ACA Provisions Summary

Large Underwritten Groups – 50 or more Full Time Equivalent Employees

January 2013
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Affordable Care Act Market Reform Provisions
Large Underwritten Group Health Plans

Introduction
The following is a summary of the major market reform provisions under the Affordable Care Act (ACA) that apply to an underwritten group health plan sponsored by a large employer. See ACA § 1304(b)(1), (3); PHSA § 2791(b)(4), (e)(3); 45 C.F.R. § 144.103 (definitions of “group health insurance coverage” and “large group market”). The scope of this summary does not include group health insurance coverage sponsored by a qualified employer, and provided under a qualified health plan (“QHP”) offered through a Small Business Health Options Program (“SHOP”) Exchange. See 45 C.F.R. Part 155, Subpart H. Health insurance issuers will not be permitted to offer QHP coverage to large employers through a SHOP Exchange until at least 2017, when states will have discretion to expand their SHOP Exchanges to the large group market. ACA § 1312(f)(1)(B); 45 C.F.R.§ 155.705(b)(9).

Retiree-Only Plans and Excepted Benefits

Certain “retiree-only” plans and excepted benefits are exempt from the market reform provisions under the ACA. For this purpose, a retiree-only plan includes any group health plan (and health insurance coverage offered in connection with a group health plan) that, on the first day of the plan year, has less than two participants who are current employees. ERISA § 732(a); Code § 9831(a); pre-ACA PHSA § 2721(a).

Excepted benefits include specified types of coverage offered under certain non-major medical plans, such as coverage only for accident or disability income insurance (or any combination thereof); liability and supplemental liability coverage; workers’ compensation insurance; on-site medical clinics; “stand-alone” dental, vision or long-term care benefits; certain specified disease or hospital indemnity (or other fixed indemnity) insurance; and certain types of coverage that are designed to supplement a group health plan. See PHSA §§ 2722(b), (d), 2791(c)(1)-(4).

Before ACA, parallel retiree-only and excepted benefit exemptions were contained in the PHSA, ERISA and the Code. ACA amendments deleted the retiree-only exemption from the PHSA entirely – and could be read as significantly narrowing the excepted benefits exemption – but did not delete or amend the parallel provisions under ERISA and the Code. However, the Department of Health and Human Services (HHS), the U.S. Departments of Labor (DOL) and the Treasury (collectively, the “agencies”) have confirmed that they will continue to treat both the retiree-only and excepted benefits exemptions as fully applicable. Preamble to Interim Final Rule on Grandfathered Plans, 75 Fed. Reg. 34538, 34539 (June 17, 2010).1

1 The states generally have primary enforcement authority under the PHSA’s market reform provisions, and may impose requirements on health insurance issuers in the large group market that are more protective than those applicable under the PHSA. Thus, despite the agencies’ approach, described above, presumably an individual state could interpret the retiree-only and/or applicable excepted benefits exemptions as no longer under the PHSA’s market reform provisions, and/or could impose its own rules that expressly eliminate these exemptions for purposes of the state’s enforcement of the market reform provisions. HHS is “encouraging” states to continue to recognize the retiree-only and excepted benefit exemptions, however. 75 Fed. Reg. at 34540.
Compliance with State Law

Although the general rule is that Title I of ERISA preempts any and all state laws insofar as they “relate to” an ERISA group health plan, health insurance coverage offered in connection with such a plan is subject to any applicable state law that “regulates insurance.” See ERISA § 514(a), (b)(2)(A). In addition, separate preemption provisions in the ACA, the PHSA, and ERISA effectively establish a federal floor that applies for purposes of Title I of the ACA and the market reform provisions in Title XXVII of the PHSA, pursuant to which state insurance laws in connection with group health insurance coverage are not preempted, provided that they do not “prevent the application” of such federal rules. ACA § 1321(d); PHSA § 2724; ERISA § 731(a).

Grandfathered Health Plans

Legal References

- ACA § 1251
- 45 C.F.R. § 147.140 (Interim Final Rule)
- DOL, Affordable Care Act Implementation FAQs Part I, Q&As 2-6 (Sept. 20, 2010)
- DOL, FAQs About the Affordable Care Act Implementation – Part II, Q&As 1-5 (Oct. 8, 2010)
- DOL, FAQs About the Affordable Care Act Implementation Part IV, Q&As 1-2 (Oct. 29, 2010)
- DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q&A 7 (Dec. 22, 2010)
- DOL, FAQs About Affordable Care Act Implementation (Part VI), Q&As 1-6 (Apr. 1, 2011)

Many of the ACA’s market reform provisions may not apply to a fully-insured, large group health plan that has continuously covered at least one person – and has not undergone certain specified changes – since March 23, 2010. In order to maintain grandfathered status for such coverage, the plan must not eliminate benefits, increase member cost-sharing requirements, decrease the employer contribution rate, or change the annual limit structure in a specified manner or by a specified amount (as applicable), when compared to the coverage that was in effect on March 23, 2010. Grandfathered status is determined separately for each benefit package under a group health plan (e.g., a PPO option, HMO option, POS option, etc.). The determination of whether a decrease in the employer contribution rate causes a loss of such status is made on a tier-by-tier basis (e.g., employee-only, employee-plus-one, family, etc.).

Certain wellness programs involving financial penalties or incentives, such as cost-sharing reductions or surcharges, may impact the analysis.

New participants – whether newly-hired employees or current employees who newly enroll in coverage – and their families generally may enroll in group health coverage without causing it to lose its grandfathered status, subject to two “anti-abuse” rules:

1. If the principal purpose of a merger, acquisition, or similar business transaction is to cover new members under a grandfathered plan, the plan will cease to be grandfathered.

2. If employees who were previously covered by a grandfathered plan (“transferor plan”) are transferred into another grandfathered plan (“transferee plan”), the transferee plan will lose its grandfathered status if (a) treating the terms of the transferee plan as an amendment to the transferor plan would cause the

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2 Grandfathered plans must continue to comply with all legal requirements that apply to such plans under ACA and/or pre-ACA law.
transferor plan to cease to be grandfathered, and (b) there is no “bona fide employment-based reason” for transferring the employees from the transferor plan to the transferee plan.

Special rules apply to fully-insured group health plans maintained pursuant to one or more collective bargaining agreements (CBAs) ratified before March 23, 2010. Specifically, such plans will be deemed to be grandfathered at least until the date that the last CBA relating to coverage that was in effect on March 23, 2010 terminates. After that date, the plan’s grandfathered status will be determined, under the regular grandfather rules, by comparing the terms of coverage in effect at that time with those in effect on March 23, 2010.

A group health plan will not relinquish its grandfathered status merely because the plan or its sponsor enters into a new insurance policy, certificate, or contract after March 23, 2010 (with the narrow exception of such a policy, certificate, or contract that became effective before November 15, 2010), provided that no other changes are made which cause the plan to run afoul of the grandfather rules. However, the plan must provide the new issuer (and the new issuer must require) documentation of all relevant plan terms – including benefits, cost-sharing, employer contributions, and annual limits – for the prior coverage, such that the issuer may determine if there has been a change in the coverage that would cause a loss of grandfathered status.

Any plan or coverage materials provided to participants or beneficiaries that describe the benefits provided under the coverage must include a statement that the plan or issuer believes the coverage to be grandfathered, as well as contact information for questions or complaints. The Interim Final Rule on grandfathered plans provides model language that may be used for this purpose. The plan or issuer also must maintain – and make available for examination by participants, beneficiaries, and regulators – records documenting the terms of the plan or coverage that were in effect on March 23, 2010, and any other necessary substantiating documents, e.g., prior and current plan documents; health insurance policies, certificates, or contracts; summary plan descriptions (“SPDs”); documentation of premiums or the cost of coverage; documentation of required employee contribution rates; etc.

**Prohibition Against Preexisting Condition Exclusions**

*Legal References*

- ACA §§ 1201(2), 1251(a)(4)(B)(i), 1255(2)
- PHS A § 2704
- 45 C.F.R. § 147.108 (Interim Final Rule)
- DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q&A 6

A group health plan – whether grandfathered or not – is prohibited from imposing any preexisting condition exclusions, effective for plan years beginning on or after January 1, 2014.³

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³ For plan years beginning on or after September 23, 2010, and prior to January 1, 2014, the prohibition against preexisting condition exclusions applies to large group health insurance coverage with respect to individuals under age 19 only. ACA § 1255(2); 45 C.F.R. § 147.108(b)(2).
Prohibition Against Lifetime and Annual Limits on Essential Health Benefits

Legal References

- ACA §§ 1001(5), 1251(a)(4)(A)(ii) and (B)(i), 1302(b), 10101(a)
- PHSA § 2711
- 45 C.F.R. § 147.126 (Interim Final Rule)
- 45 C.F.R. §§ 156.100-156.125 (proposed)
- DOL, FAQs About the Affordable Care Act Implementation Part IV, Q&A 3

A group health plan – **whether grandfathered or not** – generally is prohibited from imposing any lifetime or annual limits on the dollar value of essential health benefits (EHB), effective for plan years beginning on or after September 23, 2010. For plan years beginning prior to January 1, 2014, certain restricted annual limits may be imposed on the dollar value of EHB, i.e., $750,000 for plan years beginning between September 23, 2010 and September 22, 2011; $1.25 million for plan years beginning between September 23, 2011 and September 22, 2012; and $2 million for plan years beginning between September 23, 2012 and December 31, 2013.

HHS has issued regulations that would define EHB⁴ – at least for 2014 and 2015 – by reference to a benchmark plan, selected by each state that reflects a typical employer plan. States may designate the benchmark plan from among any of the following: (1) the largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national FEHBP plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (“HMO”) operating in the state. In states that choose not to select a benchmark plan, the default benchmark plan will be the small group plan with the largest enrollment in the respective states. If the selected benchmark plan does not offer coverage for each of the EHB categories of items and services set forth in ACA § 1302(b), then the state will need to supplement the benchmark plan to ensure that all ten categories are covered.

In applying the annual and lifetime limit prohibition, the agencies will consider a fully-insured, large group health plan to have used a permissible definition of EHB under ACA § 1302(b) as long as it uses a definition that is authorized by HHS (including any available benchmark option, as supplemented, if and to the extent necessary to ensure coverage of all ten categories of items and services). The agencies have also indicated that they intend to use their “enforcement discretion” and work with plans that make a good faith effort to comply with a reasonable interpretation of EHB for this purpose, particularly for plan years beginning before regulations are issued on point. Future guidance, including final regulations or sub-regulatory agency guidance on the prohibition against lifetime and annual dollar limits may be forthcoming.

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¹Pursuant to ACA § 1302(b), EHB must include at least the following ten categories of items and services: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. With the exception of prescription drugs, specific benefits may be substituted for those provided in a particular EHB category under the state’s benchmark plan, provided that the substituted benefits are actuarially equivalent to, and within the same EHB category as, the replaced benefits.
Prohibition Against Rescissions

Legal References

- ACA §§ 1001(5), 1251(a)(4)(A)(iii)
- PHSA § 2712
- 45 C.F.R. § 147.128 (Interim Final Rule)
- DOL, FAQs About the Affordable Care Act Implementation – Part II, Q&A 7

A group health plan – **whether grandfathered or not** – is prohibited from retroactively canceling or discontinuing (“rescinding”) coverage for any individual, unless the individual (or a person seeking coverage on his or her behalf) performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the coverage. A retroactive cancellation or discontinuance of coverage is not a rescission – and thus is not prohibited under ACA – if and to the extent that it is attributable to a failure to timely pay required premiums (including, for example, where termination of an ex-spouse’s coverage is delayed due to an employee-participant’s failure to provide timely notice of a divorce, and the ex-spouse has failed to pay the requisite premium for continuation coverage in a timely manner), or to administrative record-keeping delays in certain circumstances. For permissible rescissions, i.e., in cases of fraud or intentional misrepresentation of material fact, at least 30 days advance written notice must be provided to each participant who would be affected by the rescission.

Coverage of Preventive Health Services

Legal References

- ACA §§ 1001(5), 1251(a)(2)
- PHSA § 2713
- 45 C.F.R. § 147.130 (Interim Final Rule)
- Recommendations of the United States Preventive Services Task Force (“USPSTF”)
- Recommendations of the Advisory Committee On Immunization Practices (“ACIP”) for Children, Adolescents, and Adults
- Comprehensive Guidelines Supported by the Health Resources and Services Administration (“HRSA”) for Infants, Children, and Adolescents
- DOL, FAQs About Affordable Care Act Implementation – Part II, Q&A 8
- DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q&A 1

A group health plan must provide coverage without any cost-sharing requirements – at least with respect to in-network providers – for certain preventive health services that fall within the following four categories: (1)

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5 Although 45 C.F.R. § 147.130 is still generally an interim final rule, subsection (a)(1)(iv) – pertaining to preventive care services for women (and exemptions from contraceptive coverage requirements for group health plans sponsored by “religious employers”) – has been finalized. See 77 Fed. Reg. 8725 (Feb. 15, 2012).
These requirements do not apply to grandfathered plans.

As the lists of preventive services under these four categories continue to be updated in the future, non-grandfathered plan must ensure that they cover any newly-added services for plan years beginning on or after the date that is one year following the effective date of the adoption of the recommendation for the relevant service.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the plan may use reasonable medical management techniques to apply any relevant coverage limitations or restrictions to that end. If a covered preventive health service is provided during an office visit, and is billed separately, then the plan may impose cost-sharing requirements for the office visit (but not for the preventive health service). If the preventive health service is not billed separately, and was the primary purpose for the office visit, then the plan may not impose cost-sharing requirements for the office visit. If the preventive health service is not billed separately, and was not the primary purpose for the office visit, then the plan may impose cost-sharing requirements for the office visit (including the preventive health service).

One of the preventive care service requirements – pursuant to HRSA’s guidelines for preventive care and screenings for women – is that non-grandfathered plans provide coverage without cost-sharing for all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling prescribed for women with reproductive capacity, for plan years beginning on or after August 1, 2012. This requirement does not apply, however, to a group health plan (and health insurance coverage provided in connection with a group health plans) established or maintained by a religious employer, which is defined as an employer that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization described in Code § 6033(a)(1) and (a)(3)(A)(i) or (iii) (referring to churches, their integrated auxiliaries, and conventions or associations of churches, as well as the exclusively religious activities of any religious order).

In addition, a one-year enforcement safe harbor exemption from the contraceptive coverage requirements is available to certain non-grandfathered group health plans (and health insurance coverage offered in connection with such group health plans) established and maintained by non-profit organizations with religious objections to covering contraceptive services. In order to qualify for the safe harbor, the organization that establishes or maintains the plan must be organized and operated as a non-profit entity; the plan must have consistently not covered all or the same subset of contraceptive coverage otherwise required to be covered – consistent with applicable state law – since at least February 10, 2012, because of the organization’s religious beliefs (or the organization must certify that contraceptive coverage was provided despite actions that it (or the issuer) took before February 10, 2012 to try to exclude coverage for some or all contraceptive services, because of the organization’s religious beliefs); a notice must be provided to participants, stating that some or all contraceptive services will not be covered for the first plan year beginning on or after August 1, 2012; and the organization must self-certify that it satisfies all of these requirements (and maintain documentation of such self-certification). CCIIO’s guidance on the enforcement safe harbor provides both the notice to enrollees and self-certification documentation to be used for this purpose. Religious employers that qualify for the outright exemption from the contraceptive coverage...
requirements may invoke this one-year safe harbor without prejudicing their ability to claim the exemption at a later date.

The agencies intend to amend the preventive care services regulations to provide that – following the one-year enforcement safe harbor period – an issuer providing coverage to a non-exempt, non-profit organization that meets certain requirements must assume the responsibility to provide free contraceptive coverage without cost-sharing to members (separate from the plan and independent of the organization), in an effort to protect the organization from having to contract, arrange, or pay for such contraceptive coverage. The agencies have requested comments on potential options to implement this approach. 77 Fed. Reg. 16501, 16503, 16505-6 (Mar. 21, 2012).

**Extension of Dependent Coverage to Children up to Age 26**

*Legal References*

- ACA §§ 1001(5), 1251(a)(4)(A)(iv), (B)(ii)
- PHSA § 2714
- 45 C.F.R. § 147.120 (Interim Final Rule)
- CCIIO, Questions and Answers, Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families
- DOL, Affordable Care Act Implementation FAQs Part I, Q&A 14 DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Part V, Q&A 5

A plan that provides dependent coverage to a participant’s children must extend that coverage to such children up to age 26, regardless of their marital or student status, financial support, residency, employment, tax dependency, eligibility for other coverage, or any other factor. Although the statute and regulations do not define “children” for this purpose, agency FAQs have clarified that the application of these provisions may be limited to those children described in Code § 152(f)(1), i.e., a son, daughter, stepson, stepdaughter, adopted child, or eligible foster child.

The terms of the dependent coverage provided to such children may not vary based on age, except with respect to children who are age 26 or older (e.g., a premium surcharge for dependent coverage of children over age 18 would be prohibited). A plan need not, in any event, cover a child of a participant’s child, i.e., the participant’s grandchild (unless perhaps the participant were to adopt the grandchild).

These rules generally apply to all group health plans, whether grandfathered or not. For plan years beginning before January 1, 2014, however, a grandfathered group health plan may exclude from eligibility a child under age 26 who is eligible for coverage under another employer-sponsored group health plan (except for a plan maintained by an employer of either of the child’s parents).

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6 Under the proposed approach, the organization would need to provide written notice to the issuer that it qualified for this special rule and would not act as the plan administrator or claims administrator with respect to contraceptive benefits. In addition, the issuer would need to have access to information necessary to communicate with the group health plan members and act as a claims administrator and plan administrator with respect to contraceptive benefits.
Disclosure to HHS and Public Availability of Transparency Information

Legal References

- *ACA* §§ 10101(c), 1251(a)(2); see also ACA § 1311(e)(3)(A), (C)
- *PHSA* § 2715A
- See 45 C.F.R. §§ 155.1040, 156.220

A large group health plan must disclose to HHS and the relevant state insurance commissioner – and make available to the public – specified health plan information. This information includes (1) claims payment policies and practices; (2) periodic financial disclosures; (3) data on enrollment and disenrollment, the number of claims that are denied, and rating practices; (4) out-of-network cost-sharing and payment information; and (5) information on enrollee rights under the market reform provisions in Title I of ACA. The information must be submitted “in an accurate and timely manner” to be specified by HHS. The plan also must provide a member upon request – through an internet website and by other means for individuals without internet access – the amount of a member’s cost-sharing requirements under his or her coverage for a particular item or service furnished by a participating provider.

These requirements do not apply to grandfathered plans.

Additional guidance is expected regarding specific data formats, definitions, and reporting frequencies of the transparency information.

Required Reporting of Care Quality and Wellness Activities

Legal References

- *ACA* §§ 1001(5), 1251(a)(2), 10101(e)
- *PHSA* § 2717

A large group health plan must comply with specified reporting requirements with respect to benefits and reimbursement structures that (1) improve health outcomes through activities like quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, (2) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional, (3) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology, and (4) implement wellness and health promotion activities. The plan will need to submit annually to the federal government, and make available to enrollees “during each open enrollment period,” a report on whether the benefits provided under the coverage satisfy the elements described in these four categories.

These requirements do not apply to grandfathered plans.
Medical Loss Ratio Reporting and Rebate Requirements

Legal References

- ACA §§ 10101(f), 10103(d)(2)
- PHSA § 2718
- 45 C.F.R. Part 158
- Medical Loss Ratio Annual Reporting Form and Instructions (May 11, 2012)
- MLR Rebate Notices to Group Policyholders and Their Subscribers, Rebate Sent to the Policyholder and Rebate Sent to the Subscriber, and Instructions (May 11, 2012)
- MLR Notice to Policyholders and Subscribers when MLR Standard is Met (May 16, 2012)
- Health Insurance Oversight System (“HIOS”) User Registration Template
- HIOS Training Slides
- IRS, Medical Loss Ratio FAQs (rev. Aug. 4, 2012)

A health insurance issuer offering large group health insurance coverage, whether grandfathered or not, that fails to spend at least 85%7 of its earned premium revenues for a calendar year (less applicable federal and state taxes, and licensing and regulatory fees) on incurred claims and quality improvement expenses must distribute annual rebates to its enrollees by August 1 of the following year.8 The issuer may choose to provide the rebate in the form of a premium credit (except with respect to former enrollees), lump-sum check, credit or debit card reimbursement, or in certain cases, pre-paid debit or credit card.

For multi-state employers, a health insurance issuer offering coverage to employees in only one state might not know the total number of the employer’s employees. An issuer in this scenario could determine the employer’s size based on the information available to it. For example, assume that an employer has 20 Maryland employees covered by a policy issued by one issuer, and 150 New York employees covered by a policy issued by a different issuer. The Maryland issuer may not know the total number of employees, and may generally classify the employer as being in the small group market (e.g., for purposes of rate-setting, state law, etc.), based on the number of Maryland employees. The issuer should attempt in good faith to accurately count the total number of the employer’s employees at the time the policy is sold. But unless the issuer actually has information to indicate that the total number of employees would cause the employer to be considered a large employer, the issuer may classify the coverage based on the number of Maryland employees only (e.g., as small group market coverage).

An issuer generally must meet its obligation to provide a rebate to group health plan enrollees by providing the rebate to the policyholder – i.e., the entity that entered into a contract with the issuer to receive health insurance coverage (generally the employer, in the case of a single-employer group health plan) – with two exceptions. First, with respect to nongovernmental group health plans that are not subject to ERISA (e.g., church plans), an issuer may distribute an MLR rebate to the policyholder only if the policyholder first provides a written assurance that the rebates will be used to benefit members. Otherwise, the issuer must divide and distribute the full rebate – including

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7 For coverage offered in a state in which applicable law provides for a higher MLR standard for the large group market, that higher standard generally will be substituted for the 85% federal standard.

8 A proposed amendment to the MLR regulations would extend the deadline to distribute an MLR rebate for a given calendar year to September 30 of the following year, effective beginning with the 2014 calendar year (i.e., beginning September 30, 2015). 45 C.F.R. § 158.240(d) (proposed).
amounts attributable to premiums paid by the policyholder – directly to the individual subscribers (i.e., employee-participants) who were covered by the plan during the calendar year on which the rebate is based. Second, if the group health plan has been terminated as of the date that the rebate is to be paid, and the issuer is unable to locate the policyholder, then the issuer must distribute the rebate directly, in equal amounts, to the individual subscribers of the terminated plan.

An issuer that owes an MLR rebate in the large group market for a given year must furnish, by August 1 of the following year, an HHS-developed notice to policyholders and/or subscribers. Specifically, where the MLR rebate is paid to the policyholder, as described above, an HHS-developed notice must be furnished to each policyholder receiving the rebate, as well as each subscriber covered under the group health plan. Where the MLR rebate is paid directly to the individual subscribers, under the two exceptions described above, a separate HHS-developed notice must be furnished only to each subscriber receiving the rebate.

In addition, with respect to the 2011 calendar year only, an issuer whose MLR for large group market products met or exceeded the 85% standard, meaning the issuer did not owe a rebate for that year, is (or was) required to furnish a prescribed Notice of MLR Information to subscribers, by no later than the date that it furnishes (or furnished) the first plan document to subscribers on or after July 1, 2012. HHS has indicated that a plan document for this purpose could include, for example, insurance policies, SPDs, benefits summaries, and group contracts. This notice requirement does not apply with respect to so-called “mini-med” policies (i.e., policies with annual benefit limits of $250,000 or less), and certain non-credible experience deemed to meet or exceed the relevant MLR standard.

### Claims and Appeals Procedures

**Legal References**

- ACA §§ 10101(g), 1251(a)(2)
- PHSA § 2719
- 45 C.F.R. § 147.136 (Interim Final Rule)
- NAIC Uniform Review Model Act (Apr. 2010)
- DOL, Affordable Care Act Implementation FAQs Part I, Q&A 7 (Sept. 20, 2010)
- 2012 Culturally and Linguistically Appropriate Services (CLAS) County Data (Mar. 9, 2012)
- DOL, State Consumer Assistance Programs (Aug. 1, 2012)

A large group health plan must comply with detailed requirements pertaining to internal claims, appeals, and independent external reviews of adverse benefit determinations. Specifically, the plan generally must comply with the DOL’s pre-ACA claims and appeals regulations applicable to ERISA group health plans under 29 C.F.R. §
2560.503-1, with some modifications. These modifications include an expanded definition of adverse benefit determination, additional requirements pertaining to a full and fair review of an adverse benefit determination, avoidance of conflicts of interest, detailed requirements pertaining to notices of adverse benefit determinations, deemed exhaustion of internal appeals processes, continued coverage for certain treatments pending completion of an appeal, and minimum standards for state (or, in some states, federal) independent external reviews.

These requirements do not apply to grandfathered plans.

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9 The DOL’s pre-ACA claims procedure regulations previously did not apply to non-ERISA-covered group health plans, such as non-federal governmental and church plans. The Interim Final Rule on claims, appeals and external reviews under ACA expressly makes these pre-ACA DOL claims procedure regulations applicable to such plans, with certain modifications.
Patient Protections Relating to Choice of Provider and Emergency Services

Legal References

- ACA §§ 10101(h), 1251(a)(2)
- PHSA § 2719A
- 45 C.F.R. § 147.138 (Interim Final Rule)
- DOL, Affordable Care Act Implementation FAQs Part I, Q&A 15
- Patient Protection Model Disclosure

ACA provides separate sets of rules pertaining to a patient’s choice of health care provider, and access to emergency services, under fully-insured large group health plans.

These rules do not apply to grandfathered plans.

Patient’s Choice of Health Care Provider

A large group health plan that requires or provides for covered persons to choose a primary care provider (“PCP”) must allow the person to designate any participating PCP who is available to accept him or her. If the coverage requires or provides for covered persons to designate a PCP for a child, then the plan must allow for the designation of any participating physician who specializes in pediatrics and is available to accept the child. If OB/GYN care is covered, and designation of an in-network PCP is required, then the plan cannot require an authorization or referral by the plan, issuer, or any other person (including a PCP) as a condition for a female enrollee to receive care from an in-network OB/GYN provider.

A plan that requires covered individuals to designate a PCP must provide a notice informing each participant of the terms of the coverage regarding designation of a PCP, and of the rights described above relating to PCPs, pediatricians, and OB/GYN care. This notice must be included whenever the plan provides a participant with a benefits document (or similar description of benefits).

Emergency Services Received Out-of-Network

A large group health plan that covers services in the emergency department of a hospital cannot require a covered individual to obtain prior authorization for emergency services, regardless of whether the plan has a network of providers, and if it does have a network of providers, regardless of whether the emergency services are provided in-network or out-of-network. In addition, a plan that has a network of providers cannot impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services. Finally, a plan must comply with the following cost-sharing rules pertaining to out-of-network emergency services:

1. The plan may not impose a copayment amount or coinsurance rate for out-of-network emergency services that is greater than the amount or rate that would apply if the services had been provided in-network. Out-of-network providers may balance bill a patient for any balance remaining above what the plan paid (or is required to pay) for the services, but before the patient may become responsible for such balance billed amounts, the plan must pay the greatest of:

   a. The amount negotiated with in-network providers for the particular emergency services (reduced by any required in-network copayment or coinsurance).
b. The amount for the emergency services calculated using same method the plan generally uses for out-of-network services under the plan, but substituting the relevant in-network copayment or coinsurance for the out-of-network copayment or coinsurance requirements (e.g., if the plan generally pays 70% of the usual, customary, and reasonable (“UCR”) charges for out-of-network services under the plan, the amount calculated under this prong will be 100% of the UCR charges for the service, reduced by the in-network copayment amount or coinsurance rate that the patient would have been required to pay if the services had been provided in-network).

c. The amount for the emergency services that would be paid under Medicare (Part A or B), reduced by any in-network copayment or coinsurance for the services.

2. The plan may not impose other cost-sharing requirements (e.g., deductibles and out-of-pocket maximums) with respect to out-of-network emergency services unless such requirements apply to out-of-network benefits in general.

**Prohibition Against Discrimination in Favor of Highly Compensated Individuals**

**Legal References**

- **ACA §§ 10101(d), 1251(a)(2)**
- **PHSA § 2716**
- **Code § 105(h)**
- **Treas. Reg. § 1.105-11**

ACA extends the requirements of Code § 105(h)(2), previously applicable only to self-insured plans, to non-grandfathered, fully-insured group health plans, thus prohibiting such plans from discriminating in favor of highly compensated individuals (“HCIs”) with respect to eligibility or benefits. HCIs are defined to include the highest paid 25% of employees, as well as certain shareholders and top-paid officers. Rules applying the nondiscrimination requirements to fully-insured plans will be similar to those contained in Code § 105(h)(3), (4), and (8).

Code § 105(h) requires a self-insured plan to satisfy certain coverage or participation requirements. Specifically, the plan must benefit either (a) at least 70% of all employees, (b) at least 80% of all eligible employees (provided that at least 70% of all employees are eligible), or (c) a nondiscriminatory classification of employees. Certain employees do not have to be counted for these purposes – e.g., employees with less than three years of service, employees under age 25, part-time or seasonal employees, certain union employees, and nonresident aliens with no U.S. source income. It is not clear if these classes of employees may be excluded from consideration if coverage is provided to some (but not all) of them, however. Code § 105(h) also requires self-insured plans to provide the same benefits to non-HCI-participants as to HCI-participants.

The nondiscrimination requirements for fully-insured group health plans were scheduled to apply for plan years beginning on or after September 23, 2010, but the agencies have delayed their application pending the issuance of regulatory guidance. Compliance will likely be required only for plan years beginning a specified period of time after such guidance is issued.
Summary of Benefits and Coverage ("SBC") Documents and Uniform Glossary

Legal References

- ACA §§ 1001(5), 10101(b), 10103(d)(2)
- PHSA § 2715
- 45 C.F.R. § 147.200
- SBC Template (rev. May 11, 2012)
- Sample Completed SBC (rev. May 11, 2012)
- CCIIO, Instructions for Completing the SBC
- Sample Language for Completing the SBC
- Guides for Coverage Example Calculations (rev. May 11, 2012)
- Coverage Example Narratives
- Coverage Examples Calculator and Related Inputs Checklist, Instructions, and Algorithm Summary
- Uniform Glossary
- DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q&A 4
- DOL, FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, Q&A 1 (Nov. 17, 2011)
- DOL, FAQs About Affordable Care Act Implementation Part VIII (Mar. 19, 2012)
- DOL, FAQs About Affordable Care Act Implementation Part IX (May 11, 2012)

Health insurance issuers offering large group health insurance coverage – whether grandfathered or not – must, at specified times and in a specified manner, prepare and furnish to group health plans (or plan sponsors), participants and beneficiaries an SBC meeting certain style and content requirements. These requirements are effective beginning (1) September 23, 2012, with respect to disclosures from issuers to group health plans or plan sponsors, (2) the first day of the first open enrollment period that begins on or after September 23, 2012, with respect to disclosures to participants and beneficiaries who enroll or re-enroll through an open enrollment period, and (3) the first day of the first plan year that begins on or after September 23, 2012 (i.e., January 1, 2013 for calendar-year plans), with respect to disclosures to all other participants and beneficiaries.

An issuer must provide an SBC to a group health plan or plan sponsor: (1) within seven business days after the plan or plan sponsor applies for coverage, (2) by the first day of coverage, if there has been any modification to the terms of coverage requiring a change in the information included in the SBC, between the date that the SBC was initially furnished (upon application) and the first day of coverage, (3) upon annual renewal or reissuance of the coverage, and (4) within seven business days of a request from a plan or plan sponsor.

The plan must provide an SBC to participants and beneficiaries, for any benefit package(s) for which they are eligible: (1) as part of the written application materials for enrollment, if such written materials are distributed, (2) by no later than the first day that the participant is eligible to enroll in coverage for himself or herself (or any beneficiaries), if written application materials are not distributed, (3) on or before the first day of coverage, if there has been any change before that date to the SBC that was provided pursuant to the first or second category, above, (4) within 90 days of enrollment for members who enroll during a mid-year special enrollment period, (5) upon annual renewal, and (6) within seven business days of a request from a participant or beneficiary. Although the responsibility to provide an SBC to participants and beneficiaries under a fully-insured group health plan applies to
the plan, the plan administrator (generally the employer), and the health insurance issuer, the requirement will be deemed satisfied if any one of those parties furnishes the SBC in a timely and complete manner. Moreover, where an issuer enters into a binding contractual arrangement pursuant to which another party (e.g., the employer/plan administrator or a service provider) assumes the responsibility to complete and/or furnish the SBC, the issuer generally will not be subject to agency enforcement in connection with a failure by that other party, provided that the issuer monitors the other party’s performance under the contract, and if it knows that the SBC rules have been violated, either: (1) corrects the violation as soon as practicable, if the issuer has the information necessary to do so, or (2) communicates with participants and beneficiaries regarding the failure – and begins taking “significant steps as soon as practicable to avoid future violations” – if the issuer does not have the information necessary to correct the violation.

Only a single SBC must be provided to a participant and any beneficiaries, at the participant’s last known address, unless a particular beneficiary has a different last known address (in which case a separate SBC will need to be sent to the beneficiary). For group health plans that offer multiple benefit packages (e.g., a PPO option, HMO option, etc.), a new SBC will need to be furnished to a member automatically upon annual renewal only with respect to the benefit package in which the member is enrolled.

In addition, if the plan or issuer makes any material modification to the terms of the coverage that affects the content of the SBC, is not reflected in the most recently-furnished SBC, and occurs mid-year (i.e., other than in connection with a renewal or reissuance of coverage), then the plan or issuer must provide notice of the modification – or an updated SBC – to participants and beneficiaries at least 60 days in advance of its effective date. An issuer or plan must also make available to group health plan members, within seven business days of receiving a request, the federal government-issued Uniform Glossary.

Administrative Simplification: Standards and Operating Rules for Electronic Transactions; Health Plan Identifiers

Legal References

- ACA § 1104
- Social Security Act §§ 1171(9), 1173(a)(2)(I), (a)(4), (g)-(j)
- 45 C.F.R. Part 162, Subparts D, E, L, N

ACA requires HHS to adopt a set of operating rules that will support and augment the nine standard transactions previously established pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and one additional transaction for which HHS is required to establish a standard under ACA,\textsuperscript{10} by providing for a uniform method of transmitting relevant information and eliminating certain situation-based variations in how data content is used in connection with the standards. In addition, ACA requires HHS to adopt a standard for health claims attachments by January 1, 2014 (to be effective no later than January 1, 2016).

\textsuperscript{10} Pre-ACA regulations issued by HHS provide that all HIPAA covered entities – including health insurance issuers – that engage with another covered entity (or within the same covered entity) in any one of certain specified transactions involving the electronic transfer of health care information must conduct the transaction as a HIPAA standard transaction. The nine transactions for which HHS has already adopted standards are: (1) claims or equivalent encounter information, (2) payment and remittance advice, including any electronic funds transfers (which was added under ACA § 1104, and implemented in regulations issued in January and August 2012, effective January 1, 2014), (3) claim status inquiries and responses, (4) eligibility inquiries and responses, (5) referral certification and authorization inquiries and responses, (6) enrollment and disenrollment in a health plan, (7) health plan premium payments, (8) coordination of benefits, and (9) Medicaid pharmacy subrogation.
The first set of operating rules (related to eligibility and claim status inquiries and responses) will be effective January 1, 2013, and the second set of operating rules (related to electronic funds transfers and payment and remittance advice transactions) will be effective January 1, 2014. The remaining sets of operating rules, which HHS has yet to issue, must be effective by January 1, 2016. Moreover, health plans – including health insurance issuers – must begin certifying to HHS their compliance with the applicable standards and operating rules for certain transactions. Specifically, issuers must certify their compliance with applicable standards and operating rules for electronic funds transfers, eligibility, health claim status, and payment and remittance advice transactions by December 31, 2013. Certification is required for transactions involving claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization transactions by December 31, 2015. HHS will begin to assess penalties, by no later than April 1, 2014, against entities that fail to certify and document their compliance with the relevant standards and operating rules, and will conduct periodic audits of health plans to ensure their compliance.

ACA also requires HHS to issue regulations establishing a unique health plan identifier; final regulations implementing this requirement were issued on September 5, 2012. Under current (pre-ACA) law, HIPAA covered entities are permitted to use a variety of health plan identifiers in connection with HIPAA standard transactions – e.g., NAIC company codes, employer identification numbers and plan numbers, taxpayer identification numbers, etc. In an effort to reduce inefficiencies and costs, particularly for health care providers, the final regulations require all HIPAA covered entities to use a standard unique health plan identifier (“HPID”) – a 10-digit number that health plans will need to obtain from an Enumeration System currently being developed by HHS – whenever they identify a health plan in a standard transaction. Entities will be able to begin accessing the Enumeration System and “learn[ing] more about the application process” by October 1, 2012. The deadline for a health plan to obtain an HPID is November 5, 2014 (or November 5, 2015 for a small health plan, including a health insurance issuer with annual receipts of $5 million or less). The deadline for fully implementing the regulations – i.e., using HPIDs to identify health plans in standard transactions – is November 7, 2016 for all covered entities.11

Fair Health Insurance Premiums, Rating Reforms

Legal References

- ACA §§ 1201(4), 1251(a)(2), 1312(f)(2)(B)
- PHSA § 2701
- 45 C.F.R. § 147.102(f) (proposed)

Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering individual or small group health insurance coverage may not vary the premium rate charged for such coverage by any factor other than (1) coverage tier (i.e., individual or family coverage), (2) the applicable rating area, which will be established by the state or HHS, (3) age, provided that the rate may not vary by more than 3-to-1 for like individuals of different ages who are age 21 and older at the time of policy issuance or renewal, the rate variation for individuals under age 21 is

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11 The final regulations appear to contain a couple of typographical errors in connection with the effective date provisions. First, 45 C.F.R. § 162.504(a) states that full implementation of the HPID requirement will be required by November 5, 2014, despite multiple preamble references to November 7, 2016 being the applicable deadline. See 77 Fed. Reg. 54664, 54669, 54673, 54679, 54695 (Sept. 5, 2012). Second, 45 C.F.R. § 162.504(b)(2) provides that an HPID for a small health plan must be obtained by November 5, 2014 – the same date by which an HPID must be obtained for all other health plans – despite multiple preamble references to November 5, 2015 being the applicable deadline. See 77 Fed. Reg. at 54664, 54669, 54673, 54679.
actuarially justified, and specified uniform age bands and a uniform age rating curve are used; and (4) tobacco use, provided that the rate may not vary by more than 1.5- to-1. (Issuers may also be subject to applicable state laws that provide for ratios narrower than 3-to-1 for age (with respect to individuals age 21 and older) or 1.5-to-1 for tobacco use.)

The total premium charged to a small group generally must be determined by summing the premium amounts calculated for each covered participant and beneficiary, on a per-member basis, in accordance with these rating provisions. Special rules may apply in determining the total premium to be charged for family coverage if more than three family members under age 21 are covered, or if applicable state law does not permit any rating variations based on age or tobacco use and the state elects to establish uniform family tiers and corresponding multipliers. In addition, state law may require an issuer to charge a group (or may permit an issuer to voluntarily charge a group) a total premium based on the group’s average rating amounts, rather than the sum of such amounts calculated for each member, provided that certain requirements are satisfied.

If a state permits health insurance issuers to offer large group health insurance coverage through the state Exchange beginning in 2017 or later, pursuant to ACA § 1312(f)(2)(B), then these premium rating restrictions will also apply to all large group health insurance coverage offered in the state (regardless of whether the coverage is offered through an Exchange).

These provisions do not apply to grandfathered plans.

Guaranteed Availability of Coverage

Legal References

- ACA §§ 1001(3), 1201(4), 1251(a)(2), 1563(c)(8)
- PHSA § 2702
- 45 C.F.R. § 147.104 (proposed)

Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering large group health insurance coverage must offer to any employer in the state all products that are approved for sale in the large group market, and must accept every employer and individual in the state who applies for any of those products, subject to permissible open or special enrollment periods.

This requirement does not apply to grandfathered plans, and special exceptions apply, in certain situations, to (1) issuers offering coverage through network plans that wish to limit the employers that may apply for coverage to whose with eligible individuals who live, work, or reside in the plan’s service area, or that can demonstrate a lack of capacity to deliver services adequately to enrollees of any additional groups, and (2) issuers that can demonstrate a lack of sufficient financial reserves to underwrite additional coverage.

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12 Age bands are ranges of sequential ages that are used to segregate the various points at which the slope of premium rate variation by age changes (i.e., all individuals within a single age band pay the same premium rate based on age). An age curve, by contrast, is a specified distribution of relative rates across all age bands. HHS’s proposed regulations implementing PHSA § 2701 would provide for a single age band covering all children age 20 and under, one-year age bands starting at age 21 and ending at age 63, and a single age band covering all individuals age 64 and older. Each state may establish (and submit information to CMS regarding) its own uniform age rating curve. In a state that does not establish its own rating curve, a default age rating curve established by CMS will apply.
Guaranteed Renewability of Coverage

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Legal References

- *ACA §§ 1001(3), 1201(4), 1251(a)(2), 1563(c)(9)*
- *PHSA § 2703*
- *45 C.F.R. § 147.104 (proposed)*

Effective for plan years beginning on or after January 1, 2014, health insurance issuers offering large group health insurance coverage must renew or continue in force that coverage, at the plan sponsor’s option, subject to certain specified exceptions. These exceptions include where the plan sponsor fails to pay premiums or contributions in accordance with the terms of the coverage (including any timeliness requirements), performs an act of fraud or intentional misrepresentation of material fact, or fails to comply with a material plan provision relating to employer contribution or group participation rules (pursuant to state law); the issuer ceases to offer coverage in the large group market in that state, provided that certain notice and other requirements are satisfied; for coverage offered through a network plan, no enrollee lives, resides, or works in the issuer’s service area (or an area in which the issuer is authorized to do business); or, for large group coverage made available only through one or more bona fide associations, an employer’s membership in the association – on the basis of which the coverage is provided – ceases and the coverage is terminated uniformly without regard to any health status-related factor pertaining to any covered member. In addition, a health insurance issuer may modify upon annual renewal any large group health insurance coverage that it offers.

These provisions do not apply to grandfathered plans, but health insurance coverage offered in connection with such plans remains subject to the guaranteed renewability provisions of pre-ACA PHSA § 2712.

Prohibited Discrimination Based on Health Status

Legal References

- *ACA §§ 1201(3), (4), 1251(a)(2)*
- *PHSA § 2705*
- *45 C.F.R. §§ 146.121(including proposed paragraph (f)), 147.110 (proposed)*

Effective for plan years beginning on or after January 1, 2014, a large group health plan must comply with all the requirements of the (pre-ACA) HIPAA non-discrimination regulations under 45 C.F.R. § 146.121, with certain modifications to the provisions pertaining to wellness programs. Such plans thus may not establish rules for eligibility (or continued eligibility) for coverage, and generally may not require any individual – as a condition of enrollment or continued enrollment – to pay a premium amount greater than that required for a similarly situated enrollee, based on specified health status-related factors pertaining to the individual or his or her dependents. Such factors are, namely, health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. This general requirement effectively mirrors the pre-ACA provisions prohibiting discrimination based on a health status-related factor. See pre-ACA PHSA § 2702.

That being said, group health plans are not prohibited from establishing financial incentives for members, such as premium discounts or rebates, surcharges (or the absence of surcharges), or modified copayments or deductibles, in return for adhering to a wellness program. For this purpose, a wellness program is a program offered by an employer that is designed to promote health or prevent disease, and satisfies specified requirements that are very similar to those imposed pursuant to nondiscrimination regulations that were issued in 2006 (under pre-ACA PHSA § 2702). Specifically, if none of the conditions for obtaining a financial incentive under a wellness program require an
individual to satisfy a standard related to a health status factor, then the program simply must be made available to all similarly situated individuals. Examples include programs that reimburse fitness center membership fees, provide a reward for participating in a diagnostic testing program regardless of outcome, waive a copayment or deductible requirement for certain items or services related to a particular health condition, reimburse the cost of smoking cessation programs regardless of outcome, or provide a reward for attending a periodic health education seminar. By contrast, if any condition for obtaining the financial incentive is based on satisfying a standard related to a health status factor (e.g., a reduced premium for members who do not use tobacco), then the program will need to comply with the following five requirements:

1. The financial reward, together with all rewards for other wellness programs that are based on satisfying a standard related to a health status factor, does not exceed 30% - increased to 50% for programs that are designed to prevent or reduce tobacco use – of the total cost of coverage for any individuals who are allowed to participate in the program.\(^{13}\)

2. The program is reasonably designed to promote health or prevent disease – i.e., it has a reasonable chance of improving the health of (or preventing disease in) participating individuals, and is not overly burdensome, a subterfuge for discriminating based on a health status factor, or highly suspect in the methods used, based on all the relevant facts and circumstances.

3. Eligible individuals are given the opportunity to qualify for the reward at least once each year.

4. The full reward is available to all similarly situated individuals, which requires the program to provide for a reasonable alternative standard (or waiver of the general standard) to obtain the reward for any individual who can show that it is unreasonably difficult due to a medical condition to satisfy – or medically inadvisable to attempt to satisfy – the general standard. The plan may, if reasonable under the circumstances, require the individual to verify, e.g., with a doctor’s note, that a health status factor makes it unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the general standard.

5. Any plan materials describing the terms of the program must disclose the availability of the reasonable alternative standard (or possible waiver of the general standard, if applicable) under item #4, unless the plan materials merely disclose that a wellness program is available without actually describing its terms.

The ACA provisions described above technically do not apply to grandfathered plans, which remain subject to the predecessor provisions under the 2006 HIPAA nondiscrimination regulations. However, the agencies have interpreted these ACA nondiscrimination provisions (other than the provisions pertaining to wellness programs) to be identical to those predecessor provisions. With respect to the exception for certain wellness programs, the agencies have proposed to use their regulatory authority under HIPAA to apply to grandfathered plans the same standards that apply (under ACA) to non-grandfathered plans. Accordingly, pursuant to the agencies’ proposed regulations implementing PHSA § 2705, **grandfathered and non-grandfathered plans** alike would be subject to the same nondiscrimination provisions described above.

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\(^{13}\) Under the pre-ACA HIPAA wellness program nondiscrimination regulations, this permissible reward amount was limited 20% of the total cost of coverage.
Nondiscrimination in Health Care – Providers and Employees

Legal References

- ACA §§ 1201(4), 1251(a)(2), 1558
- PHSA § 2706

Effective for plan years beginning on or after January 1, 2014, a large group health plan may not discriminate, with respect to participation in the coverage, against any health care provider acting within the scope of his or her license or certification under applicable state law.14 In addition, such plans are subject to ACA § 1558, which prohibits an employer from discharging or in any manner discriminating against an employee for (1) receiving a premium subsidy under Code § 36B or ACA § 1402,15 (2) providing or causing to be provided information relating to a violation or believed violation of the Fair Labor Standards Act (“FLSA”), or testifying or agreeing to testify, assisting or agreeing to assist, or participating or agreeing to participate in a proceeding concerning such violation, or (3) objecting to, or refusing to participate in, any activity, practice, or assigned task that the employee reasonably believes to be in violation of the FLSA.

This requirement does not apply to grandfathered plans.

Comprehensive Health Care: Out-of-Pocket and Deductible Limits

Legal References

- ACA §§ 1201(4), 1251(a)(2), 1302(c)(1)-(2)
- PHSA § 2707(b)
- Code § 223(c)(2)(A)(ii)
- See 45 C.F.R. § 156.130 (proposed)

Effective for plan years beginning on or after January 1, 2014, a large group health plan must ensure that the total cost-sharing that may be incurred under the coverage is limited to the applicable amount in effect for health savings account-compatible high-deductible health plans under Code § 223(c) (2)(A)(iii),16 subject to specified increases after 2014. For this purpose, cost-sharing includes deductibles, co-payments, coinsurance, and similar charges, but does not include premiums; amounts incurred for non-covered services, or balanced billed amounts charged by out-of-network providers. In addition, cost-sharing amounts paid for out-of-network services are not taken into account for purposes of this cost-sharing limit.

These provisions do not apply to grandfathered plans.

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14 This does not require an issuer to contract with all health care providers willing to abide by the issuer’s terms and conditions for participation, nor does it prevent such issuers (or the agencies) from establishing varying reimbursement rates based on quality or performance measures.

15 An employee generally will not be eligible to receive a premium subsidy under Code § 36B or ACA § 1402 for any period in which he or she is enrolled in large group health insurance coverage. See Code § 36B(c)(2)(C)(iii); Prop. Treas. Reg. § 1.36B-2(c)(3)(vii).

16 For 2013, this amount is $6,250 for self-only coverage and $12,500 for any other tier of coverage.
Prohibition Against Excessive Waiting Periods

Legal References

- ACA §§ 1201(4), 1251(a)(4)(A)(i), 10103(b)
- PHSA § 2708
- IRS Notice 2012-17, 2012-9 I.R.B. 430 (Feb. 27, 2012)

Effective for plan years beginning on or after January 1, 2014, a large group health plan – whether grandfathered or not – will be prohibited from imposing a waiting period of more than 90 days for a member’s coverage to become effective. This provision does not require coverage to be offered to any particular employees or categories of employees, but provides that where coverage is in fact offered, any waiting period imposed by the plan or issuer must not exceed 90 days. A waiting period is defined as “the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.” An individual who has met the plan’s substantive eligibility conditions is otherwise eligible for this purpose.

The 90-day limitation applies only to eligibility conditions that are based on the mere passage of a period of time. A plan may impose an eligibility condition (or conditions) based on other factors, e.g., full-time employee status, a specified job category, or receipt of a professional license, unless the condition is designed to avoid compliance with the 90-day waiting period limitation. A plan that makes coverage available within 90 days will not be deemed to violate these requirements solely because an employee takes more than 90 days to elect coverage.

Where a plan conditions eligibility on an employee working a certain number of hours, and it cannot be determined at the date of hire that a new employee is reasonably expected to regularly work the requisite hours (i.e., in the case of a new “variable hour” employee), the plan may take a “reasonable period of time” to determine if the employee will meet the hours-based eligibility condition. This reasonable period of time may include a measurement period that is consistent with the timeframe that certain large employers may use – i.e., up to 12 months after the start date, pursuant to an IRS safe harbor – to determine if a new employee is a full-time employee for purposes of the employer shared responsibility requirements of Code § 4980H. Accordingly, consistent with the current IRS guidance on the employer shared responsibility provisions, the 90-day waiting period limitation will not be violated if coverage is made available by no later than 13 months after a variable hour employee’s start date (plus, if the start date is not the first day of the month, the time remaining until the first day of the next calendar month). Finally, agency guidance provides that a plan may impose a “cumulative hours of service condition” of up to 1,200 hours, for part-time employees to be eligible for coverage, without violating the waiting period provisions. Thus, a plan will not run afoul of the waiting period limitation if it requires an employee first to work up to 1,200 hours, and then to satisfy a waiting period of up to 90 days, before the effective date of his or her coverage. A cumulative hours of service condition of more than 1,200 hours would be problematic, however.

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17 The employer shared responsibility provisions under Code § 4980H require an employer with at least 50 fulltime (and full-time equivalent) employees either to offer sufficiently “affordable” and “valuable” coverage to its full-time employees (and their dependents) or pay a penalty to the IRS.
Coverage and Nondiscrimination Requirements for Participants in Clinical Trials

Legal References

- ACA §§ 10103(c), 1251(a)(2)
- PHSA § 2709

Effective for plan years beginning on or after January 1, 2014, where a member covered under a fully-insured large group health plan is eligible to participate in an approved clinical trial (according to the trial protocol), with respect to treatment of cancer or another life-threatening disease or condition, and either the member’s referring provider is a participating provider who has concluded that the member’s participation in the trial would be appropriate, or the member furnishes medical and scientific information establishing that his or her participation in the trial would be appropriate, the plan must not (1) deny the member’s participation in the clinical trial, (2) deny (or limit or impose additional conditions upon) the coverage of routine patient costs for items and services furnished in connection with the trial, or (3) discriminate against the member based on his or her participation in the clinical trial.

This requirement does not apply to grandfathered plans.

Automatic Enrollment for Employees of Large Employers (with Notice and Opt-Out)

Legal References

- ACA § 1511
- FLSA § 18A
- DOL, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q&As 2-3

ACA enacted FLSA § 18A, which generally requires certain large employers that have more than 200 full-time employees to automatically (1) enroll any new full-time employees into one of the employer’s health plans (subject to any permissible waiting period), and (2) continue the enrollment of current employees who are enrolled in a health plan offered by the employer. Such employers are also required to provide adequate notice and an opportunity for an employee to opt out of the coverage in which he or she has been automatically enrolled.

These provisions apply regardless of the grandfathered status of an employer’s plan.

Although the effective date of the statutory provisions is unclear, the DOL – which has delegated responsibility to its Employee Benefits Security Administration (“EBSA”) to issue implementing regulations, in coordination with the Treasury Department – has stated that it will not require employers to comply with the automatic enrollment provisions until final regulations are issued and applicable. In addition, the DOL has confirmed that any regulations or other guidance implementing the automatic enrollment provisions “will not be ready to take effect by 2014.” It is not clear at this time when such guidance can be expected.

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18 Due to an apparent drafting error, there are actually two PHSA §§ 2709. The duplicate provision is former (pre-ACA) PHSA § 2713, relating to disclosures of information.
Excise Tax on High Cost Employer-Sponsored Health Coverage

Legal References

- ACA § 9001
- Code § 4980I

ACA provides for the imposition of a non-deductible excise tax on health insurance issuers of fully-insured group health plans that are deemed to provide high-cost (or “Cadillac”) coverage, effective for taxable years beginning in 2018.\(^{19}\) The tax is equal to 40% of the cost or value of the coverage in excess of a specified dollar threshold – i.e., $10,200 for self-only coverage (increased to $11,850 for certain early retirees and high-risk professions) and $27,500 for all other coverage tiers (increased to $30,950 for certain early retirees and high risk professions).\(^{20}\) The threshold amounts will be indexed for inflation to “CPI-U” plus 1% (rounded to the nearest $50) in 2019, and to CPI-U in 2020 and thereafter. The CPI-U rate historically has been lower than the rate of medical inflation, which will likely cause non-high-cost plans to eventually drift into high-cost status.

For purposes of the excise tax, the cost of coverage generally is calculated in the same manner as premiums for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) – based on the aggregate value of all employer-sponsored coverage – taking into account all employer and employee premiums and contributions (whether made on a pre-tax or after-tax basis) with respect to major medical coverage, health FSAs, HRAs, HSAs, Archer MSAs, on-site clinics, and certain wellness programs. Certain “excepted benefits” are not taken into account for this purpose, including stand-alone dental, vision, and long-term care coverage, as well as accident, disability, liability and supplemental liability, workers’ compensation, automobile medical payment (“med-pay”), credit-only, and after-tax hospital (or other fixed) indemnity or specified-disease coverage.

The employer will be responsible for calculating the aggregate value of all coverage provided to each employee, allocating to the issuer its pro rata share of any excess value over the applicable threshold for the year, and reporting that amount to the issuer and the IRS. The issuer then will be responsible for calculating and paying the 40% excise tax on that amount to the IRS.

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\(^{19}\) The tax is also imposed on TPAs of self-insured group health plans, including health flexible spending arrangements (“health FSAs”) and health reimbursement arrangements (“HRAs”), and employers for health savings account (“HSA”) and Archer medical savings account (“Archer MSA”) contributions.

\(^{20}\) These thresholds may be increased automatically, if and to the extent that growth in U.S. health care costs rises by a faster-than-projected rate before 2018. Adjustments may also apply with respect to plans that have higher than average costs due to workforce age or gender composition. Notably, the applicable non-self-only threshold amount will apply to all employees covered under a multiemployer plan maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, regardless of the employee’s coverage tier under the plan (self-only, self-plus-one, family, etc.).
Reporting of Health Care Costs on Form W-2s

Legal References

- ACA § 9002
- Code § 6051(a)(14)
- Notice 2010-69, Interim Relief with Respect to Form W-2 Reporting of the Cost of Coverage of Group Health Insurance Under § 6051(a)(14)

ACA requires employers to report the cost of employer-sponsored health coverage Box 12 of Form W-2 to be issued to employees in January 2013. (This reporting was optional for Form W-2s issued in January 2012).

This Form W-2 reporting is for informational purposes only and does not mean that the cost of such health coverage is taxable. In general the amount reported includes both the portion paid by the employer and the portion paid by the employee.

The Form W-2 Reporting of Employer-Sponsored Health Coverage chart, located at www.irs.gov, describes the types of coverage that employers must report on Form W-2. Detailed information about the employer’s requirement to report the aggregate cost of an employee’s healthcare benefits on Form W-2 can be found in the instructions for the 2012 Form W-2.