)
214. . 45 CFR §158.120(a). [↑](#footnote-ref-214)
215. . Vol. 76 Federal Register No. 235, pp. 76596-76599 (December 7, 2011) at http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31291.pdf. [↑](#footnote-ref-215)
216. . DOL Technical Release No. 2011-04, Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act (December 2, 2011), at http://www.dol.gov/ebsa/newsroom/tr11-04.html. [↑](#footnote-ref-216)
217. . DOL Technical Release No. 2011-04, Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act (December 2, 2011), at http://www.dol.gov/ebsa/newsroom/tr11-04.html. [↑](#footnote-ref-217)
218. . *See, e.g.*, Advisory Opinions 2001-02A (February 15, 2001); 99-08A (May 20, 1999); 94-31A (September 9, 1994); and 92-02A (January 17, 1992). [↑](#footnote-ref-218)
219. . IRS Medical Loss Ratio (MLR) FAQs Q/A-2 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-219)
220. . IRS Medical Loss Ratio (MLR) FAQs Q/A-3 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-220)
221. . IRS Medical Loss Ratio (MLR) FAQs Q/A-4 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-221)
222. . IRS Medical Loss Ratio (MLR) FAQs Q/A-5&6 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-222)
223. . IRS Medical Loss Ratio (MLR) FAQs Q/A-7 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-223)
224. . IRS Medical Loss Ratio (MLR) FAQs Q/A-8&9 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-224)
225. . IRS Medical Loss Ratio (MLR) FAQs Q/A-10 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-225)
226. . IRS Medical Loss Ratio (MLR) FAQs Q/A-11 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-226)
227. . IRS Medical Loss Ratio (MLR) FAQs Q/A-12 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-227)
228. . IRS Medical Loss Ratio (MLR) FAQs Q/A-13 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-228)
229. . IRS Medical Loss Ratio (MLR) FAQs Q/A-14 at http://www.irs.gov/newsroom/article/0,,id=256167,00.html. [↑](#footnote-ref-229)
230. . PHSA §2715(a), ERISA Sec. 715, and IRC Sec. 9815. [↑](#footnote-ref-230)
231. . FAQs at http://www.dol.gov/ebsa/faqs/faq-aca14.html. [↑](#footnote-ref-231)
232. . SBC Template at http://www.dol.gov/ebsa/pdf/correctedsbctemplate2.pdf. [↑](#footnote-ref-232)
233. . Sample Completed SBC at http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC2.pdf. [↑](#footnote-ref-233)
234. . Treas. Reg. §54.9815-2715(a)(1)(ii); DOL Reg. §2590.715-2715(a)(1)(ii); HHS Reg. §147.200(a)(1)(ii). [↑](#footnote-ref-234)
235. . Treas. Reg. §54.9815-2715(a)(1)(ii)(F); DOL Reg. §2590.715-2715(a)(1)(ii)(F); HHS Reg. §147.200(a)(1)(ii)(F). [↑](#footnote-ref-235)
236. . PPACA, §§1251(a) and 10101(d) (2010). [↑](#footnote-ref-236)
237. . Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8670 (February 14, 2012). [↑](#footnote-ref-237)
238. . Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8670–8671 (February 14, 2012). [↑](#footnote-ref-238)
239. . Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8671 (February 14, 2012). [↑](#footnote-ref-239)
240. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part VIII, Q/A-6, at http://www.dol.gov/ebsa/faqs/faq-aca8.html. [↑](#footnote-ref-240)
241. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part IX, Q/A-10, at http://www.dol.gov/ebsa/faqs/faq-aca9.html [↑](#footnote-ref-241)
242. . Preamble: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8674–8675 (February 14, 2012). [↑](#footnote-ref-242)
243. . HHS, DOL & TREASURY, FAQs About the Affordable Care Act Implementation Part VIII, Q/A-6, at http://www.dol.gov/ebsa/faqs/faq-aca8.html. [↑](#footnote-ref-243)
244. . See http://www.dol.gov/ebsa/pdf/correctedsbctemplate2.pdf and http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf. [↑](#footnote-ref-244)
245. . Final Rule: Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668 (February 14, 2012); Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials; and Guidance for Compliance, 77 Fed. Reg. 8706 (February 14, 2012). [↑](#footnote-ref-245)
246. . Treas. Reg. §54.9815-2715(a)(1)(iii)(A); DOL Reg. §2590.715-2715(a)(1)(iii)(A); HHS Reg. §147.200(a)(1)(iii)(A). [↑](#footnote-ref-246)
247. . Treas. Reg. §54.9815-2715(a)(1)(iii)(A); DOL Reg. §2590.715-2715(a)(1)(iii)(A); HHS Reg. §147.200(a)(1)(iii)(A). [↑](#footnote-ref-247)
248. . IRC Sec. 4980D, which does not apply to insurers. [↑](#footnote-ref-248)
249. . IRC Sec. 4980D(c)(1). [↑](#footnote-ref-249)
250. . IRC Sec. 4980D(c)(2). See IRC Sec. 4980D(c)(2)(B)(ii), which gives church plans 270 days after the date of mailing by the Secretary of a notice of default with respect to the plan’s failure. [↑](#footnote-ref-250)
251. . Treas. Reg. §54.9815-2715(f); DOL Reg. §2590.715-2715(f); HHS Reg. §147.200(f). [↑](#footnote-ref-251)
252. . The distribution date was postponed twice. The law required HHS to provide guidance by March 23, 2011, although HHS did not do so until August 18, 2011, when it issued proposed regulations. The August 18, 2011, SBC proposed regulations required that the SBCs be distributed to health plan participants beginning March 23, 2012. Many comments to the proposed regulations were made, and the deadline was again postponed until final regulations were later issued. [↑](#footnote-ref-252)
253. . Treas. Reg. §54.9815-2715(a)(1)(ii)(F); DOL Reg. §2590.715-2715(a)(1)(ii)(F); HHS Reg. §147.200(a)(1)(ii)(F). [↑](#footnote-ref-253)
254. . Treas. Reg. §54.9815-2715(b); DOL Reg. §2590.715-2715(b); HHS Reg. §147.200(b). [↑](#footnote-ref-254)
255. . ERISA Sec. 102. [↑](#footnote-ref-255)
256. . Treas. Reg. §54.9815-2715(b); DOL Reg. §2590.715-2715(b); HHS Reg. §147.200(b). [↑](#footnote-ref-256)
257. . DOL Reg. §2590.715-2715(a)(4)(ii)(A); Treas. Reg. §54.9815-2715(a)(4)(ii)(A). The requirements of the DOL are in DOL Reg. §2520.104b-1(c). [↑](#footnote-ref-257)
258. . http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html. [↑](#footnote-ref-258)
259. . http://cciio.cms.gov/resources/other/index.html#sbcug. [↑](#footnote-ref-259)
260. . See http://cciio.cms.gov/resources/other/index.html#sbcug. [↑](#footnote-ref-260)
261. . http://cciio.cms.gov/resources/files/sbc-sample.pdf. [↑](#footnote-ref-261)
262. . http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-finhttp://cciio.cms.gov/resources/files/sbc-sample.pdfal.pdf. [↑](#footnote-ref-262)
263. . http://cciio.cms.gov/resources/other/index.html#sbcug. [↑](#footnote-ref-263)
264. . PHSA §2715(e). [↑](#footnote-ref-264)
265. . Preamble to Final Rule: Summary of Benefits and Coverage and the Uniform Glossary, 77 Fed. Reg. 8668, 8678 (February 14, 2012); ERISA Sec. 514(b)(2)(B). [↑](#footnote-ref-265)
266. . See What This Plan Covers and What it Costs: Instruction Guide for Group Coverage, February 2012, athttp://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf. [↑](#footnote-ref-266)
267. . What This Plan Covers and What it Costs: Instruction Guide for Group Coverage, February 2012, at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf. [↑](#footnote-ref-267)
268. . See FAQs About the Affordable Care Act Implementation Part V, Q/A-2, at http://www.dol.gov/ebsa/faqs/faqaca5.html. [↑](#footnote-ref-268)
269. . FLSA §18B. [↑](#footnote-ref-269)
270. . FAQs About the Affordable Care Act Implementation Part XI, Q/A-1 at http://www.dol.gov/ebsa/faqs/faq-aca11.html. [↑](#footnote-ref-270)
271. . 29 U.S.C. §§206 and 207. [↑](#footnote-ref-271)
272. . 29 U.S.C. §203(d). [↑](#footnote-ref-272)
273. . PPACA §1104. [↑](#footnote-ref-273)
274. . 76 Fed. Reg. 40458 (July 8, 2011). [↑](#footnote-ref-274)
275. . 76 Fed. Reg. 40458 (July 8, 2011). [↑](#footnote-ref-275)
276. . SSA §1173(g)(4)(B). [↑](#footnote-ref-276)
277. . Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice, 77 Fed. Reg. 1556, 1564 (January 10, 2012). [↑](#footnote-ref-277)
278. . PPACA §1104(c)(1). [↑](#footnote-ref-278)
279. . Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets, 77 Fed. Reg. 22950 (April 17, 2012). [↑](#footnote-ref-279)
280. . Prop. HHS Reg. §162.514. [↑](#footnote-ref-280)
281. . Prop. HHS Reg. §162.504(b). [↑](#footnote-ref-281)
282. . Prop. HHS Reg. §162.103. [↑](#footnote-ref-282)
283. . Prop. HHS Reg. §162.512. [↑](#footnote-ref-283)
284. . Prop. HHS Reg. §162.510. [↑](#footnote-ref-284)
285. . 77 Fed. Reg. 22950, 22958 (April 17, 2012). [↑](#footnote-ref-285)
286. . 77 Fed. Reg. 22950, 22962-63 (April 17, 2012). [↑](#footnote-ref-286)
287. . SSA §1173(i). [↑](#footnote-ref-287)
288. . SSA §1173(j)(1)(A). [↑](#footnote-ref-288)
289. . SSA §1173(j)(1)(B). [↑](#footnote-ref-289)
290. . SSA §1173(j)(1)(C). [↑](#footnote-ref-290)
291. . SSA §1173(j)(1)(E). [↑](#footnote-ref-291)
292. . DOL Tech. Rel. 2012-01 (Feb. 9, 2012) IRS Notice 2012-17 (Feb. 10, 2012); HHS Bulletin: Frequently-Asked-Questions from Employers Regarding Automatic Enrollment , Employer Shared Responsibility, and Waiting Periods (Feb. 9, 2012).. See FAQs About the Affordable Care Act Implementation Part V, Q/A-2, at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>; . [↑](#footnote-ref-292)
293. . The term “health benefits plan” is not defined under the FLSA, although the term is used periodically in other provisions of healthcare reform, for example, in the new requirement to report health insurance coverage. [↑](#footnote-ref-293)
294. . FLSA §18A. [↑](#footnote-ref-294)
295. . FLSA §18A. [↑](#footnote-ref-295)
296. . FLSA §18A. [↑](#footnote-ref-296)
297. . FAQs About the Affordable Care Act Implementation Part V, Q/A-2, at http://www.dol.gov/ebsa/faqs/faq-aca5.html. [↑](#footnote-ref-297)
298. . IRC Sec. 4980H(c)(4)(A). [↑](#footnote-ref-298)
299. . 29 U.S.C. §218. [↑](#footnote-ref-299)
300. . PPACA §§1001 and 1562(e), (f). [↑](#footnote-ref-300)
301. . PHSA §2716(a), which imposes such requirements in IRC Sec. 9815, and ERISA Sec. 715. PHSA §2716(a) requires nongrandfathered insured group health plans to satisfy the requirements of Code section 105(h)(2) (relating to prohibition on discrimination in favor of highly compensated individuals). For this purpose, “rules similar to the rules contained in” Code section 105(h)(3) (relating to nondiscriminatory eligibility), (4) (relating to nondiscriminatory benefits) and (8) (apply the rules to controlled groups). Code section 105(h)(5) (relating to which employees are “highly compensated”) is not included, which means that the regulations are not bound to the highest paid 25 percent text in defining the group in favor of which a nongrandfathered insured plan cannot discriminate. [↑](#footnote-ref-301)
302. . IRS Notice 2011-1. [↑](#footnote-ref-302)
303. . Joint Committee Staff Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable Care Act. (JCX-18-10) 3/21/10, p. 50. [↑](#footnote-ref-303)
304. . IRC Sec. 4980D. [↑](#footnote-ref-304)
305. . IRC Sec. 4980D(d)(1). [↑](#footnote-ref-305)
306. . IRC Sec. 4980D(b)(1). [↑](#footnote-ref-306)
307. . See also Notice 2010-63. [↑](#footnote-ref-307)
308. . IRC Sec. 4980D(b)(2)(A). [↑](#footnote-ref-308)
309. . IRC Sec. 4980D(b)(2)(B). [↑](#footnote-ref-309)
310. . IRC Sec. 4980D(f)(3)(A). [↑](#footnote-ref-310)
311. . IRC Sec. 4980D(f)(3)(B). [↑](#footnote-ref-311)
312. . IRC Sec. 4980D(c)(1). [↑](#footnote-ref-312)
313. . Defined in IRC Sec. 414(e). [↑](#footnote-ref-313)
314. . IRC Secs. 414(e)(4)(c) and 4980D(c)(2)(B)(ii). [↑](#footnote-ref-314)
315. . IRC Sec. 4980D(c)(2)(A). [↑](#footnote-ref-315)
316. . IRC Sec. 4980D(c)(2)(B)(i). [↑](#footnote-ref-316)
317. . IRC Sec. 4980D(b)((3)(A). [↑](#footnote-ref-317)
318. . IRC Sec. 4980D(b)(3)(B). [↑](#footnote-ref-318)
319. . IRC Sec. 4980D(c)(3)(A)(i). [↑](#footnote-ref-319)
320. . A specified multiple employer health plan is a group health plan that is either a multiemployer plan or a multiple employer welfare arrangement (MEWA), as defined in section 3(40) of ERISA , as in effect on March 23, 2010. IRC Sec. 4980D(f)((2). IRC Sec. 4980D(c)(3)(ii) provides that if not all persons who are treated as a single employer for purposes of IRC Sec. 4980D have the same tax year, the tax years taken into account are determined under principles similar to the principles of IRC Sec. 1561. However, IRC Sec. 414(t), which provides for application of controlled group rules to various sections of the Code, references IRC Sec. 4980B, but not IRC Sec. 4980D. IRC Sec. 4980(D)(2)(A), for purposes of determining if an entity is a small employer, references sections 414(b)(c), (m), and (o). [↑](#footnote-ref-320)
321. . IRC Sec. 4980D(c)(3)(B)(i). For purposes of this section, all plans of which the same trust forms a part are treated as one plan. [↑](#footnote-ref-321)
322. . IRC Sec. 4980D(C)(3)(B)(ii). [↑](#footnote-ref-322)
323. . IRC Sec. 4980D(C)(4). [↑](#footnote-ref-323)
324. . IRC Sec. 4980D(d)(2)(A) defines a small employer as an employer who, with respect to a calendar year and a plan year, employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employed at least two employees on the first day of the plan year. For these purposes, as for tax-qualified plans, all persons treated as a single employer under sections 414(b), (c), (m), and (o) are treated as one employer. With respect to an employer that was not in existence during the preceding calendar year, the determination of whether such employer is a small employer is based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year. IRC Sec. 4980D(d)(2)(B). All references to “employer” include a reference to any predecessor of such employer. IRC Sec. 4980D(d)(2)(C). [↑](#footnote-ref-324)
325. . IRC Sec. 4980D(d)(3) provides that health insurance coverage has the meaning set forth in IRC Sec. 9832. [↑](#footnote-ref-325)
326. . IRC Sec. 4980D(d)(3) provides that health insurance issuer has the meaning set forth in IRC Sec. 9832. [↑](#footnote-ref-326)
327. . The exemption for certain insured small employer plans does not apply to a failure described in IRC Sec. 9811, i.e. standards relating to benefits for mothers and newborns. [↑](#footnote-ref-327)
328. . IRC Sec. 4980D(e)(1). [↑](#footnote-ref-328)
329. . IRC Sec. 4980D(e)(2). [↑](#footnote-ref-329)
330. . IRC Sec. 4980D(e)(3). [↑](#footnote-ref-330)
331. . Reg. §§54.6011-2 and 54.4980D-1, A-1(a). [↑](#footnote-ref-331)
332. . Reg. §54.6151-1. An automatic six-month extension for filing Form 8928 is available for applications filed on or after June 24, 2011, by submitting a Form 7004 on or before the prescribed day for filing the return and remitting the amount of the estimated tax liability. Reg. §54.6081-1(b). [↑](#footnote-ref-332)
333. . Reg. 54.6071-1(b)(1). An extension for filing the employer's income tax return does not extend the time for filing Form 8928. Reg. 54.4980D-1, A-1(b). [↑](#footnote-ref-333)
334. . Reg. §§54.6071-1(b)(2) and 54.4980D-1, A-1(c). [↑](#footnote-ref-334)
335. . DOL Tech. Rel. 2012-01 (February 9, 2012); IRS Notice 2012-17 (February 10, 2012); HHS Bulletin: Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods (February 9, 2012) at http://cciio.cms.gov/resources/files/Files2/02102012/employer\_faq\_bulletin\_2\_9\_12\_final.pdf. [↑](#footnote-ref-335)
336. . PHSA §2708. [↑](#footnote-ref-336)
337. . PHSA §2708. [↑](#footnote-ref-337)
338. . Treas. Reg. §54.9801-3(a)(3)(iii); DOL Reg. §2590.701-3(a)(3)(iii); HHS Reg. §146.111(a)(3)(iii). [↑](#footnote-ref-338)
339. . DOL Tech. Rel. 2012-01, Q/A-7 (February 9, 2012), available at http://www.dol.gov/ebsa/newsroom/tr12-01.html. [↑](#footnote-ref-339)
340. . IRS Notice 2012-59 (August 31, 2012); DOL Tech. Rel. 2012-02 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708 (August 31, 2012) at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-340)
341. . IRS Notice 2012-59, Q/A-1 (August 31, 2012); DOL Tech. Rel. 2012-02, Q/A-1 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708, Q/A-1 (August 31, 2012), at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-341)
342. . IRS Notice 2012-59, Q/A-1 (August 31, 2012); DOL Tech. Rel. 2012-02, Q/A-1 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708, Q/A-1 (August 31, 2012), at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-342)
343. . IRC Sec. 4980H. [↑](#footnote-ref-343)
344. . IRS Notice 2012-59 (August 31, 2012); DOL Tech. Rel. 2012-02 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708 (August 31, 2012) at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-344)
345. . IRS Notice 2012-59, Q/A-2 (August 31, 2012; DOL Tech. Rel. 2012-02, Q/A-2 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708, Q/A-2 (August 31, 2012) at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-345)
346. . IRS Notice 2012-59, Q/A-4 (August 31, 2012); DOL Tech. Rel. 2012-02, Q/A-4 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708, Q/A-4 (August 31, 2012) at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf. [↑](#footnote-ref-346)
347. . IRS Notice 2012-59, Q/A-3 (August 31, 2012); DOL Tech. Rel. 2012-02, Q/A-3 (August 31, 2012); HHS Guidance on 90-Day Waiting Period Limitation PHSA §2708, Q/A-3 (August 31, 2012) at http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf (as visited October 23, 2012). [↑](#footnote-ref-347)
348. . PPACA §10103(e)(2) (2010). [↑](#footnote-ref-348)
349. . PHSA §2704(a); IRC Sec. 9815, and ERISA Sec. 715. [↑](#footnote-ref-349)
350. . Treas. Reg. §54.9801-2; DOL Reg. §2590.701-2; HHS Reg. §144.103. [↑](#footnote-ref-350)
351. . Treas. Reg. §54.9801-2; DOL Reg. §2590.701-2; HHS Reg. §144.103. [↑](#footnote-ref-351)
352. . Prop. Reg. §54.9801-5. [↑](#footnote-ref-352)
353. . PPACA §1302(c)(1)(A) (2010); IRC Sec. 223(c)(2)(A)(ii). [↑](#footnote-ref-353)
354. . HHS Reg. §156.130(c). [↑](#footnote-ref-354)
355. . FAQs About the Affordable Care Act Implementation Part XII, Q/A-2 at http://www.dol.gov/ebsa/faqs/faq- aca12.html. [↑](#footnote-ref-355)
356. . Id. [↑](#footnote-ref-356)
357. . PPACA §1302(c)(1)(B) (2010); PPACA §1302(c)(4) (2010). [↑](#footnote-ref-357)
358. . PPACA §1302(c)(4) (2010). [↑](#footnote-ref-358)
359. . PPACA §1302(c)(2)(A) (2010). [↑](#footnote-ref-359)
360. Section 213, Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93 (Apr. 1, 2014), amending both PPACA § 1302(c) and PHSA § 2707(b). [↑](#footnote-ref-360)
361. . PHSA §2709(a)(1)(B). [↑](#footnote-ref-361)
362. . PHSA §2709(a)(1)(C). [↑](#footnote-ref-362)
363. . PHSA §§2709(a)(3),(4) and 2709(c). [↑](#footnote-ref-363)
364. . PHSA §2709(a)(2). [↑](#footnote-ref-364)
365. . PHSA §2709(b). [↑](#footnote-ref-365)
366. . A “life-threatening condition” is a disease or condition likely to result in death unless the disease or condition is interrupted. PHSA §2709(e). [↑](#footnote-ref-366)
367. . PHSA §2709(d)(1)(A). [↑](#footnote-ref-367)
368. . PHSA §2709(d)(1)(B). [↑](#footnote-ref-368)
369. . PHSA §2709(d)(1)(C). [↑](#footnote-ref-369)
370. . PHSA §2701(a)(5). [↑](#footnote-ref-370)
371. . PHSA §2701(a)(2)(A). [↑](#footnote-ref-371)
372. . PPACA §1201(4). [↑](#footnote-ref-372)
373. . PHSA §2701. [↑](#footnote-ref-373)
374. . PHSA §2701(a)(1)(B). [↑](#footnote-ref-374)
375. . PPACA §1201(2)(A). [↑](#footnote-ref-375)
376. . PHSA §2701. [↑](#footnote-ref-376)
377. . PPACA §1255. [↑](#footnote-ref-377)
378. . 42 U.S.C. §§300gg, 300gg-1, and 300gg-11. [↑](#footnote-ref-378)
379. . PHSA §§2701 and 2702. [↑](#footnote-ref-379)
380. . PPACA §1311(b)(1). [↑](#footnote-ref-380)
381. . PPACA §1311(e)(3)(A). [↑](#footnote-ref-381)
382. . PHSA §2715A. [↑](#footnote-ref-382)
383. . PPACA §§1251(a) and 10103(d)(1); Treas. Reg. §54.9815-1251T(c)(1). [↑](#footnote-ref-383)
384. . PPACA §§1251(a) and 10103(d)(1); Treas. Reg. §54.9815-1251T(c)(1). [↑](#footnote-ref-384)
385. . PPACA §1311(e)(3)(A). [↑](#footnote-ref-385)
386. . PPACA §1311(e)(3)(B). [↑](#footnote-ref-386)
387. . PPACA §1311(e)(3)(C). [↑](#footnote-ref-387)
388. . PPACA §1311(e)(3)(C). [↑](#footnote-ref-388)
389. . PHSA §2706(a). [↑](#footnote-ref-389)
390. . PHSA §2706(a). [↑](#footnote-ref-390)
391. . PPACA §1255. [↑](#footnote-ref-391)
392. . 42 U.S.C. §300gg-22(a)(1). [↑](#footnote-ref-392)
393. . 42 U.S.C. §300gg-22(a)(2). [↑](#footnote-ref-393)
394. . 42 U.S.C. §300gg-22(b)(2)(C)(i). [↑](#footnote-ref-394)
395. . 42 U.S.C. §300gg-22(b)(2)(C)(iii). [↑](#footnote-ref-395)
396. . 42 U.S.C. §300gg-22(b)(2)(D). [↑](#footnote-ref-396)
397. . 42 U.S.C. §300gg-22(b)(2)(E). [↑](#footnote-ref-397)