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The Obama Administration Delays Implementation of Several Key Affordable Care Act

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In separate recent announcements, the Obama administration has delayed implementation of several key provisions of the Affordable Care Act ("ACA") to provide affected stakeholders additional time to rollout certain ACA requirements.

ACA's mandate provisions

On July 2, 2013, the Department of Treasury **announced** that the Administration will provide an additional year before the ACA's mandatory employer and insurer reporting requirements begin. In its announcement, the Treasury Department stated that the reporting requirements will be voluntary in 2014 and mandatory in 2015. Likewise, the large employer shared responsibility payments will not apply until 2015.The Treasury Department explicitly acknowledged its concerns regarding the complexity of the reporting requirements and the need for additional time to implement them effectively. The U.S. House of Representatives will vote this week to affirm the delay in the employer mandate. Significantly, there also will be a vote to delay the individual mandate implementation until 2015.

Final rule for strengthening medicaid, the Children's Health Insurance Program ("CHIP") and the new health insurance marketplace (CMS-2334-F)

Additionally, the Centers for Medicare & Medicaid Services ("CMS") issued a **Final Rule** that provided for delays of additional ACA provisions regarding Medicaid, CHIP and health insurance exchanges ("Exchanges"). According to **Fact Sheet (CMS-2334-F)** released by CMS published on July 5, 2013, the Final Rule aims to assist states in the preparation for the availability of new coverage. Notably, the CMS' fact sheet that was issued with the Final Rule does not emphasize that the implementation of several of the key provisions relating to the programs have been delayed.

In particular, the Final Rule delays the requirements regarding the verification of employees' access to employer-sponsored health insurance coverage until the 2015 plan year. Specifically, CMS' commentary published with the Final Rule provides:

> After reviewing and considering the appropriate public comments and completing a technical analysis, we have concluded that the service described in the proposed rule is not feasible for implementation for the first year of operations. This service would involve a large amount of systems development on both the state and federal side, which cannot occur in time for October 1, 2013. As such, in the final rule, we maintain the proposed language, with a clarification that the option to rely on HHS to perform this verification is effective for eligibility determinations that are effective on or after January 1, 2015 —meaning that the Exchange will be able to rely on HHS to perform this function as part of the eligibility determination system under section 1411 of the Affordable Care Act beginning with open enrollment for the 2015 plan year.
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> To provide relief to state-based Exchanges that were planning to rely on this service, we note that we are also delaying the date by which an Exchange must implement the sample-based review. For

> eligibility determinations for insurance affordability programs that are effective before January 1, 2015, we added paragraph (d)(3)(iv) to specify that if the Exchange does not have any of the information specified in §155.320(d)(2)(i) through (d)(2)(iii) for an applicant, the Exchange may accept the applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification, instead of following the procedure in §155.320(d)(3)(iii).
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> While we believe it is important for Exchanges to implement the procedure in §155.320(d)(3)(iii) to support program integrity and minimize financial risks on behalf of the tax filer at reconciliation, we acknowledge that some Exchanges may not have the resources and operational capability to conduct the sampling process in the first year.

Several proposed changes in the **Proposed Rule**, published on January 22, 2013, were not addressed in the Final Rule. CMS states that the Final Rule includes the provisions that are the "most important for implementation" of the ACA in 2014 . For example, the Final Rule does not address proposed provisions regarding Small Business Health Options Program ("SHOP") coordination with individual market Exchanges. CMS expects to address these outstanding proposals in future rulemaking.

Additionally, for income verification, CMS is providing Exchanges with temporary expanded discretion to accept an attestation of projected annual household income without further verification for the first year of operations, as described in greater detail in the Final Rule. For 2014, a statistically valid sample will be conducted to audit individuals with large income discrepancies. Thereafter, audit standards will tighten.

The Final Rule includes the following key provisions:

- Provides options for a coordinated eligibility determination appeals process between the Exchanges, state Medicaid and the CHIP;
- Allows state Medicaid programs to delegate the authority to conduct Medicaid fair hearings to the Exchanges, provided certain conditions are satisfied;
- Creates parameters surrounding notices to applicants, enrollees and beneficiaries to include clear and accurate information regarding eligibility for health coverage;
- Provides guidance on the design and use of Alternative Benefit Plans (formerly known as benchmark and benchmark-equivalent plans) and their coverage of essential health benefit plans;
- Updates and simplifies policies on Medicaid premium and cost-sharing requirements, including permitting higher cost sharing for prescription drugs and non-emergency use of emergency rooms, and updates the maximum allowable cost-sharing levels;
- Announces that Medicaid and CHIP agencies will begin accepting the single streamlined application during the initial open enrollment period (October 1, 2013–January 1, 2014);
- Provides guidance to state Medicaid plans on the procedures for the Exchanges to verify access to employer-sponsored coverage and ensure whether individuals are eligible for premium tax credits or cost-sharing reductions within the Exchanges; and
- Finalizes policies regarding hospitals' ability to make presumptive eligibility determinations.

GAO report

These announcements come shortly after the release of the two separate June 19, 2013 reports published by the Government Accountability Office ("GAO"), **Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges** and **Status of Federal and State Efforts to Establish Health Insurance Exchanges for Small Businesses**, each cast doubt on the timely and smooth implementation of the Exchanges.

Because enrollment in the Exchanges is scheduled to begin in October 2013, it is likely there will be significant additional guidance related to ACA's implementation released by the federal departments in the upcoming months. Industry stakeholders should carefully monitor developments for future guidance.

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