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# FINAL RULE ISSUED ON PROGRAM INTEGRITY: EXCHANGE, SHOP AND ELIGIBILITY APPEALS

On August 30, 2013, the Centers for Medicare and Medicaid Services (CMS), and Health and Human Services (HHS), released the final rule on the Exchange's Program Integrity, the Small Business Health Options Program (SHOP) and the eligibility appeals inside of the Exchange. Some highlights of the rule are below.

## SUMMARY

### The Role of Web Brokers and Agents in the Federal Exchange

The final rule requires that Web-brokers doing business in the Federal Exchange prominently display a standardized disclaimer provided by HHS (to be released in the future). The disclaimer must include:

- The Web-broker's website is not related to the Exchange web site;
- The Web-broker's site may not contain all of the Qualified Health Plans (QHPs) being offered in the Exchange;
- The Web-broker's affirmation to comply with Federal law; and
- That the Web-broker is subject to HHS's Privacy and Security standards

State Exchanges may have similar or stricter requirements in relation to these disclaimers.

Web-brokers must provide consumers an opportunity to view all QHPs offered in the Exchange within that state, and must help all consumers, including consumers who may be qualified for Medicaid.

Web-brokers may provide other non-affiliated agents and brokers, access to sell Federal Exchange coverage through their website. However, the Web-broker must:

- Ensure that the non-affiliated agents and brokers are licensed and trained to sell insurance through the Exchange;
- Provide a list to the Exchange of any non-affiliated agents and brokers who may be selling insurance through the site; and
- Terminate the non-affiliated agent or broker agreement, and report to HHS, for any legal violations the non-affiliated agent or broker may have committed

All agents and brokers can terminate the relationship with the Federal Exchange with a 30 day notice of termination.

## Final Rule Issued on Program Integrity: Exchange, SHOP, and Eligibility Appeals (Continued)

### The Appeals Process for Employers

The final rule establishes the appeals process for an employer when the Exchange determines that the employer did not provide affordable and minimum value coverage.

The Exchange is to first notify the employer when an employee is not offered affordable or minimum value coverage (without providing the employee's tax return information to the employer).

Employers then have 90 days from the date of the Notice to appeal the decision. The employee will receive a notice of the employer's appeal, allowing for additional evidence to be submitted by the employee.

If an employer prevails on the appeal, then the Exchange will re-determine the employee's subsidy eligibility, and the employee will be allowed an additional appeal. However, if the employee wins the appeal, the employer's only other remedy will be to appeal to the Internal Revenue Service (IRS) regarding the tax penalty, if the IRS assesses a penalty to the employer.

### Small Business Health Options Program Rules

The final rule provides that states choosing to run only the Small Business Health Options Program (SHOP) option, in their state, shall only use SHOP navigators to provide information and education to consumers. Enrollment into SHOP QHPs shall only be completed through agents and brokers.

State-based SHOPs have the authority to limit enrollment to electronic applications, and are not required to receive paper or phone applications.

Termination of employers in the SHOP may occur either through employer cancellation or failure to pay premiums. If premiums are not received within 31 days of the due date, QHPs may cancel the policy. However, an employer has an additional 30 days to cure the default, after the policy is cancelled.

**Action**

Employers should be aware of future communications from Exchanges regarding Appeals Notices, along with rights to appeal unfavorable decisions. Also, small group employers (as defined by their state), should be aware of how to apply for SHOP coverage within their state.

**For more information regarding this final rule, go to:**

http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf

**For a fact sheet on this final rule, go to:**

http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pi-final-8-28-2013.html

# FINAL RULE ISSUED ON ELIGIBLE EMPLOYER SPONSORED COVERAGE & INDIVIDUAL MANDATE

### Eligible Employer Sponsored Plan

While the final rule mainly focused on the Individual Mandate, it also provided some insight as to what would be considered an eligible employer sponsored plan.

Defining eligible employer sponsored plans are important because:

- If an employee participates in an eligible employer sponsored plan, the employee would not be subject to a penalty under the Individual Mandate; and
- The employer may escape some or all of the employer mandate penalties for offering an eligible employer sponsored plan

The final rule reiterated that eligible employer sponsored plans include:

- Self-insured employer coverage
- COBRA coverage (so long as the previous employee is enrolled in such coverage)
- Retiree coverage (so long as the retiree is enrolled in such coverage)

## Final Rule Issued on Eligible Employer Sponsored Coverage & Individual Mandate (Continued)

- Plans offered on behalf of employers, which include collectively bargained plans, as well as coverage offered through PEOs or leasing companies on behalf of clients

Unfortunately, at this time, the final rule does not address whether an employer subsidy (or an offer through a pre-tax arrangement) that allows an employee to purchase an individual policy, would be considered an "eligible employer sponsored plan." The final rule only alludes that "future guidance" will be released on this topic.

### Individual Mandate

The final rule in relation to the Individual Mandate includes the following topics:

- Hardships, on a case by case basis, may cause an individual to be exempt from the Individual Mandate penalty. Some hardships include:
  - Individuals who have no access to affordable coverage; and
  - Individuals who may be entitled to expanded Medicaid coverage, but reside in a state that has chosen not to expand Medicaid coverage
- An individual who has coverage on any one day in a month is considered to have coverage for the entire month
- An exemption exists for individuals who have gaps in coverage that are less than three months. If the coverage gap overlaps two consecutive years (e.g., gap is from November 1, 2013 to January 31, 2014), no penalty would be due for the months in the first tax year (i.e., 2013), so long as that time is less than three months, and so long as there were no other gaps in coverage in the first year
- Other exemptions for individuals include: incarceration, members of Indian tribes, and religious objections

**Action**

Employers, even though they may not be directly affected by the Individual Mandate, should be aware of how the Individual Mandate impacts their employees. It is also important for employers to understand what an eligible employer sponsored plan is and how they affect potential penalties to employees.

**For more information regarding this final rule, go to:**

http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf

# PROPOSED REGULATIONS ON SMALL BUSINESS HEALTH CARE TAX CREDIT

The Internal Revenue Service (IRS) issued proposed regulations on August 26, 2013, addressing the small business health care tax credit. Much of the proposed regulations were based upon previous guidance in IRS Notices 2010-44 and 2010-82.

Eligible small employers for the program include small employers with 25 or less Full-Time Equivalent (FTE) employees, who average less than $50,000 in annual wages (adjusted for inflation). Control group/common ownership rules apply.

Employers may only claim the tax credit for two consecutive years, beginning in 2014. The proposed rules also contain safeguards against an employer creating successor entities that attempt to avoid the consecutive two-year limit.

Employers must contribute to all employee premiums in a "uniform percentage" amount of at least 50%.

Additional highlights are as follows:

- The maximum credit amount has increased from 35% to 50% of paid premiums for for-profit entities, and from 25% to 35% for non-profit entities
- The tax credit may only be obtained through coverage purchased through the Small Business Health Options Program (SHOP)

**Action**

Applicable small employers should discuss their eligibility for the SHOP with their Barney & Barney, LLC representative, and should also discuss the availability of a tax credit with their company's tax advisor.

**For more information regarding this proposed rule, go to:**

http://www.gpo.gov/fdsys/pkg/FR-2013-08-26/pdf/2013-20769.pdf

# QUESTIONS OF THE MONTH: MARKETPLACE NOTICE & THE 90-DAY WAITING PERIOD LIMITATION

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments).

**Q1:** Is it permissible for another entity (such as an issuer, multiemployer plan, or third-party administrator) to send the Marketplace Notice of Coverage Options on behalf of an employer to satisfy the employer's obligations?

**A1:** Yes, an employer will have satisfied its obligation to provide the notice with respect to an individual if another party provides a timely and complete notice. The Department of Labor notes that employers are required to provide notice to all employees, regardless of whether an employee is enrolled in, or eligible for, coverage under a group health plan. Accordingly, an employer is not relieved of its statutory obligation to provide notice if another entity sends the notice to only participants enrolled in the plan, if some employees are not enrolled in the plan. When providing notices on behalf of employers, multiemployer plans, issuers, and third party administrators should take proper steps to ensure that a notice is provided to all employees regardless of plan enrollment, or communicate clearly to employers that the plan, issuer, or third party administrator will provide notice only to a subset of employees (e.g., employees enrolled in the plan) and advise of the residual obligations of employers with respect to other employees (e.g., employees who are not enrolled in the plan). Source: http://www.dol.gov/ebsa/faqs/faq-aca16.html

**Q2:** Can an employer be fined for failing to provide employees with notice about the Affordable Care Act's new Health Insurance Marketplace?

**A2:** No. If your company is covered by the Fair Labor Standards Act, it should provide a written notice to its employees about the Health Insurance Marketplace by October 1, 2013, but there is no fine or penalty under the law for failing to provide the notice. Source: http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html

**Q3:** Will the Departments be issuing final regulations under PHS Act section 2708 that give plans and issuers sufficient time to comply with the waiting period limitation?

**A3:** Yes. As stated in the proposed rules, plans and issuers can rely on guidance provided in the March 2013 proposed rules at least through 2014. To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to January 1, 2015 and the Departments expect they will give plans and issuers sufficient time to comply. Under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation. Therefore, for example, if a multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation).
Source: http://www.dol.gov/ebsa/faqs/faq-aca16.html

# IMPORTANT DATES

## PLAN YEARS ON / AFTER 08/01/2012

- **Health Care Reform's Women's Preventive Services Mandate** with no cost-sharing (for calendar year plans the effective date was 01/01/2013)

## PLAN YEARS ON / AFTER 09/23/2012

- **Health Care Reform's Annual Dollar Limits** for "essential health benefits" restricted to no less than $2 million, absent a waiver (for calendar year plans the effective date was 01/01/2013)

## PLAN YEARS ON / AFTER 09/23/2012

- **Summary of Benefits and Coverage (SBC)** must be provided to plan participants and prospective participants when marketing, 30 days prior to renewal, upon demand within 7 days, and upon special enrollment election (for calendar year plans the effective date was 01/01/2013

## PLAN YEARS ENDING ON / AFTER 10/01/2012

- **Comparative Effectiveness Fee**. Fully-insured carriers and self-funded plan sponsors will be subject to a fee in the amount of $1 per covered life. The Fee is due 07/31 of each year using Form 720 "Quarterly Federal Excise Tax Return"

## PLAN YEARS ON / AFTER 01/01/2013

- **Flexible Spending Accounts** limited to $2,500 for employee contributions

## 60 DAYS AFTER THE BEGINNING OF THE PLAN YEAR

- **Employer Creditable Coverage Reporting to CMS** due (e.g., if a plan effective date is 01/01, reporting must be completed by 03/01)

## OCTOBER 2013

- **10/01/2013 – Notice of Exchange**. Ongoing employees must receive notice before 10/01/2013; for each new employee, notice must be provided upon hire beginning 10/01/2013
- **10/01/2013 –Exchange Initial Open Enrollment** begins
- **10/15/2013 – Medicare Part D Creditable and/or Non-Creditable Coverage Notice** to plan participants due (if not previously provided earlier in the year as part of the Benefits Information Guide or at open enrollment)

## NOVEMBER 2013

- **11/14/2013 – Barney & Barney's Legislative Compliance 2014 Outlook Seminar** in San Diego, CA
- **11/15/2013 – Reinsurance Fee** reporting due for carriers and self-funded plans (including HRA plan sponsors where not integrated with a self-funded plan)

## JANUARY 2014

- **01/01/2014 –** Federal **90-day Waiting Period** effective for calendar year plans; California state **60-day Waiting Period** effective for calendar year plans

## JANUARY 2015

- **01/01/2015 – Employer Mandate** effective for calendar year plans