FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 35

December 20, 2016

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act, the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[1], and the 21st Century Cures Act (Cures Act)[2]. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at www.dol.gov/ebsa/healthreform/index.html and www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the laws and benefit from them, as intended.

Special Enrollment for Group Health Plans

Under HIPAA, group health plans and health insurance issuers providing group health insurance coverage are required to provide special enrollment periods to current employees and dependents during which otherwise eligible individuals who previously declined health coverage have the option to enroll under the terms of the plan (regardless of any open enrollment period). Generally, a special enrollment period must be offered for circumstances in which an employee or dependents lose eligibility for any group health plan or health insurance coverage in which the employee or their dependents were previously enrolled, and upon certain life events such as when a person becomes a dependent of an eligible employee by birth, marriage, or adoption.[3] The Children's Health Insurance Program (CHIP) Reauthorization Act added other special enrollment rights to group health plan coverage for circumstances in which an employee or dependents lose Medicaid or CHIP, or become eligible for assistance for group health plan coverage under Medicaid or CHIP. Special enrollment periods are available in several circumstances set forth in the Departments' regulations, including when (subject to certain exceptions) an individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and dependents' loss of coverage under the spouse's plan), when an employer terminates contributions toward health coverage (other than COBRA continuation coverage), or when coverage is no longer offered to a group of similarly situated individuals.[4] The Departments' regulations require that employees receive a notice of special enrollment at or before the time they are first offered the opportunity to enroll in the group health plan.

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[1] Pub. L. 104-191, 110 Stat. 1936.
[2] Pub.L. 114-255.
[3] Internal Revenue Code (Code) section 9801(f); Employee Retirement Income Security Act (ERISA) section 701(f); Public Health Service (PHS) Act section 2704(f); 26 CFR 54.9801-6(a); 29 CFR 2590.701-6(a); 45 CFR 146.117(a).
[4] Code section 9801(f)(1)(C); ERISA section 701(f)(1)(C); PHS Act section 2704(f)(1)(C); 26 CFR 54.9801-6 (a)(3); 29 CFR 2590.701-6(a)(3); 45 CFR 146.117(a)(3). A model notice is available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappc.pdf.

Q1: If an individual who enrolled in individual market health insurance coverage, including coverage purchased through a Marketplace, loses eligibility for that coverage, is the individual entitled to a special enrollment period in an employer-sponsored group health plan for which the individual is otherwise eligible and had previously declined to enroll?

Yes. Employees and their dependents are eligible for special enrollment in a group health plan if they are otherwise eligible to enroll in the plan, and at the time coverage under the plan was previously offered, they had other group health plan or health insurance coverage (regardless of whether the coverage was obtained inside or outside of a Marketplace) for which they have lost eligibility. Accordingly, if an individual loses eligibility for coverage in the individual market, including coverage purchased through a Marketplace (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact), that individual is entitled to special enrollment in group health plan coverage for which he or she is otherwise eligible. These individuals will be eligible for special enrollment in the group health plan coverage regardless of whether they may enroll in other individual market coverage, through or outside of a Marketplace.

Coverage of Preventive Services under the Affordable Care Act

PHS Act section 2713 and its implementing regulations[5] require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to cover without the imposition of any cost-sharing requirements, the following recommended preventive services:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009, which are not considered in effect for this purpose;[6]
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

[5] See 26 CFR 54.9815-2713, 29 CFR 2590.715-2713, 45 CFR 147.130.
[6] The USPSTF published updated breast cancer screening recommendations in January 2016. However, section 229 of the Consolidated Omnibus Appropriations Act of 2016 (Pub. L. 114-113) requires that for purposes of PHS Act section 2713, USPSTF recommendations relating to breast cancer screening, mammography, and prevention issued before 2009 remain in effect until January 1, 2018.

- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.[7]

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service, then the plan or issuer may use reasonable medical management techniques to determine any such coverage limitations.[8]

Q2: HRSA updated its Women's Preventive Services Guidelines on December 20, 2016. When must non-grandfathered group health plans and health insurance issuers begin offering coverage for preventive services without cost sharing based on the updated guidelines?

Women's preventive services are required to be covered without cost sharing in accordance with the updated guidelines for plan years (or, in the individual market, policy years) beginning on or after December 20, 2017.[9] Until the new guidelines become applicable, non-grandfathered group health plans and health insurance issuers are required to provide coverage without cost sharing consistent with the previous HRSA guidelines and PHS Act section 2713 for any items or services that continue to be recommended.

HRSA's updated women's preventive services guidelines were recently released based on recommendations developed by the Women's Preventive Services Initiative (WPSI), a coalition of national health professional organizations and consumer and patient groups with expertise in women's health. The update is available at https://www.hrsa.gov/womensguidelines2016. WPSI is led, through a competitive cooperative agreement, by the American College of Obstetricians and Gynecologists. In developing these guidelines, WPSI engaged its coalition of health professional organizations and consumer and patient advocates to develop, review, and update recommendations for women's preventive services.

These updated guidelines complement and build upon recommendations from entities such as the USPSTF. These recommendations update prior work by the Institutes of Medicine (IOM) to develop the initial Women's Preventive Service Guidelines, meet a recommended five-year benchmark for updates (by the IOM), and help ensure the guidelines remain current with the existing science and evidence-based practices. Similar to the processes of the USPSTF, ACIP, and Bright Futures[10] for developing evidence-based guidelines, WPSI established a process for stakeholders to provide public comment that included defining the scope of the recommended

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[7] Under the HRSA Women's Preventive Services Guidelines, group health plans established or maintained by religious employers (and group health insurance coverage provided in connection with such plans) are exempt from the requirement to cover contraceptive services under section 2713 of the PHS Act, as incorporated into ERISA and the Code. 45 CFR 147.131(a). Additionally, accommodations for religious objections to contraception are available to group health plans established or maintained by certain eligible organizations (and group health insurance coverage provided in connection with such plans), as well as student health insurance coverage arranged by eligible organizations, with respect to the contraceptive coverage requirement.

[8] See 26 CFR 54.9815-2713(a)(4), 29 CFR 2590.715-2713(a)(4), 45 CFR 147.130(a)(4).

[9] See 26 CFR 54.9815-2713(b), 29 CFR 2590.715-2713(b), 45 CFR 147.130(b).

[10] For more information on Bright Futures, see https://brightfutures.aap.org.

guidelines, identifying and assessing the evidence base, and disseminating the final HRSA-supported guidelines.

Qualified Small Employer Health Reimbursement Arrangements

On September 13, 2013, DOL published Technical Release 2013-03[11] addressing the application of the Affordable Care Act market reforms to health reimbursement arrangements (HRAs) and employer payment plans (EPPs).[12] The Treasury Department and the Internal Revenue Service (IRS) contemporaneously published parallel guidance in Notice 2013-54[13] and HHS issued guidance stating that it concurred in the application of the laws under its jurisdiction as set forth in the guidance issued by DOL, Treasury, and IRS.[14] Subsequent guidance reiterated and clarified the application of the market reforms to HRAs and EPPs.[15]

EPPs and HRAs typically consist of an arrangement under which an employer reimburses medical expenses (whether in the form of direct payments or reimbursements for premiums or other medical costs) up to a certain amount. As explained in Technical Release 2013-03 and Notice 2013-54, EPPs and HRAs are group health plans that are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual dollar limits under PHS Act section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713. The 2013 guidance generally provides that EPPs and HRAs will fail to comply with these group market reform requirements because these arrangements, by their definitions, reimburse or pay medical expenses on the employee's behalf only up to a certain dollar amount each year.

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[11] Technical Release 2013-03 is available at http://www.dol.gov/ebsa/newsroom/tr13-03.html.

[12] Section 1001 of the Affordable Care Act added new PHS Act sections 2711-2719. Section 1563 of the Affordable Care Act (as amended by Affordable Care Act section 10107(b)) added Code section 9815(a) and ERISA section 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

[13] 2013-40 IRB 287. Notice 2013-54 is available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf.

[14] See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf.

[15] There have been several issuances on the topics addressed in the 2013 guidance: (1) FAQs About Affordable Care Act Implementation (Part XI), issued on January 24, 2013 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca11.html) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (2) IRS Notice 2013-54 and DOL Technical Release 2013-03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements (http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements); (4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by DOL (http://www.dol.gov/ebsa/faqs/faq-aca22.html) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf); (5) Notice 2015-17, 2015-14 IRB 845, issued by Treasury and IRS on February 18, 2015; and (6) Notice 2015-87, 2015-52 IRB 889, Q&A-1 to Q&A-6, issued by Treasury and IRS on December 16, 2015. See also 26 CFR 54.9815-2711(d), 29 CFR 2590.715-2711(d), and 45 CFR 147.126(d) (80 FR 72192, Nov. 18, 2015).

The 2013 guidance further provided that an HRA will not fail to meet the group market reform provisions of the Affordable Care Act when "integrated" with a group health plan that otherwise complies with those provisions under the integration methods described in that guidance. On November 18, 2015, the Departments issued final regulations implementing PHS Act section 2711, which incorporate the general rule set forth in the 2013 guidance clarifying that an HRA or EPP cannot be integrated with individual market policies to satisfy the market reforms.[16]

Q3: The Cures Act, enacted on December 13, 2016, includes provisions allowing small employers to offer arrangements similar to an HRA or EPP that may be used to pay or reimburse for medical expenses, including coverage on the individual market. How do these provisions of the Cures Act affect the Departments' previous guidance regarding HRAs and EPPs?

To address concerns raised by application of the group market provisions to certain arrangements of small employers, section 18001 of the Cures Act introduces a new type of tax-preferred arrangement that small employers may use to help their employees pay for medical expenses – the "qualified small employer health reimbursement arrangement" (QSEHRA). The Cures Act amends Code section 9831, ERISA section 733, and PHS Act section 2791, and provides that a QSEHRA is not a group health plan.

Under the Cures Act, a QSEHRA is an arrangement offered by an eligible employer that meets the following criteria:

(1) The arrangement is funded solely by an eligible employer, and no salary reduction contributions may be made under the arrangement;
(2) The arrangement provides, after the employee provides proof of coverage for the payment to, or reimbursement of, an eligible employee for expenses for medical care (as defined in Code section 213(d)) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement);
(3) The amount of payments and reimbursements described in (2) for any year do not exceed $4,950 ($10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee) (with amounts to be indexed for increases in cost of living); and
(4) The arrangement is provided on the same terms[17] to all eligible employees of the eligible employer.

To be an eligible employer that may offer a QSEHRA, the employer may not be an applicable large employer (ALE) as defined in Code section 4980H(c)(2) (and thus may not be an employer that, generally, employed at least 50 full-time employees, including full-time equivalent

[16] 26 CFR 54.9815-2711(d), 29 CFR 2590.715-2711(d), and 45 CFR 147.126(d); See also 80 FR 72192, Nov. 18, 2015.
[17] Certain variations are permitted if they are in accordance with the variation in the price of an insurance policy based on age or number of family members. Code section 9831(d)(2)(C).

employees, in the prior calendar year) and may not offer a group health plan to any of its employees.

The Departments' prior guidance concluded that EPPs and non-integrated HRAs are group health plans that fail to comply with the group market reform requirements that prohibit annual dollar limits under PHS Act section 2711 and that require the provision of certain preventive services without cost sharing under PHS Act section 2713. Because a QSEHRA is statutorily excluded from the definition of a group health plan, the group market reform requirements do not apply to a QSEHRA. With respect to EPPs and HRAs that do not qualify as QSEHRAs, the Departments' prior guidance continues to apply.

The statutory exclusion of QSEHRAs from the group health plan definition is effective for plan years beginning after December 31, 2016. With respect to plan years beginning on or before December 31, 2016, the Cures Act provides that the relief under Notice 2015-17[18] applies. Q&A 1 of Notice 2015-17 provides that the excise tax under Code section 4980D will not be asserted with respect to employers that are not ALEs for any failure to satisfy the market reforms by EPPs that pay, or reimburse employees for, individual health policy premiums or Medicare Part B or Part D premiums. That relief was limited to periods before July 1, 2015. Employers eligible for that relief were not required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans under chapter 100 of the Code, including the market reforms) solely as a result of having such an arrangement for the periods prior to July 1, 2015.

Pursuant to the extension provided under the Cures Act, for plan years beginning on or before December 31, 2016, the excise tax under Code section 4980D will not be asserted for any failure to satisfy the market reforms by EPPs that pay, or reimburse employees for, individual health policy premiums or Medicare Part B or Part D premiums, with respect to employers otherwise eligible for the relief under Q&A 1 of Notice 2015-17. Such employers are also not required to file IRS Form 8928 solely as a result of having such an arrangement for the plan years beginning on or before December 31, 2016.

As noted in Q&A 1 of Notice 2015-17, the relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums. Consequently, the extension of the relief by the Cures Act is similarly limited to EPPs and does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums. In addition, as an employer-provided group health plan, coverage by an HRA or EPP that is not a QSEHRA and that is eligible for the extended relief under the Cures Act would
be minimum essential coverage. Consequently, a taxpayer would not be allowed a premium tax credit under Code section 36B for the Marketplace coverage of an employee, or an individual related to the employee, who is covered by an HRA or EPP other than a QSEHRA.[19]

[18] 2015-14 IRB 845.
[19] See Code section 36B(c)(2)(C)(iii).

Q&A 2 of Notice 2015-17 clarifies the treatment of certain S corporation healthcare arrangements for 2-percent shareholder employees, generally providing that, until additional guidance provides otherwise, taxpayers may continue to rely on Notice 2008-1[20] for all federal income and employment tax treatment of such arrangements, and that such arrangements will not be treated as failing to satisfy the market reforms. As additional guidance with respect to these arrangements has not been issued, the guidance under Q&A 2 of Notice 2015-17 continues to apply. The Cures Act's extension of the relief under Notice 2015-17 to plan years beginning on or before December 31, 2016 does not modify Q&A 2 of Notice 2015-17, which continues to apply to such arrangements until additional guidance provides otherwise.

As noted above, the Departments' prior regulations and guidance continue to apply with respect to EPPs and HRAs that do not qualify as QSEHRAs, including such arrangements offered by employers that are not eligible employers as defined under the Cures Act. An employer that is considered an applicable large employer as defined in Code section 4980H(c)(2) is not permitted to offer a QSEHRA.

[20] 2008-2 IRB 1.