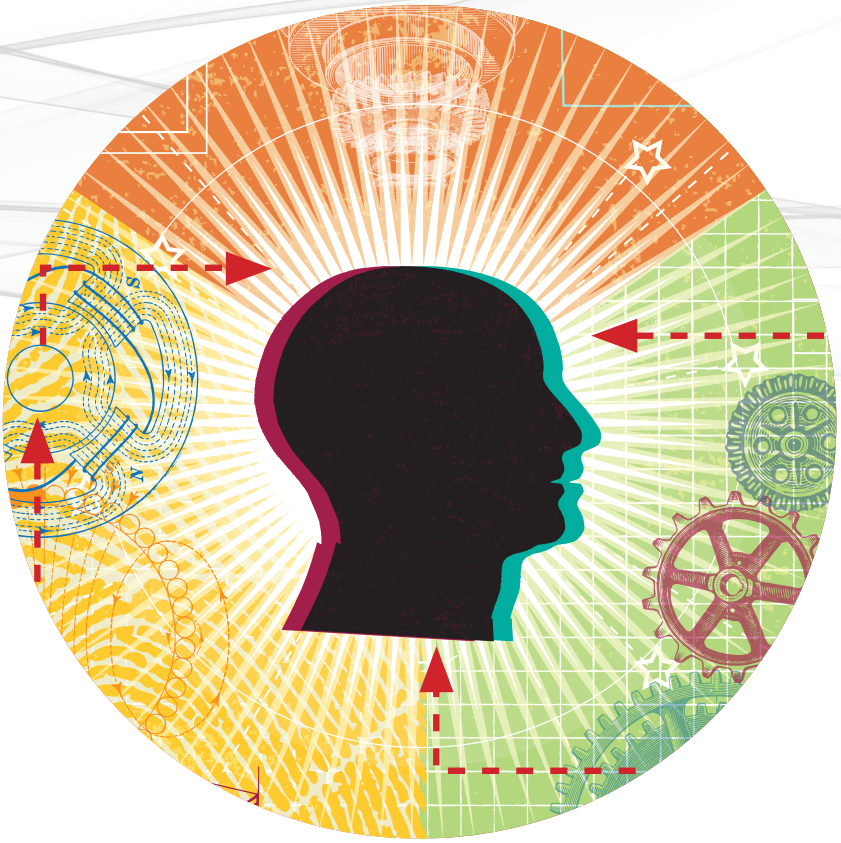

ACA Laws, Regulations, and Guidance

Payer Compliance

James Bingham

An HTMS White Paper

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HTMS provides strategic and operational consulting support to issuers doing business on public marketplaces. In this role we are required to study the relevant regulations and guidance that are intended to provide direction for this work. HTMS does not provide legal advice or any interpretation of the law.

With the passage of the Affordable Care Act (ACA) in 2010, the traditionally stable health care industry began a fundamental transformation that involved defining and refining requirements for health care coverage, expanding access to health insurance, and providing subsidies to those who need financial support. These changes significantly impacted the health insurance industry, the economy, and the lives of Americans. The Centers for Medicare and Medicaid Services (CMS) is on point to provide guidance and clarifications to support the implementation of this significant legislation.

These transformative changes have been particularly challenging for insurers, with many organizations seeking a comprehensive instruction manual or guidebook that spells out the rules for complying, and implications for not complying, with the ACA. Unfortunately, no such roadmap exists.

In this paper, we lay out processes, documents, and systems that CMS uses to help the health care industry adopt the ACA. Our focus is on guiding payers—also known as insurers, carriers, and issuers—to navigate the resources in order to comply with the ACA.

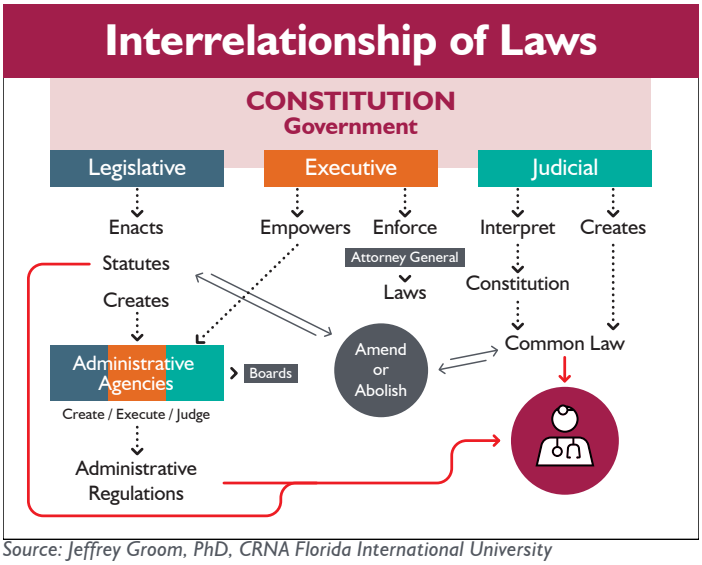
After briefly reviewing the legal and regulatory structure in the United States, we touch on a few ACA-related concepts and key resources, describe the ACA's regulatory rulemaking process, walk through several example scenarios to demonstrate how a payer might react to new ACA issues, and identify a list of resources that can be used as reference and to stay abreast of changes.

Legal and Regulatory Overview

In the United States, the federal Constitution is the overarching legal authority that guides the laws and regulations in the country. Laws passed by Congress provide the next level of guidance on behalf the of people they are elected to represent. Federal regulations from federal agencies provide further guidance and specificity to help interpret and apply the laws. States have a similar hierarchy: state constitutional provisions trump state statutes, which in turn prevail over state regulations. Where state laws and regulations conflict with those at the federal level, federal law rules.

The legislative branch of government is responsible for enacting and modifying laws. The executive branch is responsible for applying and enforcing laws. And the judicial branch is responsible for resolving disputes related to the interpretation and application of laws.

In order to facilitate the application and enforcement of the ACA, federal agencies establish, publish, and discuss regulations. Impacted stakeholders are expected to comply with these regulations, which have the force of law. Some provisions of the ACA are left to states and other entities to regulate. In these cases, it is up to a state's Department of Insurance (DOI), exchange marketplace, or responsible organization to assist stakeholders and ensure payer compliance.



Source: Jeffrey Groom, PhD, CRNA Florida International University

The Affordable Care Act

The ACA consists of two key laws: the Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010, and the Health Care and Education

Reconciliation Act amendment, signed into law on March 30, 2010. They became public laws 111-148 and 111-152, respectively, finding their way into statutes 124 Stat. 119 through 124 Stat. 1025, and 124 Stat. 1029 through 124 Stat. 1083.

These laws then were codified into regulations—ultimately ending up mostly in Title 45 (Public Welfare) of the Code of Federal Regulations (CFR)—governed by various regulatory departments, principally:

- the Department of Health and Human Services (**HHS**), for most of the insurance industry, including establishing and regulating ACA exchanges, or marketplaces
  - » most regulatory oversight of the ACA is handled by the Centers for Medicare and Medicaid Services, or **CMS**
    - ♦ a sub-agency of CMS, the Center for Consumer Information and Insurance Oversight (**CCIIO**), was created out of the ACA specifically to implement much of the ACA and handle many day-to-day ACA operations
  - » to a much lesser degree than CMS, the Public Health Services (**PHS**) agency regulates certain aspects of the ACA
- the Department of **Treasury**, for financial aspects of the law
  - » the Internal Revenue Service (**IRS**) regulates many of the ACA's tax-related provisions
- the Department of Labor (**DOL**), for businesses and self-funded groups
- the Office of Personnel Management (**OPM**), an independent agency, for overseeing the Multi-State Plan Program (MSPP)

Some states have enacted statutes (laws) covering various aspects of the ACA. California, for instance, mirrored much of the ACA's language in bills signed into law in late 2010 by then-governor Arnold Schwarzenegger. Other states created or modified laws to address aspects of the ACA, such as Washington's statutes on essential health benefits (EHBs), and Kentucky's laws on participation in the state's public exchange.

Typically, enforcement of these statutes, and of health care and/or insurance, falls to the state's Department of Insurance (DOI). Some states have more than one such regulatory body, as with California's Department of Insurance (CDI), Department of Managed Health Care (DMHC), and Department of Health Care Services (DHCS). Although heavily federal, the ACA does not eliminate or supplant state-level regulatory oversight.

Given the varied regulatory landscape, compliance can be a significant challenge. Payers contend with layers of regulations, sometimes conflicting, issued by multiple sources of authority.

Regulations and Exchanges

Regulations define terms of doing business. Often the regulatory body will publish proposed regulations in the form of a Notice of Proposed Rulemaking (NPRM), which represents a set of new regulations or changes to existing regulations. Stakeholders and the public are given a chance to review these proposed regulations and provide comments back to the regulator. After collecting, consolidating, and considering the comments, the regulatory agency will issue final regulations. Once regulations are in effect, they become guiding principles and practices that impacted organizations must follow. Reviewing the NPRM and final regulations can provide valuable insight into regulatory intent and direction.

One component of the ACA has been an especially active moving target to implement: the creation of health insurance marketplaces, or exchanges.

These online shopping portals and benefit plan delivery channels were designed to make health coverage easily available to individuals and small businesses by offering qualified health plans (QHPs) directly to consumers and employers. Through the ACA, all states were encouraged to create their own exchanges, but more than two-thirds of states elected instead to have the Federally-Facilitated Marketplace (FFM) provide this functionality.

One component of the ACA has been an especially active moving target to implement: the creation of health insurance marketplaces, or exchanges.

In addition to complying with laws and regulations at the federal and state levels, and answering to regulators such as CMS, the IRS, and the state DOI, payers participating in a state-level

exchange also must comply with rules and requirements laid out by the exchange. Often payers find these compliance requirements to be a heavy lift, and it is not uncommon to find an exchange requirement appearing to conflict with a regulatory one.

Demonstrating the challenges facing payers in the ACA world, a common exchange requirement is that payers must be accredited. This involves having a third-party organization determine that the payer meets certain minimal standards in the payer's organization and practices. These minimal standards are considerably complex, requiring significant organizational commitment and touching virtually all areas of the business. Some payers invest heavily to bring their companies up to the accreditation standards. Payers also must ensure that they retain accredited status year after year.

Federally-Facilitated Marketplace

The FFM is the ACA exchange established by CMS to provide health coverage to those eligible for ACA subsidies, or to anyone else eligible to purchase an individual-market benefit plan. While some states established their own ACA exchanges, or state-based marketplaces (SBMs), which have processes and requirements similar to the FFM, most states did not, and thus use the FFM as the backbone for ACA business. Hundreds of payers offer health care products through the FFM, and thus must comply with FFM requirements. For small group business in non-SBM states, payers work with the FF-SHOP, or Federally-Facilitated Small Business Health Options Program, as the group-market ACA exchange.

To comply with ACA and FFM rules, CMS has organized a number of teams to handle different aspects of the overall process.

In order to offer benefit plans through the FFM, payers first must obtain certification from the exchange identifying their benefit plans as QHPs, and then work with the FFM to administer the QHPs, enroll members, exchange data, handle disputes, coordinate notices and reports, submit to compliance reviews, and more.

To comply with ACA and FFM rules, CMS has organized a number of teams to handle different aspects of the overall process.

There are teams for enrollment, risk adjustment, reinsurance, risk corridors & MLR (medical loss ratio), EDGE (external data gathering environment) server, technical matters, RBIS (rate and benefits information system), financial management, SHOP, QHP certification, agents & brokers, market oversight, communications, and others.

Each team has various ways to interact with payers, including regular (often weekly) webinars, dedicated team e-mailboxes, communication blasts, document repositories, and one-on-one assistance. Even with multiple communication channels, and partly due to so many teams, at times it can be difficult to reach effective help to address a particular issue. Also, CMS can take weeks or longer to respond to payers' questions. That said, generally speaking, the level of access payers have to CMS works well.

FFM Resources

Three principle resources payers have for working with the FFM are the CCIIO website, zONE (CMS opportunity to network and engage), and RegTAP (registration for technical assistance portal). Payers seeking regulatory compliance material and guidance use these resources extensively.

The CCIIO website has areas dedicated to regulations and guidance, QHP certification forms and instructions, agent and broker communications, and other broad categories. It is publicly accessible, with no access restrictions.

zONE is a CMS collaboration and document platform that includes technical material and technical workgroups. It has areas and content dedicated to different stakeholders, including an issuer community particularly relevant to payers. Users go through a somewhat detailed screening process before being granted access.

RegTAP is an information sharing and collaboration system requiring registration and login to access the site:

- It contains a library of documents, guidance, technical reference material, presentations, and other resources that payers can download for use.
- There is a repository of frequently asked questions (FAQs), with about a dozen or so added each week. These are helpful to answer detailed, scenario-specific questions that usually apply to multiple payers.
  - » Although both the library and FAQs can be searched, that functionality is rather rudimentary, often making it difficult to find what is being sought.
  - » Some library and FAQ items were posted years ago. While CMS does periodically review RegTAP content and remove or update what is no longer applicable or

relevant, anything over a couple years old should be double checked, as guidance may have changed.

- There also is a RegTAP inquiry mechanism to submit questions and comments, giving payers the ability to route their submissions to specific CMS teams.
- Additionally and importantly, payers and their supporting contractors and vendors can register for and attend topic-specific webinars, usually in the form of a series of conference calls and slide presentations that span weeks or months. These webinars are held by leadership personnel on the relevant CMS teams, and act as a forum for CMS to share new information and to take questions in real time directly from payers, often providing answers on the spot.
  - » These webinars have proven to be extremely helpful both to those asking questions and to others on the calls who apply CMS's answers/guidance to their own situations.

Regulatory Process Summary

The ACA represents about a thousand pages of text, most of which describe the intent or outcome of the law, but with little information about how to implement these components. Since the ACA's passage, CMS and other agencies have published voluminous regulations, explanations, and clarifications to help the industry comply with the law.

The final clarification for a regulation could come in the form of a rule, letter to issuers, FAQ, verbal statement, presentation, slide deck, or another announcement.

ACA regulatory evolution frequently follows this process:

1. start with the law (**ACA**)
2. through the **Federal Register,**
   - HHS publishes a Notice of Proposed Rulemaking (NPRM) containing proposed new or modified regulations
     - » stakeholders are given an opportunity to review and comment on the proposed regulations
   - CMS considers submitted stakeholder comments and finalizes the regulations, publishing a **Final Rule**
     - » the preamble of the Final Rule explains each regulation and the comments received, describing the analysis that led to the regulation's final wording
3. the new or modified regulations in the Final Rule make their way into the Code of Federal Regulations (**CFR**)
4. uncertainty or potential bias in implementing or operationalizing the regulations results in CMS issuing written **guidance**, clarifying or limiting specific provisions or concepts
   - these take the form of letters to issuers, issuer bulletins, policy guides, and frequently asked questions (FAQs), among others
5. where ambiguity remains, stakeholders pose scenario-centric questions to agency subject-matter experts (SMEs) who respond verbally or via e-mail with an **interpretation** of the relevant regulations and guidance

The final clarification for a regulation could come in the form of a rule, letter to issuers, FAQ, verbal statement, presentation, slide deck, or another announcement.

Therefore, a payer would seek the most recent form of communication on a given topic—which could be shared with stakeholders in a range of formats—and, should that communication tend to conflict with a more authoritative source, the payer would resolve the conflict, even soliciting advice and direction from CMS on how to proceed.

Regulatory Process Example

The following demonstrates a part of the ACA making its way into regulation, getting changed, and being disputed in the courts:

- **APTC**
  A key element of the health care reform effort is to provide financial assistance to those needing help to pay for coverage premiums. In the ACA, this takes the form of an advanced premium tax credit, or APTC. The idea is that someone required to have insurance coverage but for whom the full premium payment amount exceeds a specified threshold based on income would be entitled to a tax credit for some or all of the premiums paid during the tax year. Since the tax credit does not come until taxes are filed the following year, per the ACA, eligible enrollees can get any or all of that anticipated tax credit in advance, applied at the time premium payments are due, thus reducing the amount required "out of pocket" for the person's premium.
- **ACA Requirement**
  APTC provisions are in the ACA's Subtitle E (Affordable Coverage Choices for All Americans), Part I (Premium Tax Credits and Cost-Sharing Reductions), Subparts A (Premium

Tax Credits and Cost-Sharing Reductions) and B (Eligibility Determinations), or, ACA sections 1401, 1402, and 1411 through 1415.

- **Initial Regulations**
  Section 1401 directs adding a new section to the Internal Revenue Code (IRC): Section 36B. Because the IRC is Title 26 of the United States Code (USC), the language of ACA section 1401 made its way into 26 USC 36, and thus became a new entry into the IRC (specifically, IRC chapter 1, subchapter A, part IV, subpart C, section 36B).

- **Proposed Regulation Changes**
  The statute (and thus IRC) contains some detail relating to the premium tax credit, but in order to be truly useful to insurance companies and taxpayers, the IRS developed additional specificity. In August, 2011, the IRS published in the Federal Register proposed regulations related to IRC 36B. This "Proposed Rule" (NPRM) was to add several sections to CFR Title 26, specifically, 26 CFR 1.36B-0 through 26 CFR 1.36B-5.

- **Final Regulation Changes**
  After a public comment period, during which interested parties were able to provide input to the IRS on the proposed regulations, and after a public hearing, the IRS published in May, 2012, final regulations (a "Final Rule") that addressed many of the submitted comments and concerns, and explained in a preamble the IRS's rationale behind the regulations. In July, 2012, the IRS published a minor technical correction to better communicate a provision of the regulations. Then, in July, 2014, the IRS published temporary provisions, with pre-determined, fixed effective periods.

- **Dispute**
  The wording from the law, carried into the USC text, is that premium assistance is for those enrolled "through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act". However, when the IRS drafted the related proposed regulations, the wording became "enrolled in a qualified health plan through an Exchange", dropping the latter portion of the ACA line. Although similar, the difference was center stage in federal lawsuits.

- **Court Ruling**
  Some people argued that the law, as written, specifically restricted premium assistance to those enrolled through "1311" exchanges, and that federal exchanges are not exchanges under ACA section 1311. The Treasury determined that federal exchange enrollees were entitled to premium subsidies, in part because of the aforementioned IRS rewording of the statutory provision. A lawsuit on this—King v. Burwell—made its way to the U.S. Supreme Court, with the plaintiffs arguing that the IRS did not have the authority to interpret the law in the way that it did. The Supreme Court concluded that the IRS regulation was a permissible interpretation of the statute, thus securing premium subsidies for federal exchange enrollees.

This example demonstrates how a law (legislative branch) makes its way into regulations (executive branch), and how courts (judicial branch) weigh in on the law and regulations – the three branches of government working together, the result of which is clear, well-vetted, and reliable direction informing and instructing those affected.

State laws and regulations operate similarly, with the dominant regulatory body being a state's DOI. While a state may codify federal provisions into its own laws or regulations, usually a state will tailor laws and regulations to the business and political environments particular to that state.

Beyond laws and regulations, regulatory bodies often communicate guidance and recommendations.

While these do not have the force of law, they provide clarity, effectively enhancing industry efficiency and effectiveness. This guidance is communicated via memos, FAQs, and even verbal statements made on stakeholder calls, among other forms.

Beyond laws and regulations, regulatory bodies often communicate guidance and recommendations.

Outside government channels, many provisions, especially the most contentious and complicated, are analyzed, summarized, and discussed by trade associations, consulting firms, and research organizations.

Examples of the Compliance Research Process in Action

What does all of this mean, practically? To bring it home for payers, here are a few scenarios a payer might encounter, and steps that can be taken to handle them. These do not represent a comprehensive research process, or even necessarily best practices, but rather simply demonstrate ways payers might use available resources when facing an ACA issue.

Example # 1 — Identifying the Regulation

Often it can be unclear initially how CMS expects payers to administer particular requirements, and finding relevant regulatory answers can be daunting.

Imagine you are asked about a concept. Searching RegTAP FAQs by keyword, you find a promising result, but CMS refers to it by different terminology than you know it by. The FAQ provides a precise search phrase you can use in subsequent research. Checking the RegTAP library, you come across a presentation that seems to be on point. This presentation provides a regulatory reference. While the presentation seems to offer the information you need, you also want to read the official regulation. Now that you have a regulatory citation, it is simple to search for that regulation on eCFR.gov, the electronic code of federal regulations website. The regulation refers to several other CFR sections. After researching those, you now have a more complete picture of what is currently required.

However, while you are working on your organization's compliance with those requirements, you run into some questions that don't seem to be covered in the materials you have collected. You might enter a help desk ticket with CMS—e-mail CMS_FEPS@cms.hhs.gov, or call 1-855-CMS-1515—to get a written answer, and also attend the appropriate weekly CMS webinar and verbally ask your question. If the right CMS resource is not on the call, giving the CMS call representatives your help desk ticket number may produce a quicker answer to your help desk inquiry.

Example #2 — Coverage Termination

In preparing to sell QHPs on the FFM, you are to develop policies and procedures for when members decide to terminate their coverage.

You find coverage termination in CFR Title 45 sections 155.430 and 156.270, and both look promising. The first says that the exchange must allow for an enrollee to actively terminate a member's coverage, and the exchange must establish a process for that. It also references what is done when a person passively terminates coverage due to halting premium payments, including potential grace period implications. The second regulatory section discusses the grace period in more detail.

You check on RegTAP and, sure enough, there is a draft FFM enrollment guide from late 2013 covering coverage termination. This is a great step-by-step guide for both voluntary and involuntary terminations, including a lot of detail around grace periods and notice requirements. Being draft and a bit long in the tooth, you want to see if there is anything additional or more current that supports, refines, or contradicts this guide.

[Note: CMS published an updated version of the enrollment guide (October, 2015) as this article was going to press.]

From the regulatory history at the bottom of CFR web pages on eCFR.gov, you identify a number of documents from which the regulations were crafted. Interestingly, you find that, where the member must give "reasonable notice", CMS believes 14 days is reasonable, a concrete figure you can include in your termination policy and provide to your customer service reps.

Looking for additional guidance, searching RegTAP FAQs, you find a number of responses related to terminations. For instance, FAQ #10760 ties to special enrollment periods (SEPs), #10031 provides flexibility around the 14-day "reasonable notice" period, #10017 talks about claims when terminations are retroactive, #4938 instructs payers where to go with questions about retroactive terminations, and #3742 covers terminated members and EDGE server submissions. There are other termination FAQs, as well, giving you a good sense of what your obligations and allowances are.

You also know that state regulations might come into play for notice requirements, non-APTC grace periods, and "free look" periods, so for complete compliance you investigate and incorporate state-specific rules and regulations.

Taken all together, you have enough information to begin formulating termination policies and procedures.

Example #3 — Cost Transparency

Imagine that members frequently ask your customer service reps how much it would cost someone to see a particular provider for a specific service.

You might quickly jump to the SBC (summary of benefits and coverage), which lists a number of services and includes a member's cost sharing amounts. However, this does not satisfy members who push back that many services are not listed on the SBC, and even for those that are, the actual dollar amounts a member would have to pay are not known if the SBC lists only coinsurance percentages.

You are tempted to tell these members that there is not much you can do, but you want to be sure there is not a requirement that you have to provide the requested information, so you do a little digging.

You start by searching the eCFR for particular terms. This can be slow, but once you get going, one reference leads to others. If you know the section number, searching the eCFR is quick and efficient. From the regulations, pulling precise words and phrases can assist in finding what may be more detailed guidance in RegTAP or zONE.

You hear that the ACA has a provision to provide relevant information transparently to consumers, so you pull out the ACA (or pull up the .pdf) and find that section 1311(f)(3) has transparency provisions. Wanting to learn what those provisions mean, practically, to payers, you check the Federal Register.

However, references in the Federal Register for 1311(f)(3) seem to cover something different, so you double check the ACA. Sure enough, 1311(f) in the ACA amends 1311(e), so the relevant provisions actually are in 1311(e)(3). Back to the Federal Register, you come across a rule on the establishment of exchanges and qualified health plans from July 15, 2011. This looks good, but you quickly spot that this is a proposed rule, with the corresponding final rule published March 27, 2012. Wanting the best authority, you grab that final rule.

Halfway down, in subpart K, section d, you find just what you were looking for. Skimming that section you pick up on a couple of regulatory citations: § 155.1040 and § 156.220. You know from experience that most of the ACA regulations are in Title 45 of the Code of Federal Regulations (CFR), so you head over to eCFR.gov and quickly look up those two sections. Incidentally, if you didn't know the full citation, you could go to the end of the final rule—after the preamble—where all regulatory updates in that rule are consolidated for convenience.

The first CFR section is an exchange requirement. The second applies to payers. According to the second one, payers are required to provide a set of information to the exchange and also to the public, along with cost information to enrollees. You haven't been providing this, and begin to feel nervous that you could be out of compliance.

However, you want to see if there is any more guidance on this. You go back to the final rule and read the preamble narrative (subpart K, section d). You notice that exchanges have flexibility in how they implement this, so, at a minimum, you would want to check with your specific exchange.

Two-thirds of states rely on the federal exchange, or FFM, so let's assume that that is your exchange. You could send the FFM an e-mail asking about transparency requirements, but you feel confident you can chase it down and don't want to wait for a response, which could take days or weeks.

You do a search through issuer bulletins, of which there are more than a dozen, and don't get a hit. Then you look through the letters to issuers and find that, for 2015, CMS was deferring the regulation in order that there be enough time for industry data to accumulate. From the 2016 letter to issuers, you learn that CMS is going to begin requiring payers to comply with the regulation. That letter references the 2016 payment notice, or NBPP (Notice of Benefit and Payment Parameters).

Pulling up the 2016 NBPP, you find that CMS does, indeed, intend to require that payers supply information in support of the transparency regulations. In the NBPP, CMS answers a few stakeholder comments and concerns, explaining CMS's reasons behind its decisions. Generally, NBPPs update and expand on previous annual versions, so you may want to look at the 2015 or earlier NBPPs.

The 2016 NBPP references an FAQ (#15) from 2013, so you bring it up; it is on both the CCIIO and DOL websites. The FAQ reiterates that CMS was delaying ACA transparency requirements until at least a year's worth of data became available. You search through the other FAQs to see if there is anything more current. Sure enough, FAQ #28, from August, 2015, mentions an August 11, 2015, HHS proposal. You locate the published notice in the Federal Register, and also identify related paperwork reduction act (PRA) content.

The PRA material includes an expanded summary of the Federal Register notice, along with lists of data elements payers will be required to send to the FFM and to display on payers' websites. Although this is only a proposal, you expect that CMS will, in fact, hold payers to these requirements come 2016. The Federal Register notice seeks stakeholder comments, and presumably CMS could revise the proposed requirements based on comments it receives, but you suspect the requirements will be largely as they are in the notice.

To be a little more thorough, you check in the RegTAP FAQs and find only one FAQ, from late 2014, relating to transparency. It indicates that CMS will not enforce the transparency requirements until further guidance is provided. Additionally, a web search reveals a number of non-CMS articles on the transparency requirements, including a Kaiser Family Foundation write-up from 2012 on the benefits of this provision, which might influence your company's decision to establish a more comprehensive transparency solution.

Taking all of this together, you conclude that you are not out of compliance today, but that your organization will have to provide certain information to the exchange and also put information on your website. Since there is no mention of the cost transparency portion of the provision (which speaks to members' questions)—only the data transparency portion—presumably the ACA's cost transparency requirement will not be needed before 2016. If desired, you could submit a help desk inquiry or send CMS's oversight team an e-mail to find out for sure.

Compliance in the Context of the Business

For the most part, regulation of health care payers has been a state responsibility, and compliance chiefly meant satisfying the requirements of a DOI. With the ACA, especially when selling QHPs, payers have a whole host of new federal-level regulations to contend with, in addition to new sources of information and systems to learn. ACA compliance is complicated, and being compliant is challenging and resource-intensive, but help is available.

The role that compliance plays in a health plan, as described in this article, marks a departure from the role that it has played historically for many organizations. In an exchange environment, business owners and IT firms are required to become more engaged with regulations, and those in charge of compliance have a more direct role to play in the operations and strategy of an organization. This can be an ominous but also exciting transition as payers embrace the new frontiers of health care coverage.

For areas a payer is less knowledgeable, or situations somewhat complex, or the outcome potentially more serious, payers are encouraged to consult legal, regulatory, compliance, and health care industry experts.

Although somewhat daunting, payers are able to research, interpret, and integrate much of the evolving ACA without outside help, but it can consume considerable time and resources, and sometimes the risks of getting it wrong can hit a company hard. As the industry again matures to a stable state, day-to-day unknowns will be answered and become part of normal business practice.

However, for areas a payer is less knowledgeable, or situations somewhat complex, or the outcome potentially more serious, payers are encouraged to consult legal, regulatory, compliance, and health care industry experts.

It should be pointed out, as well, that being compliant is not as simple or straightforward as just reading a regulation and either doing what it says or not violating it. Compliance is a complex interaction of collating disparate source material, including verbal direction, considering that in light of current business and industry environments, and even discussing with other impacted stakeholders for their perspectives, and then deciding to do or not do specific actions, accepting the associated risks.

Disclaimer

This article is intended to convey general principles, proven productive in practice. Nothing in this article should be considered or taken as legal advice or binding direction. Competent counsel should be consulted, and common sense considered, prior to acting on any content herein.

About the Author

James Bingham is a part of Change Healthcare Consulting's Retail Transformation practice, which has worked with organizations around the country to address strategic, operational, and service issues related to doing business on public and private exchanges.

ACA Resources

For reference, here is a non-exhaustive list of official and unofficial resources for health care payers and others affected by ACA regulations (*current at the time of initial publication*):

ACA – Affordable Care Act

- PPACA – Patient Protection and Affordable Care Act – www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
- Health Care and Education Reconciliation Act of 2010 – www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf

FR – Federal Register – Official Publisher of Proposed and Final Federal Rules and Regulations

- NPRMs – Notices of Proposed Rulemaking
- FRs – Final Rules
- RFIs – Requests for Information
- PRAs – Paperwork Reduction Act Issuances
- Notices of Benefit and Payment Parameters (NBPPs) – annual updates to financial limits and restrictions
- Comment Periods

CFR – Code of Federal Regulations – www.ecfr.gov

- 26 CFR 1.36B – IRS regulations on the premium tax credit
- 45 CFR 147 – requirements for the individual and small group markets
  - » guaranteed availability, guaranteed renewability, no annual or lifetime limits, coverage to age 26, no pre-existing conditions, coverage of preventive services, essential health benefits (EHBs), mental health parity, and summary of benefits and coverage (SBC) provisions
- 45 CFR 148 – requirements for the individual market
- 45 CFR 153 – reinsurance, risk corridors, and risk adjustment programs (the 3 Rs)
- 45 CFR 154 – rate increases
- 45 CFR 155 – exchanges
  - » establishing exchanges, operating exchanges, qualified health plan (QHP) certification, eligibility, enrollment periods, transparency
- 45 CFR 156 – issuer standards
  - » multi-state plans (MSPs), benchmark plans, essential health benefits (EHBs), prescription drugs, non-discrimination, actuarial values (AVs), cost-sharing reduction (CSR), metal levels (platinum, gold, silver, bronze), catastrophic plans, QHP certification, marketing, network adequacy, essential community providers (ECPs), grace periods, accreditation, advanced premium tax credit (APTC), consumer operated and oriented plans (CO-OPs), minimum essential coverage (MEC), federally-facilitated marketplace (FFM) non-compliance, quality rating system (QRS)
- 45 CFR 157 – employer SHOP participation

CCIIO – Center for Consumer Information and Insurance Oversight

- Regulations and Guidance – www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html
  - » Published Regulations
  - » Final rules, proposed rules, interim rules
  - » Grandfathered plans, exchanges, medical loss ratio (MLR), preventive services, rate increases, summary of benefits and coverage (SBC), qualified health plans (QHPs), rates, tax credits, employers, 3 Rs (risk adjustment, reinsurance, risk corridors)
  - » Letters to Issuers – annual exchange operational guidance from CMS to health care payers
  - » Issuer Bulletins – periodic topic-specific guidance
- Letters – www.cms.gov/CCIIO/Resources/Letters/index.html – exchange-related communication memos
- QHP Applications – www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html – Qualified Health Plan (QHP) templates and instructions
- Forms, Reports, and other Resources – www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html – instructions, guidance, and model notices
- Training Resources – www.cms.gov/CCIIO/Resources/Training-Resources/index.html – instructional guidance for payers
- FAQs – www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html – CCIIO fact sheets and frequently-asked questions

RegTAP – Registration for Technical Assistance Portal – www.regtap.info

- Webinars – registration for CMS-hosted calls related to QHPs, enrollment and eligibility, 3 Rs, financial management, and other topics
- Library – repository of CMS guidance, technical instruction, and other communications
- FAQs – answers to thousands of frequently asked questions
- Inquiries – ability to submit questions and suggestions directly to specific CMS teams

EIDM – Enterprise Identity and Access Management System – enterprise portal for access to HIOS and zONE

- HIOS – Health Insurance Oversight System – series of modules payers use to upload submissions and enter information, such as many parts of the QHP application, to CMS
  - » access to RBIS and Plan Finder
- zONE – CMS Opportunity to Network and Engage – collaboration site and repository for technical and reference documentation, including written materials and technical workgroups

SERFF – System for Electronic Rate and Form Filing – www.serff.com

- Qualified Health Plan (QHP) Templates and Instructions

DOL – Department of Labor

- EBSA – Employee Benefits Security Administration – www.dol.gov/ebsa/ – resource for employers and payers offering group coverage
- FAQs – www.dol.gov/ebsa/healthreform/regulations/acaimplementationfaqs.html – dozens of frequently asked questions lists pertinent to businesses and payers

IRS – Internal Revenue Service

- APTC – Advance Payments of the Premium Tax Credit
- 6055/6056 – Annual Coverage Reporting Requirements (1094 and 1095 Forms)
- ACA Info – www.irs.gov/Affordable-Care-Act/Affordable-Care-Act-Tax-Provisions – provisions affecting individuals, employers, and others

SCOTUS – Supreme Court of the United States

- SCOTUSblog – www.scotusblog.com

States

- laws
- regulations
- regulators
- exchanges

Acts

- ERISA – Employee Retirement Income Security Act
- PHSA – Public Health Services Act
- MHPAEA – Mental Health Parity and Addiction Equity Act
- SSA – Social Security Act

Others

- KFF – Kaiser Family Foundation – http://kff.org – non-authoritative source explaining many ACA concepts
- Health Affairs – www.healthaffairs.org – trade publication with articles and blogs on current ACA topics
- AHIP – America's Health Insurance Plans – national association of payers and related organizations
- external counsel – law firms with a focused practice on the health insurance industry, regulatory compliance, or the ACA