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Implementing the Affordable Care Act: Delays, Extensions, and Other Actions Taken by the Administration

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Introduction

The two federal agencies primarily responsible for administering the private health insurance provisions in the Patient Protection and Affordable Care Act (ACA)—the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS), and the Internal Revenue Service (IRS) within the Treasury Department—have taken certain actions to delay, extend, or otherwise modify the law’s implementation.¹

Table 1 summarizes selected administrative actions taken by CMS and the IRS to address ACA implementation. The table entries, which are grouped under general topic headings, are not organized in any particular priority order. Each entry includes a brief summary of the action and some accompanying explanatory material and comments to help provide additional context. Where available, links are provided to relevant regulatory and guidance documents online. Readers are encouraged to review these documents for more details about each action taken.

This report is updated periodically to reflect significant ACA implementation actions taken by the Administration. A companion CRS report summarizes all the *legislative* actions taken by Congress since the ACA’s enactment to repeal, defund, delay, or otherwise amend the law.²

Actions Address Key Elements of the ACA

The actions summarized in **Table 1**, which address some of the ACA’s core insurance expansion provisions,³ are not the result of a single policy decision. They represent multiple separate decisions taken by the Administration to address a variety of factors affecting the implementation of specific provisions of the law. In compiling the table, CRS made decisions about which administrative actions to include, and which ones to leave out. Generally, CRS included the more significant actions that have been the subject of debate among health policy analysts and, in some instances, the target of criticism by opponents of the ACA. The table is not intended to be a comprehensive list of ACA-related administrative actions.

Employer Mandate Delays

Perhaps the most controversial action is the Administration’s decision to delay enforcement of the ACA’s “employer mandate.” On July 9, 2013, the IRS announced that it would not take

¹ The ACA was signed into law on March 23, 2010 (P.L. 111-148). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152), which amended numerous provisions in the ACA. HCERA also included multiple new freestanding provisions related to the ACA. Several other bills enacted during the 111th and 112th Congresses made additional changes to selected ACA provisions. All references to the ACA in this report refer, collectively, to the law as amended and to the related HCERA provisions.

² CRS Report R43289, *Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act*, by C. Stephen Redhead and Janet Kinzer.

³ A detailed examination of the ACA is beyond the scope of this report. Readers who are unfamiliar with the ACA’s provisions to restructure the private health insurance market and expand access to affordable health insurance through the competitive marketplaces—or exchanges—and the expansion of state Medicaid programs will find numerous CRS products that provide more in-depth information on the law at <http://www.crs.gov/pages/subissue.aspx?cliid=3746&parentid=13&preview=False>.

enforcement action against employers who fail to comply with the law's employer mandate until the beginning of 2015. This ACA provision, which took effect on January 1, 2014, requires employers with 50 or more full-time equivalent employees to offer their full-time workers affordable health coverage or pay a penalty if one or more employees purchase coverage through an exchange and receive a premium tax credit. The IRS subsequently announced that employers with at least 50 but fewer than 100 full-time equivalent employees will have an additional year to comply with the employer mandate. According to the Administration, these actions were taken after it concluded that the ACA's employer mandate could not be enforced until the related requirement that employers report the coverage they offer to their employees had been fully implemented. The IRS says that it is working with stakeholders to simplify the reporting process consistent with effective implementation of the law.⁴

Renewal of Noncompliant Plans

Other controversial administrative actions include those taken in response to the decision by insurers to cancel individual and small-group health plans that do not meet the ACA's new standards for health insurance coverage, which also took effect on January 1, 2014. On November 14, 2013, the Administration notified state insurance commissioners of the option to delay enforcement of certain health insurance reforms under the ACA. It encouraged state officials to permit insurers to renew noncompliant policies in the individual and small-group market for policy years starting between January 1, 2014, and October 1, 2014.⁵ The Administration has since extended this policy for two years. Thus, at the option of state regulators, insurers may continue to renew noncompliant policies at any time through October 1, 2016.⁶

Special Enrollment Periods and Hardship Exemptions

Finally, HHS has been criticized for providing a special enrollment period for individuals who were unable to enroll in a qualified health plan (QHP) offered through a federally facilitated exchange prior to the March 31, 2014, deadline due to technical problems or other exceptional circumstances.⁷ The special enrollment period allows the individuals to enroll in a QHP after the 2014 open enrollment period closes. These individuals were also granted a hardship exemption from the ACA's "individual mandate" penalty. Under the law, most U.S. citizens and legal residents are required to maintain ACA-compliant health coverage beginning in 2014. Those without coverage for three consecutive months are subject to a penalty unless they qualify for one of the statutory exemptions or are covered under a hardship exemption established by CMS.

⁴ Internal Revenue Service, "Transition Relief for 2014 Under §§ 6055 (Information Reporting), 6056 (Information Reporting) and 4980H (Employer Shared Responsibility Provisions)," Notice 2013-45, July 9, 2013, <http://www.irs.gov/pub/irs-drop/n-13-45.PDF>.

⁵ The White House, "Fact Sheet: New Administration Proposal to Help Consumers Facing Cancellations," November 14, 2013, <http://www.whitehouse.gov/the-press-office/2013/11/14/fact-sheet-new-administration-proposal-help-consumers-facing-cancellatio>.

⁶ Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Insurance Standards Bulletin Series - Extension of Transitional Policy through October 1, 2016," March 5, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

⁷ Department of Health & Human Services, Centers for Medicare & Medicaid Services, "Guidance for Issuers on Special Enrollment Periods for Complex Cases in the Federally-facilitated Marketplace after the Initial Open Enrollment Period," March 26, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf>.

Arguments For and Against the Administrative Actions

Opponents of the ACA, who believe that the law is fundamentally flawed, argue that some of the Administration's actions effectively rewrite the law in an effort to make it work and confuse the public. The ACA's critics also assert that the actions taken by the Administration to delay enforcement of the employer mandate are illegal and raise concerns that the President is not upholding his constitutional duty to faithfully execute federal law.⁸

The Administration counters that its actions are not a refusal to implement and enforce the ACA as written. Instead, they represent temporary corrections necessary to ensure the effective implementation of a very large and complex law. Agency officials point to a number of factors that have made it difficult to meet various ACA deadlines. Those factors include a lack of appropriations to help fund implementation activities, technological problems including the poorly managed launch of the websites for the federally facilitated exchange and the state-based exchanges, and the need to phase in the various interconnected parts of the law so as to avoid unnecessary disruption of employment and insurance markets.⁹

Regarding the employer mandate delay, the Administration says that its actions are no different from those taken by previous administrations faced with the challenges of implementing a complicated law. The Administration notes that its decision to grant employers "transition relief," taken pursuant to administrative authority under the Internal Revenue Code to "prescribe all needful rules and regulations" to administer tax laws,¹⁰ is part of an established practice to provide relief to taxpayers who might otherwise struggle to comply with new tax law.¹¹

Notwithstanding the Administration's arguments, critics question whether some of the recent delays of ACA provisions exceed the executive's traditional discretion in enforcing law to the point that they represent a blatant disregard of the law. For example, they argue that the decision to encourage states to allow insurers to renew noncompliant policies for people who want to keep their current plans directly contravenes provisions of the ACA that had become politically inconvenient.¹²

⁸ Simon Lazarus, "Delaying Parts of Obamacare: 'Blatantly Illegal' or Routine Adjustment?," *The Atlantic*, July 17, 2013, <http://www.theatlantic.com/national/archive/2013/07/delaying-parts-of-obamacare-blatantly-illegal-or-routine-adjustment/277873/>.

⁹ Timothy Stoltzfus Jost and Simon Lazarus, "Obama's ACA Delays - Breaking the Law or Making it Work?," *New England Journal of Medicine*, April 2, 2014, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1403294>.

¹⁰ Section 7805(a) of the Internal Revenue Code; 26 U.S.C. §7805(a).

¹¹ Letter from Mark J. Mazur, Assistant Secretary for Tax Policy, to Honorable Fred Upton, Chairman, Committee on Energy and Commerce, July 9, 2013, <http://democrats.energycommerce.house.gov/sites/default/files/documents/Upton-Treasury-ACA-2013-7-9.pdf>. For a legal analysis of the Administration's decision to delay enforcement of the employer mandate, see CRS Legal Sidebar, *Obama Administration Delays Implementation of ACA's Employer Responsibility Requirements: A Brief Legal Overview*, posted July 8, 2013, <http://www.crs.gov/LegalSidebar/details.aspx?ProdId=582>.

¹² Nicholas Bagley, "The Legality of Delaying Key Elements of the ACA," *New England Journal of Medicine*, April 2, 2014, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1402641>. For a legal analysis of the Administration's decision to permit insurers to renew noncompliant policies for individuals and small businesses, see CRS Legal Sidebar, *Obama Administration's "Fix" for Insurance Cancellations: A Legal Overview*, posted November 18, 2013, <http://www.crs.gov/LegalSidebar/details.aspx?ProdId=724>.

Congressional Lawsuit

On July 30, 2014, the House voted 225-201 to approve a resolution (H.Res. 676) authorizing litigation “for actions by the President or other executive branch officials inconsistent with their duties under the Constitution of the United States.”¹³ The resolution authorizes Speaker John Boehner to sue the Obama Administration on behalf of the House of Representatives over implementation of the private health insurance provisions (i.e., Title I) of the ACA. The Speaker has indicated that any such lawsuit would specifically challenge the Administration’s delay of the ACA employer mandate. “In 2013, the President changed the health care law without a vote of Congress, effectively creating his own law by literally waiving the employer mandate and the penalties for failing to comply with it,” said Mr. Boehner.¹⁴

¹³ Full text of the resolution is at <http://www.gpo.gov/fdsys/pkg/BILLS-113hres676rh/pdf/BILLS-113hres676rh.pdf>. H.Res. 676 is a simple resolution; that is, a non-legislative measure that is effective only in the chamber in which it was approved. It does not require concurrence by the other chamber (Senate) or approval by the President.

¹⁴ Jonathan Weisman, “Suit Against Obama to Focus on Health Law, Boehner Says,” *New York Times*, July 10, 2014, http://www.nytimes.com/2014/07/11/us/politics/boehner-says-obama-lawsuit-will-focus-on-health-law.html?ref=us&_r=0.

Table I. Selected Administrative Delays and Other Changes to ACA Implementation

Summary of Administrative Action	Explanatory Notes and Comments
<p>Hardship Exemptions and Special Enrollment Periods</p> <p>On October 28, 2013, CMS announced a hardship exemption from the individual mandate penalty for individuals who waited until after February 15, 2014, to enroll in a qualified health plan (QHP) offered through an exchange during the 2014 open enrollment period. See http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf. [Note: HHS followed that action with additional announcements aimed at individuals seeking to enroll for coverage beginning January 1, 2014. For example, on November 22, 2013, HHS extended the December 15 deadline to sign up for health coverage beginning January 1 by eight days, to December 23. Citing delays due to heavy use of Healthcare.gov, HHS on December 23 announced a 24-hour grace period for individuals trying to sign up for coverage beginning January 1, effectively extending the deadline to December 24. For more information, see <a data-bbox="176 683 562 711" href="http://www.nytimes.com/interactive/2013/12/20/us/politics/changes-and-delays-to-health-law.html?_r=1&.">http://www.nytimes.com/interactive/2013/12/20/us/politics/changes-and-delays-to-health-law.html?_r=1&.]</p> <p>On March 26, 2014, five days prior to the close of the 2014 open enrollment period, CMS announced that people who attested that they were unable to enroll in a QHP through the federally facilitated exchange for various specified circumstances would be eligible for a special enrollment period (pursuant to ACA Section 1311(c)(6)(C), as implemented by 45 C.F.R. 155.420) enabling them to enroll after open enrollment closed on March 31. These individuals also were eligible for a hardship exemption for the months prior to the effective date of their coverage, because they were treated as if they had enrolled in coverage by March 31. On May 2, 2014, CMS announced a comparable hardship exemption for all the months prior to the effective date of coverage for those individuals who obtained MEC effective on or before May 1, 2014, outside of an exchange.</p> <p>On May 2, 2014, CMS also announced (1) a special enrollment period through July 1, 2014, for individuals eligible for or enrolled in COBRA continuation coverage, giving them the option of enrolling in a qualified health plan through a federally facilitated exchange; (2) a special enrollment period for individuals whose individual health plans are up for renewal, giving them the option of enrolling in a qualified health plan through a federally facilitated exchange; and (3) special enrollment periods and hardship exemptions for individuals beginning or ending their service in AmeriCorps, VISTA, or the National Civilian Community Corps (NCCC). For more information, see http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf.</p>	<p>ACA Section 1501(b) requires most U.S. citizens and legal residents to maintain minimum essential coverage (MEC) beginning in 2014. Individuals without coverage for three consecutive months will have to pay a penalty unless they qualify for one of the statutory exemptions or are covered under a hardship exemption established by CMS.</p> <p>CMS specified in regulation (45 C.F.R. 155.410) that the initial open enrollment period for individuals to enroll in coverage through an exchange would extend from October 1, 2013, through March 31, 2014. For individuals who sign up for coverage between the 1st and 15th of a given month, the coverage effective date is the first day of the immediately following month. However, for those who sign up between the 16th and end of a given month, the coverage effective date is the first day of the second following month. Thus, an individual who signed up on February 16, 2014, would not be insured until April 1, 2014. That individual would be uninsured for the first three months of 2014 and would have to pay a fine, unless otherwise exempt. CMS exercised its authority under IRC Section 5000A(e)(5), as added by ACA Section 1501(b), to establish a hardship exemption in order to provide relief for such individuals who waited until after February 15, 2014, to enroll.</p> <p>The circumstances that warrant a special enrollment period include a natural disaster, a serious medical condition, unresolved casework, errors related to immigration status, and technical problems with Healthcare.gov. For a complete list, see http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf.</p> <p>State-based exchanges are encouraged to adopt similar special enrollment periods to the ones established for federally facilitated exchanges.</p>

Summary of Administrative Action

Explanatory Notes and Comments

State-Based Exchanges and Retroactive Payment of Subsidies

On February 27, 2014, CMS issued guidance allowing state-based exchanges to provide advance payments of the premium tax credit and cost-sharing reductions on a retroactive basis for eligible individuals who were unable to enroll in a QHP through the exchange because IT problems prevented timely eligibility determinations. CMS considers this situation an exceptional circumstance under 45 C.F.R. 155.420. Once a successful eligibility determination is obtained and the individual enrolls in the QHP through the exchange, the exchange may deem the coverage to have started on the date the individual originally submitted an application and encountered the IT problems. This would allow the individual to get the premium tax credit and cost-sharing reductions retroactively if they qualify based on income.

Additionally, if an individual covered under this exceptional circumstance has enrolled in the QHP outside of the exchange, then once that individual receives an eligibility determination for exchange coverage, the exchange may deem the individual to have been enrolled in the QHP through the exchange retroactive to the date the individual enrolled outside of the exchange. Again, this would allow the individual to get the premium tax credit and cost-sharing reductions retroactively if he or she qualifies based on income. Upon making an eligibility determination, the exchange also must provide a special enrollment period under 45 C.F.R. 155.420 to allow these individuals the opportunity to change QHPs prospectively.

Individuals must receive an eligibility determination in order to enroll in a QHP offered through an exchange and receive the premium tax credit and cost-sharing reductions authorized by the ACA.

The February 27, 2014, guidance is at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf>. CMS issued clarifications to the February 27 guidance on March 14; see <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/retroactive-advance-payments-ptc-csrs-03-14-14.pdf>.

Renewal of Noncompliant Health Plans

On November 14, 2013, the Administration established a transition policy—which it encouraged state insurance commissioners to adopt—in response to the decision of insurers to send cancellation notices to individuals and small businesses with health plans in the individual and small group markets that did not meet the ACA’s new standards for health insurance coverage. Under the policy, insurers could choose to renew such noncompliant health plans for a policy year starting between January 1, 2014, and October 1, 2014, if permitted by state regulators. CMS also indicated that it would consider the impact of this transition policy in assessing whether to extend it. The intent of the policy was to allow Americans whose insurance companies cancelled their insurance coverage for 2014 to remain in their plans. See <http://www.whitehouse.gov/the-press-office/2013/11/14/fact-sheet-new-administration-proposal-help-consumers-facing-cancellatio>.

On December 19, 2013, CMS issued further clarification of the options available to consumers with cancelled policies. These consumers are eligible for a hardship exemption from the individual mandate penalty if other available options are unaffordable, or they can purchase a catastrophic plan if one is offered in their area. See <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf>.

Under the ACA, health plans that consumers had at the time the law was enacted in 2010 were “grandfathered” in and have existed largely unchanged since the law’s enactment. Grandfathered plans do not have to adopt many of the ACA’s new requirements for health insurance, including coverage of essential health benefits and other consumer protections that took effect at the beginning of 2014. However, new (i.e., non-grandfathered) plans purchased since the law’s enactment have to meet all the ACA requirements. For a January 8, 2014, update on state decisions regarding the transition policy on health plan cancellations, see <http://www.commonwealthfund.org/Blog/2013/Nov/State-Decisions-on-Policy-Cancellations-Fix.aspx>.

Summary of Administrative Action

Explanatory Notes and Comments

On March 5, 2014, CMS extended the transition policy for two years, to policy years beginning on or before October 1, 2016. Thus, at the option of state regulators, insurers who issued (or plan to issue) a policy in the individual or small group market under the November 14, 2013, transition policy may renew such policies at any time through October 1, 2016. CMS also indicated that it would consider the impact of the two-year extension in assessing whether an additional one-year extension is appropriate. CMS also extended the hardship exemption established for consumers with cancelled policies until October 1, 2016. See <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

Exchange Applicant Eligibility and Verification

HHS's July 15, 2013, final rule on health insurance exchange eligibility and enrollment included two, one-year delays regarding verification of applicant information. First, the rule permits state-based exchanges during 2014 to audit fewer than 100% of exchange applicants who report income at least 10% below the amount indicated by IRS and SSA records, provided the sample size used is statistically significant. The government initially had proposed an audit of all such individuals.

Second, state-based exchanges will not be required until 2015 to verify applicants' information about employer coverage in order to determine eligibility for premium tax credits. During 2014 the exchanges may accept an applicant's attestation regarding employer coverage without further verification. See 78 *Federal Register* 42159, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

Under IRC Section 36B(b), as added by ACA Section 1401(a), individuals and families who enroll in qualified health plans (QHPs) offered through an exchange are eligible for refundable premium tax credits if their income is between 100% and 400% of the federal poverty level.

Under IRC Section 36B(c)(2)(C), as added by ACA Section 1401(a), individuals whose employer offers a health plan that is affordable (i.e., the employee's share of the premium does not exceed 9.5% of the employee's household income) and provides minimum value (i.e., the plan's share of the total allowed costs of benefits provided under the plan is at least 60%) are not eligible for a premium tax credit through the exchange.

2015 Open Enrollment

On November 22, 2013, HHS announced that it was planning to delay by one month the open enrollment period for plan years that begin in 2015. The dates for the 2015 open enrollment period were included in the final rule for benefit and payment parameters for 2015, which was published on March 11, 2014. See 79 *Federal Register* 13743, <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>.

The open enrollment period for 2015 will begin November 15, 2014—instead of October 15, 2014—and extend through February 15, 2015.

Employer Mandate and Insurer Reporting

On July 9, 2013, the IRS provided transition relief to employers by delaying until 2015 the ACA requirement that employers with at least 50 full-time equivalent employees provide health coverage for their full-time workers or risk paying a penalty. The IRS also delayed until 2015 the requirement for employers and insurers to report certain information to the IRS. The agency indicated that these actions were taken pursuant to its administrative authority under IRC Section 7805(a) to grant transition relief when implementing new legislation. See <http://www.irs.gov/pub/irs-drop/n-13-45.PDF>.

The IRS's February 12, 2014, final rule on the ACA's employer mandate included an additional year of transition relief for employers with at least 50 but fewer than 100 full-time equivalent employees, provided the employers meet certain other requirements such as not reducing their workforce to qualify for the additional relief and maintaining previously offered coverage. These employers would not be subject to the ACA's employer mandate until 2016. In addition, employers subject to the mandate in 2015 (i.e., those with 100 or more full-time equivalent employees) can avoid a penalty by offering coverage to at least 70% of their full-time employees, as opposed to 95% of such employees (as described in the explanatory notes). See 79 *Federal Register* 8543, <http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf>.

Generally, under IRC Section 4980H ("Shared Responsibility for Employers Regarding Health Coverage"), as added by ACA Section 1513, employers with at least 50 full-time equivalent employees are liable for a penalty if (1) they do not offer health coverage or they offer coverage to fewer than 95% of their full-time employees (and their dependents) and at least one full-time employee receives a premium tax credit for coverage purchased through an exchange; or (2) they offer health coverage to all or at least 95% of full-time employees, but at least one full-time employee receives a premium tax credit for coverage purchased through an exchange because the employer didn't offer coverage to that employee or because the coverage offered was either unaffordable or did not provide minimum value (see explanatory note for "Exchange Applicant Eligibility and Verification"). IRC Section 6055, as added by ACA Section 1502(a), requires reporting by insurers, self-insuring employers, and other parties that provide health coverage. IRC Section 6056, as added by ACA Section 1514(a), requires certain employers to report on the health coverage they offer to their full-time employees. For more information on the ACA employer mandate, including transition relief, see <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>.

W-2 Reporting of Employer-Sponsored Health Coverage

In a series of notices, the IRS has provided transition relief to employers by giving them additional time to make any necessary changes to payroll systems and procedures in order to comply with the ACA's W-2 reporting requirement. First, it made reporting on the 2011 W-2—typically provided to employees in January 2012—optional. Second, while employers are generally required to report the cost of health benefits on the W-2 for 2012 and subsequent years, the IRS has provided transition relief for certain employers and with respect to certain types of coverage. Employers covered by the transition relief are not required to report until future guidance is issued.

IRC Section 6051(a), as amended by ACA Section 9002, generally requires the cost of employer-sponsored health coverage to be reported on Form W-2 (Wage and Tax Statement). This reporting requirement applies to taxable years beginning after December 31, 2010. For more information on the W-2 reporting requirement and associated transition relief, see <http://www.irs.gov/uac/Employer-Provided-Health-Coverage-Informational-Reporting-Requirements-Questions-and-Answers>.

Annual Limits on Cost-Sharing and Deductibles

Plans may use more than one service provider to help administer benefits (e.g., a separate pharmacy benefits manager for coverage of pharmaceuticals), each of which may impose different cost-sharing. To allow service providers more time to coordinate their cost-sharing requirements so that the plan meets the ACA's annual cost-sharing limits, the Administration on February 20, 2013, announced a one-year grace period to allow each service provider to apply the cost-sharing limits to the benefits they administer. Under this policy, for example, many group health plans will be able to maintain separate cost-sharing limits for medical coverage (e.g., hospital and doctors' services) and for prescription drug coverage. However, this policy applies only to the first plan year beginning in 2014. See <http://www.dol.gov/ebsa/faqs/faq-aca12.html>.

PHSA Section 2707(b), as added by ACA Section 1201, requires group health plans to ensure that any annual cost-sharing (e.g., deductibles, coinsurance, copayments) imposed under the plan for a plan year beginning on or after January 1, 2014, does not exceed the limitations established under ACA Section 1302(c)(1) and (c)(2). Under ACA Section 1302(c)(1), annual cost-sharing for a plan year beginning in 2014 may not exceed the current-law Health Savings Accounts limits; for each plan year thereafter these limits are indexed to the percentage increase in average per-capita premiums. Under ACA Section 1302(c)(2), which applies only to the small group market, the deductible for a plan year beginning in 2014 may not exceed \$2,000 for individuals and \$4,000 for families; again, for each plan year thereafter these limits are indexed to the percentage increase in average per-capita premiums.

Summary of Administrative Action

Explanatory Notes and Comments

Pre-Existing Condition Insurance Plan (PCIP)

On March 14, 2014, HHS announced that individuals enrolled in a PCIP who had not yet found new health insurance coverage through an exchange could purchase an additional month of PCIP coverage through April 30, 2014, at which time the program would be terminated. [Note: The PCIP program was originally scheduled to terminate on January 1, 2014. However, on December 12, 2013, HHS announced that the PCIP program would be extended through the end of January 2014. Then on January 14, 2014, HHS announced that individuals could keep their PCIP coverage for two additional months, through March 31, 2014.]

HHS provided former PCIP participants with a 60-day special enrollment period, beginning on May 1, 2014, to enroll in a QHP offered through an exchange. The new coverage is effective back to May 1 to avoid a lapse in health insurance coverage.

ACA Section 1101 instructed the HHS Secretary to establish a temporary program—PCIP—to provide health insurance coverage for eligible individuals who have been uninsured for six months and have a pre-existing condition. PCIP was federally administered in 23 states and DC; the remaining states administered their own PCIPs. The ACA appropriated \$5 billion, to remain available without fiscal year limitation, to pay claims against (and administrative costs of) PCIPs that are in excess of premiums collected from enrollees. The federally-run PCIP and state-run PCIPs stopped accepting new enrollees on February 16, 2013, and March 2, 2013, respectively, because of the finite amount of available funding. Under the law, PCIP coverage was to end on January 1, 2014, and the Secretary was instructed to develop procedures for transitioning individuals enrolled in PCIP into qualified health plans offered through the exchanges. However, ACA Section 1101(g)(3) gave the Secretary the authority to extend PCIP coverage, if necessary, to avoid a lapse in coverage for such individuals. For more information, see <https://www.pcip.gov/>.

Basic Health Plan Option

On February 7, 2013, HHS announced that implementation of the Basic Health Program (BHP) would be delayed by one year until 2015. The BHP gives states the option of using ACA subsidies to help cover certain low-income individuals whose income is too high to qualify for Medicaid. See <http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-BHP.pdf>.

ACA Section 1331, as amended, permits states to establish a BHP in which states contract with private-sector and cooperative health plans to provide health insurance coverage for certain low-income individuals not eligible for the state's Medicaid program with incomes between 133% and 200% of the federal poverty level. States that decide to offer a BHP receive federal funding equal to 95% of the value of the premium tax credits and cost-sharing subsidies that eligible individuals would have received had they purchased coverage through an exchange. For more information, see <http://medicaid.gov/Basic-Health-Program/Behavioral-Health-Program.html>.

Summary of Administrative Action

Explanatory Notes and Comments

Small Business Health Options Program (SHOP) Exchanges

HHS's June 4, 2013, final rule for the SHOP exchanges included a transition policy that delayed until 2015 the implementation of **employee choice** in federally facilitated SHOP exchanges. For plan years beginning in 2014, federally facilitated SHOP exchanges will only allow employers to select one QHP to offer to their employees, while state-based SHOP exchanges may allow employers to choose one or more QHPs to offer to their employees. See 78 *Federal Register* 33233, <http://www.gpo.gov/fdsys/pkg/FR-2013-06-04/pdf/2013-13149.pdf>. HHS's May 27, 2014, final rule on exchange and market standards for 2015 gives state insurance commissioners the option to recommend that a SHOP exchange delay implementation of employee choice until 2016. See 79 *Federal Register* 30239, <http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>.

On November 27, 2013, HHS announced that federally facilitated SHOP exchanges will not accept **online enrollments** for one year, until November 2014. In the meantime, small businesses can enroll in plans listed on these exchanges through an insurance agent or broker, or directly with the insurance carrier. [Note: This announcement represented the third delay in launching the online SHOP exchange, which was originally expected to be fully functional at the beginning of October 2013.] See <http://www.hhs.gov/healthcare/facts/blog/2013/11/direct-new-path-to-shop-marketplace.html>. On March 14, 2014, CMS announced that it would consider requests from states that are not yet able to enroll small businesses through their SHOP exchanges online to use the same direct enrollment approach that the federally facilitated SHOP exchanges have implemented for 2014. See <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/retroactive-advance-payments-ptc-csrs-03-14-14.pdf>.

Electronic Reporting

HHS's July 15, 2013, final rule on health insurance exchange eligibility and enrollment delayed until 2015 a requirement that state Medicaid agencies provide notices electronically to beneficiaries. Between October 1, 2013, and January 1, 2015, state Medicaid agencies must give individuals the choice to receive notices in electronic format or by regular mail. Agencies must ensure that an individual's choice to receive electronic notices is confirmed by regular mail, and must inform the individual of his or her right to switch to receiving notice through regular mail. [42 C.F.R. 435.918] See 78 *Federal Register* 42159, <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

ACA Section 1311 requires each state (or the federal government on its behalf) to establish a SHOP exchange through which small employers will be able to purchase plans for their employees. Initially, states can choose to open SHOP exchanges to companies with up to 100 employees or limit participation to companies with 50 or fewer employees. By 2016, states must open the exchanges to companies with up to 100 employees. Beginning in 2017, states have the option to open SHOP exchanges to companies with more than 100 employees. Employers with fewer than 25 employees may qualify for tax credits if they purchase insurance coverage for their employees through a SHOP exchange. For more information, see <https://www.healthcare.gov/small-businesses/>.

Employee choice refers to giving employees the option to choose from more than one QHP offered by an employer. Under this policy, an employer picks a level of coverage based on actuarial value (i.e., the bronze, silver, gold, or platinum tier) and the employees can then choose any plan offered within that tier of coverage.

Eighteen states with a federally facilitated SHOP exchange have elected to delay employee choice until 2016. The remaining 14 states with a federally facilitated SHOP exchange will join most state-based SHOP exchanges in making employee choice available in 2015. See <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html>.

Exchanges must also provide required notices by regular mail or, if an individual elects, electronically, provided that the specifications for electronic notices in 42 C.F.R. 435.918 are met. However, exchanges may choose to delay until 2015 the requirement in 42 C.F.R. 435.918(b)(1) that individuals who elect to receive electronic notices receive confirmation by mail. [45 C.F.R. 155.230(d)]

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