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

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March 3, 2015

Congressional Research Service

7-5700

www.crs.gov

R43474

Summary

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 a series of actions to delay, extend, or otherwise modify the law’s implementation.

The most significant of these actions was the decision by the IRS to delay implementation of the law’s “employer mandate.” This ACA provision, which took effect on January 1, 2014, requires employers with 50 or more full-time equivalent employees (FTEs) to offer their full-time workers health coverage that meets certain standards of affordability and minimum value. Those employers who do not provide such coverage risk having to pay a penalty if one or more of their employees obtain subsidized coverage through an exchange. The IRS announced that it would not take any enforcement action against employers who fail to comply with the law’s employer mandate until the beginning of 2015. Subsequently, the agency announced that employers with at least 50 but fewer than 100 FTEs would have an additional year to comply with the employer mandate.

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 standards for health insurance coverage, which also took effect on January 1, 2014.

Opponents of the ACA argue that these administrative actions are an attempt to rewrite the law in order to make it work. They assert that some of the Administration’s actions are illegal and raise concerns that the President is not upholding his constitutional duty to faithfully execute federal law. The Administration counters that its actions are authorized by federal law and represent temporary corrections necessary to ensure the effective implementation of a very large and complex act.

On July 30, 2014, the House approved a resolution (H.Res. 676) authorizing Speaker John Boehner, on behalf of the House, to sue the President or other executive branch officials for failing to “to act in a manner consistent with [their] duties under the Constitution and laws of the United States with respect to implementation of the [ACA].” A lawsuit was filed on November 21, 2014, consisting of two counts. First, it claimed that the Administration had violated the Constitution by delaying the ACA employer mandate. Second, the lawsuit challenged the Administration’s authority to pay cost-sharing subsidies, arguing that the law had not appropriated any funding for them.

This report summarizes selected administrative actions taken by CMS and the IRS to address ACA implementation. A companion product, CRS Report R43289, *Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act*, summarizes all the legislative actions taken by Congress since the ACA’s enactment to repeal, defund, delay, or otherwise amend the law.

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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 a series of actions to delay, extend, or otherwise modify the law’s implementation.¹

Table 1 summarizes the more significant actions taken to date, which target implementation of the ACA’s complex set of interconnected provisions to expand private insurance coverage for the medically uninsured and underinsured.² These actions are not the result of a single policy decision. Instead, they represent many separate decisions taken by the Administration to address a variety of factors affecting the implementation of specific provisions of the law.

The Administration announced a series of delays and other changes before and during the first (i.e., 2014) open enrollment period and the problematic launch of the federal—and some state-run—exchanges. The second (i.e., 2015) open enrollment period that closed on February 15, 2015, experienced far fewer administrative and technical problems. Recent administrative actions have largely focused on the ACA’s tax provisions. The 2014 tax filing season (deadline April 15, 2015) is the first one in which individuals must indicate on their tax return whether they have health insurance coverage that meets the ACA’s standards. Those without coverage risk being penalized unless they can claim an exemption. In addition, everyone who enrolled in coverage for 2014 through an exchange and received advance payments of the premium tax credit must file a federal tax return in which they reconcile those payments with the actual tax credit to which they are entitled.

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 many instances, the target of criticism by opponents of the ACA. It is important to keep in mind that the table is not—nor is it intended to be—a comprehensive list of ACA-related administrative actions.

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, including the motivation and legal authority for taking it.

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 some new health reform provisions. Several other bills enacted during the 111th, 112th, and 113th Congresses made additional changes to specific ACA provisions. All references to the ACA in this report refer, collectively, to the law as amended and to the related HCERA provisions.

² 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>.

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.³

Employer Mandate Delays

Perhaps the most controversial administrative action taken by the Administration was its decision to delay enforcement of the ACA's "employer mandate." On July 9, 2013, the IRS announced that it would not take any enforcement action against employers who fail to comply with the law's employer mandate until the beginning of 2015 (see **Table 1**). This ACA provision, which took effect on January 1, 2014, requires employers with 50 or more full-time equivalent employees (FTEs) to offer their full-time workers health coverage that meets certain standards of affordability and minimum value. Those employers who do not provide such coverage risk having to pay a penalty if one or more of their employees obtain subsidized coverage through an exchange. The IRS subsequently announced that employers with at least 50 but fewer than 100 FTEs will have an additional year to comply with the employer mandate (see **Table 1**).

According to the Administration, these actions were taken after it was 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 indicated that it would work 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 subsequently 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 (see **Table 1**).⁶

³ CRS Report R43289, *Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act*, by C. Stephen Redhead and Janet Kinzer.

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>.

Special Enrollment Periods and Hardship Exemptions

The Administration has been criticized for creating numerous special enrollment periods that enable individuals to enroll in an exchange plan outside the annual open enrollment period. Individuals can qualify for a special enrollment period as a result of a variety of events that affect their ability to obtain or maintain health insurance coverage (e.g., moving, losing job-based coverage, gaining legal U.S. residency).⁷ Special enrollment periods were also established last year and again this year for individuals unable to begin or complete the process of enrolling in an exchange plan before the end of the open enrollment period because of technical problems or other circumstances.⁸ State-run exchanges are encouraged to adopt special enrollment periods that are similar to the ones established for federally facilitated exchanges.

In addition, the Administration has established numerous hardship exemptions 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 or more consecutive months are subject to a penalty unless they meet one of the statutory exemptions, or qualify for one of the health coverage-related or hardship exemptions established by CMS.⁹ In some instances the hardship exemption is tied to qualifying for a special enrollment period. For example, individuals who qualified for a special enrollment period to finish enrolling in an exchange plan after the 2014 open enrollment period closed on March 31, 2014, were granted a hardship exemption so that they would not be penalized for being uninsured for the first four months of the year (see **Table 1**).

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 ACA in an effort to make it work and add to the public's confusion about the law. The ACA's critics 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.¹⁰

⁷ For more information about special enrollment periods, see <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>.

⁸ 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>.

⁹ For more information about the exemptions, see <https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/#hardshipexemptions>.

¹⁰ 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/>.

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 over the past three years. 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 exchanges and some state-run 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.¹¹

Regarding the delay of the employer mandate, 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,¹² is part of an established practice to provide relief to taxpayers who might otherwise struggle to comply with new tax law.¹³

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.¹⁴

U.S. House of Representatives v. Burwell

On July 30, 2014, the House voted 225-201 to approve a resolution (H.Res. 676) authorizing Speaker John Boehner, on behalf of the House, to sue the President or other executive branch officials for failing to “to act in a manner consistent with [their] duties under the Constitution and laws of the United States with respect to implementation of the [ACA].”¹⁵ The Speaker 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

¹¹ 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>.

¹² Section 7805(a) of the Internal Revenue Code; 26 U.S.C. §7805(a).

¹³ 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>.

¹⁴ 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>.

¹⁵ Full text of the resolution is at <http://www.gpo.gov/fdsys/pkg/BILLS-113hres676eh/pdf/BILLS-113hres676eh.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.

Congress, effectively creating his own law by literally waiving the employer mandate and the penalties for failing to comply with it,” said Mr. Boehner.¹⁶

A lawsuit was filed on November 21, 2014, consisting of two counts.¹⁷ First, it claimed that the Administration had violated the Constitution by delaying the ACA employer mandate. Second, the lawsuit challenged the ACA’s cost-sharing subsidies. These are paid to insurance companies to reduce the out-of-pocket health care costs of certain individuals and their families receiving premium tax credits. Unlike the premium tax credits, for which the ACA provided a permanent appropriation, the lawsuit argues that the law did not appropriate any funding for the cost-sharing subsidies.

¹⁶ 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.

¹⁷ *United States House of Representatives v. Burwell*, No. 14-cv-01967 (D.D.C., 2014); <https://jonathanturley.files.wordpress.com/2014/11/house-v-burwell-d-d-c-complaint-filed.pdf>.

Table I. Selected Administrative Delays and Other Actions Regarding ACA Implementation

Summary of Administrative Action	Explanatory Notes and Comments
<p>Open Enrollment, 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.</p> <p>Citing problems and delays with Healthcare.gov, HHS took several actions in November and December 2013 that extended until December 24 the deadline for individuals to sign up for health coverage beginning January 1, 2014. For more information, see 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, CMS announced that people “in line” to enroll in a federal exchange QHP as of March 31, the final day of open enrollment, but unable to complete the enrollment process would be given a limited amount of additional time—a special enrollment period (SEP)—to do so. These individuals also were eligible for a hardship exemption for the months prior to the effective date of their coverage and treated as if they had enrolled in coverage by March 31. [Note: On May 2, 2014, CMS announced a comparable hardship exemption for those individuals who obtained minimum essential coverage (MEC) effective on or before May 1, 2014, outside of an exchange.] For more information, see http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf.</p> <p>On February 16, 2015, the day after the 2015 open enrollment period ended, CMS announced a one-week extension (February 16-22) for individuals who were in line at a federal exchange and unable to complete enrollment by February 15. Enrollments completed during this SEP period had a coverage effective date of March 1. See https://www.healthcare.gov/blog/open-enrollment-is-over/. Each state running its own exchange also provided an “in-line” extension for those unable to complete the enrollment process by the close of the 2015 open enrollment period.</p> <p>HHS’s February 27, 2015, final rule (“Notice of Benefits and Payment Parameters for 2016”) added more SEPs. One is for individuals in non-Medicaid expansion states whose income increases to the federal poverty level, making them eligible for exchange subsidies. See 80 <i>Federal Register</i> 10750, http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.</p>	<p>The first (i.e., 2014) open enrollment period for individuals to enroll in coverage through an exchange ran from October 1, 2013, through March 31, 2014. The 2015 open enrollment period ran from November 15, 2014, through February 15, 2015. The 2016 open enrollment period will begin on November 1, 2015, and extend through January 31, 2016.</p> <p>The ACA individual mandate requires most U.S. citizens and legal residents to maintain MEC beginning in 2014. Individuals without coverage for three consecutive months have to pay a penalty unless they meet one of the statutory exemptions, or qualify for one of the health coverage-related or hardship exemptions established by CMS. For more information on the exemptions, see https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/.</p> <p>For individuals who sign up for coverage between the 1st and 15th of the month, the coverage begins on the first day of the next month. If you sign up between the 16th and end of the month, the coverage begins on the first day of the second following month. Thus, individuals who signed up on February 16, 2014, would not have been insured until April 1, 2014, leaving them uninsured for the first three months of 2014 and subject to a penalty when they file their 2014 taxes, unless otherwise exempt.</p> <p>Individuals can enroll in an exchange QHP only during the open enrollment period unless they qualify for a special enrollment period. CMS has created numerous SEPs, pursuant to ACA Section 1311(c)(6)(C), for various significant events including changes in family status, loss of job-based health coverage, and other unforeseen events (see 45 C.F.R. 155.420). Last year, CMS established SEPs and hardship exemptions for individuals beginning or ending their service in AmeriCorps, VISTA, or the National Civilian Community Corps (NCCC). For more information on SEPs, see https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/.</p> <p>State-based exchanges are encouraged to adopt SEPs that are similar to the ones CMS established for federally facilitated exchanges.</p> <p>Note: CMS has created an SEP for individuals and families who are subject to the 2014 individual mandate penalty when they file their 2014 taxes. See discussion under “2014 Tax Season.”</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 considered 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 insurers sending cancellation notices to individuals and small businesses with grandfathered 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. 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 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>.

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.

If a plan is cancelled outside the open enrollment period, affected individuals get a special enrollment period if they wish to enroll in an exchange plan. Those who can’t afford an exchange plan and apply for a hardship exemption on that basis can buy a catastrophic health plan. For more information on all the options available to individuals whose grandfathered health plan is cancelled (or changed), see <https://www.healthcare.gov/current-plan-changed-or-cancelled/#questions>.

A majority of states continue to permit renewal of grandfathered health plans; see <http://www.healthinsurance.org/blog/2014/10/03/like-your-grandmothered-health-plan/>.

Summary of Administrative Action

Explanatory Notes and Comments

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.

2014 Tax Season

On January 26, 2015, the IRS announced that it would waive two penalties that apply to the underpayment of taxes for those who have an amount due on their 2014 income tax return as a result of reconciling advance payments of the premium tax credit with the premium tax credit allowed on the tax return. For more information, see <http://www.irs.gov/pub/irs-drop/n-15-09.pdf>.

On February 20, 2015, CMS announced a special enrollment period for individuals and families living in states with a federal exchange who did not have coverage in 2014 and who are subject to the individual mandate penalty when they file their 2014 taxes. Its purpose is to allow these individuals and families who were unaware or didn't understand the implications of the individual mandate to enroll in 2015 health insurance coverage. The special enrollment period will begin on March 15 and run through April 30. If an individual enrolls before the 15th of the month, coverage will begin on the first day of the following month. Individuals taking advantage of this special enrollment period still have to pay a penalty for the months they were uninsured and did not receive an exemption in 2014 and 2015. For more information, see <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20.html>.

The ACA's individual mandate requires individuals and families to have MEC or pay a penalty when they file their federal income taxes, unless they qualify for an exemption. Individuals can claim an exemption using Form 8965. For more information, see <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions>.

Individuals who purchased coverage through an exchange in 2014 will receive a Form 1095-A, which provides information about the coverage and includes the amount of advance premium tax credit payments received during 2014. This information is used to complete Form 8962, on which individuals reconcile (i.e., compare) the advance credit payments they received in 2014 with the premium tax credit they are eligible to claim on their return based on actual income and family circumstances for the 2014 tax year. If the advance payments that were paid to an insurer in 2014 exceed the actual credit to which an individual is entitled, then the individual must pay the difference when filing their federal income tax return (or subtract the amount from any refund due).

About 800,000 people who had coverage through the federal exchange in 2014 and received advance payments of premium tax credits were sent an incorrect Form 1095-A in late January. On February 20, 2015, CMS announced that it will send an updated Form 1095-A to those individuals in early March with the correct information for calculating the premium tax credit. For more information, see <https://www.healthcare.gov/blog/is-your-form-1095a-correct/>.

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 (FTEs) provide health coverage for their full-time workers or risk paying a penalty. The IRS also delayed the reporting requirements for MEC providers and employers under IRS Sections 6055 and 6056 (see the explanatory notes). The first information returns filed with the IRS and statements furnished to covered individuals are not due until early 2016, for coverage provided in 2015. 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 FTEs, 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, the rule states that 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 during that year, 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>.

For more information on the ACA employer mandate, including transition relief, see <http://www.irs.gov/Affordable-Care-Act/Employers>.

Generally, under IRC Section 4980H (“Shared Responsibility for Employers Regarding Health Coverage”), as added by ACA Section 1513, employers with at least 50 (FTEs) 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 every provider of MEC (e.g., insurers, small self-insuring employers) annually to report coverage information by filing a return with the IRS (Form 1095-B, with a single transmittal form 1094-B) and furnishing a statement to covered individuals. For more information, see <http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage>.

IRC Section 6056, as added by ACA Section 1514(a), requires employers with at least 50 FTEs (including those that self-insure) annually to report information about health insurance coverage offered to their employees (and their dependents) by filing a return with the IRS (Form 1095-C, with a single transmittal form 1094-C) and furnishing a statement to employees. For more information, see <http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Applicable-Large-Employers>.

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/Affordable-Care-Act/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage>.

Summary of Administrative Action

Explanatory Notes and Comments

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 were able to maintain separate cost-sharing limits for medical coverage (e.g., hospital and doctors' services) and for prescription drug coverage. However, this policy applied 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.

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 SEP, beginning on May 1, 2014, to enroll in a QHP offered through an exchange. The new coverage was effective as of May 1 to avoid a lapse in health insurance coverage. For more information, see <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/PCIP-bulletin-4-24-14.pdf>.

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 they 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 delayed until 2015 the implementation of **employee choice** in federally facilitated SHOP exchanges. Employee choice remains voluntary until 2016. Fourteen states with federally facilitated SHOP exchanges are offering employee choice for 2015; the remaining federally facilitated SHOP states will follow suit in 2016. The majority of state-based SHOP exchanges have chosen to implement employee choice. For more information, see <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html>.

Online enrollment in the federally facilitated SHOP exchanges began on November 15, 2014 (i.e., the beginning of the 2015 open enrollment period) after multiple delays. It was originally set to begin on October 1, 2013, the same day the individual exchanges opened for 2014 enrollment. Prior to this date, small businesses were able to enroll in plans listed on these exchanges through an insurance agent or broker, or directly with the insurance carrier. CMS also permitted states that were not yet able to enroll small businesses through their state-based SHOP exchanges online to use the same direct enrollment approach that the federally facilitated SHOP exchanges employed. For more information, see <https://www.healthcare.gov/blog/get-coverage-now-through-the-SHOP-Marketplace/>.

Small Employer Health Care Arrangements

In a series of published guidance, the Departments of Labor, HHS, and the Treasury concluded that employer health care arrangements, such as health reimbursement arrangements (HRAs), are group health plans that typically consist of a promise by an employer to reimburse medical expenses up to a certain amount. The Departments further determined that such arrangements are subject to the ACA's group market reforms, including the prohibition on annual limits on coverage. Beginning January 2014, employers using HRAs could be subject to a penalty, calculated on per day, per employee basis, under IRC Section 4980D.

On February 18, 2015, the IRS announced that it was providing transition relief to employers with fewer than 50 FTEs regarding HRAs and similar arrangements, to give them more time to transition to the SHOP exchanges. Such employers will not be assessed the penalty until July 1, 2015. In the meantime, lawmakers are planning to introduce legislation to find a permanent solution. For more information, see <http://www.irs.gov/pub/irs-drop/n-15-17.pdf>.

The ACA 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. Small employers can enroll in a SHOP exchange at any time of the year; there is no restricted enrollment period. 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 multiple QHPs offered by an employer, as opposed to an employer selecting one QHP to offer to their employees. Under the ACA's employee choice model, 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. States running their own SHOP exchanges are permitted to use other models that would give employees a wider choice of plans across tiers. For more information, see http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_125.pdf.

Small employers, especially those with 10 or fewer employees, sometimes establish a tax-free HRA with their workers if they are unable to purchase small group coverage. Under an HRA, employees are encouraged to purchase their own insurance coverage, submit the premium amount they paid to the employer, and the employer then reimburses the employees. Alternatively, the employer pays the employees' premiums directly. If accounted for appropriately, the employer's payments are not taxed.

Summary of Administrative Action

Explanatory Notes and Comments

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>.

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)]

Source: Prepared by the Congressional Research Service based on a review of the documents cited in the table.

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