DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage

I. Purpose

The final regulations at 45 CFR § 156.604 outline a process by which other types of coverage not statutorily specified and not designated through regulation as minimum essential coverage may apply to the United States Department of Health and Human Services (HHS) to be recognized as minimum essential coverage. Such plans or policies must meet substantially all of the requirements of the provisions of Title I of the Affordable Care Act that apply to non-grandfathered health plans in the individual market. The preamble states that HHS will provide an administrative process for applying for recognition as minimum essential coverage in the future. This memorandum constitutes guidance regarding that process.

II. Coverage Designated as Minimum Essential Coverage

Section 5000A of the Internal Revenue Code (the Code), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), provides that all non-exempt individuals must maintain minimum essential coverage or pay the individual shared responsibility payment.[1] Sponsors of coverage that has been designated as minimum essential coverage, either by statute or regulation, will not have to apply for recognition as minimum essential coverage.

The types of coverage that have been statutorily designated as minimum essential coverage include the following:

[1] The eligibility standards for exemptions can be found at 45 CFR § 155.605. The IRS regulations at 78 FR 53659-62 (August 30, 2013) provide exemptions from the requirement to maintain minimum essential coverage for the following individuals: (1) members of recognized religious sects; (2) members of health care sharing ministries; (3) exempt noncitizens; (4) incarcerated individuals; (5) individuals with no affordable coverage; (6) household income below filing threshold; (7) members of federally recognized Indian tribes; (8) individuals who qualify for a hardship exemption certification; and (9) individuals with a short coverage gap of a continuous period of less than three months in which the individual is not covered under minimum essential coverage.

1. Government sponsored programs,[2]
2. Employer-sponsored plans,
3. Plans in the individual market, and
4. Grandfathered health plans.[3]

The types of coverage that are designated in the final regulations[4] at 45 CFR §156.602 as minimum essential coverage include the following:

1. Refugee Medical Assistance supported by the Administration for Children and Families;
2. Medicare Advantage plans;
3. State High-Risk Pools (for plan or policy years beginning on or before December 31, 2014); and
4. Self-insured Student Health Plans (for plan or policy years beginning on or before December 31, 2014).

Clarification of minimum essential coverage rules with respect to foreign insurance and partnerships

The regulation implementing Internal Revenue Code (Code) section 5000A(f)(1)(B) provides that a self-insured group health plan is generally minimum essential coverage, without regard to where the plan is located. Pursuant to HHS's authority under Code section 5000A(f)(1)(E), coverage under a group health plan provided through insurance regulated by a foreign government will be recognized as minimum essential coverage for a month with respect to an individual who, for such month, is physically absent from the United States for at least one day of the month. Coverage under a group health plan provided through insurance regulated by a foreign government will also be recognized as minimum essential coverage with respect to an individual who is physically present in the United States for an entire month if the coverage provides health benefits within the United States while the individual is on expatriate status. Sponsors of these plans intending to qualify as minimum essential coverage must provide a notice as described in section VIII below to their enrollees who are citizens or nationals of the United States and also comply with the reporting requirements of section 6055 of the Internal Revenue Code with respect to those enrollees.

Pursuant to HHS's authority under section 5000A(f)(1)(E), any plan, fund, or program that would be minimum essential coverage with respect to an individual but for the fact that the coverage is provided to business owners (such as present or former partners, limited liability company members, or sole proprietors, regardless of whether such individuals are considered employees), or to their spouses or dependents (as defined under the terms of the plan, fund, or

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[2] Pursuant to IRC section 5000A(f)(1)(A)(ii), Medicaid coverage is considered to be minimum essential coverage. However, in the IRS's August 30, 2013 final regulation, IRS indicated that Medicaid medically needy coverage and coverage under a Social Security Act section 1115 demonstration program were not being addressed, and indicated that medically needy and 1115 demonstration coverage would not automatically be recognized as Medicaid coverage qualifying as minimum essential coverage under section 5000A(f)(1)(A)(ii). Pursuant to its authority under IRC section 5000A(f)(1)(E), HHS will provide additional sub-regulatory guidance regarding the standards and process by which HHS may recognize medically needy coverage and coverage under a section 1115 demonstration as minimum essential coverage in each state.

[3] For a definition of grandfathered health plans see 45 CFR § 147.140.

[4] "Final regulations" refers to *Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; Final Rule, 78* FR 39493 (July 1, 2013).

program), will be recognized as minimum essential coverage with respect to any individual covered under the plan, fund, or program. Sponsors of these plans must provide a notice to their enrollees as described in section VIII below and also comply with the reporting requirements of section 6055 of the Internal Revenue Code with respect to those enrollees.

III. The 'Substantially All' Standard

As is indicated in section I, in order for the Secretary to recognize coverage as minimum essential coverage under 45 C.F.R. § 156.604, the Secretary must determine that the coverage meets substantially all the requirements of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market. The Secretary will determine whether a plan or policy meets this "substantially all" standard where the applicant certifies that the plan complies with the following provisions:

PHS Act § 2701 – Fair health insurance premiums (Only the prohibition on rating based on gender)

PHS Act § 2704 - Prohibition on pre-existing condition exclusions

PHS Act § 2705 - Prohibition against discrimination based on health status; Genetic Information Nondiscrimination Act

PHS Act § 2707(a) - Provision of essential health benefits

PHS Act § 2711 - Prohibition against lifetime and annual limits

PHS Act § 2712- Prohibition against rescissions

PHS Act§ 2713 - Coverage of preventive health services

PHS Act § 2714 - Extension of dependent coverage

PHS Act § 2715 - Summary of benefits in coverage. Plan should begin providing the summary of benefits and coverage as soon as practicable, but no later than January 1, 2015.

PHS Act § 2719 – Appeals Process

PHS Act § 2719A - Patient Protections

PHS Act § 2725 – Newborns' and Mothers' Health Protection Act

PHS Act § 2726 - Mental Health Parity and Addiction Equity Act

PHS Act § 2727 - Women's Health and Cancer Rights Act

ACA § 1302(d)(1) - Actuarial value no less than 60 percent.[5]

We note that, in addition to meeting the "substantially all" test with respect to compliance with Title I provisions that would not otherwise apply, to the extent that requirements in Title I would directly apply to the coverage by their own terms, we will evaluate the plan or policy to see if it complies with these requirements as well. Such other requirements may include, for example, PHS Act 2702 (guarantee availability), § 2703 (guaranteed renewability), PHS Act § 2706 (Non-discrimination against providers in health care), and PHS Act § 2709 (Coverage for individuals participating in clinical trials).

HHS also foresees that there may be situations where recognition of a plan as minimum essential coverage is reasonable and appropriate even where the plan does not meet the 'substantially all' standard. Accordingly, plans that do not meet all of the foregoing requirements will be evaluated on a case-by-case basis.

IV. Applicants

To be considered for recognition as minimum essential coverage, the plan sponsor or government agency may apply to be recognized as minimum essential coverage under the process described in section V of this guidance.

The statute and 45 CFR 156.602 designate certain types of coverage described in section II as minimum essential coverage. Plans or policies that fall into the categories set forth in the statute or designated as minimum essential coverage in HHS regulations do not have to submit an application to be recognized as minimum essential coverage. **Applications from these plans or policies will not be reviewed or processed.**

V. How to Apply to be Recognized as Minimum Essential Coverage

An application for recognition as minimum essential coverage must include the following information:

1. Identity of the plan sponsor and appropriate contact persons;

2. Basic information about the plan, including:
    a. Name of the organization sponsoring the plan;
    b. Name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization;
    c. Address of the individual named above;
    d. Phone number of the individual named above;
    e. Number of enrollees at the time of application;
    f. Description of eligibility criteria;
    g. Cost sharing requirements, including deductible and out-of-pocket maximum limit; and

[5] To determine if the coverage meets the actuarial value, the actuarial value calculator can be used. The calculator can be found on CCIIO's website at: http://www.cms.gov/cciio/index.html.

h. Essential health benefits covered

3. A certification by the appropriate individual, named pursuant to 45 CFR § 156.604(a)(2)(ii)(B), that the coverage sponsored by the organization substantially complies with the requirements of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market, and any plan documentation (e.g., summary of benefits or contract) or other information that demonstrate that the coverage substantially complies with these requirements.

Applicants should follow the steps below when applying to be recognized as minimum essential coverage:

4. To begin this process, applicants will need to register for access to the Health Insurance Oversight System (HIOS), request access to the minimum essential coverage application module (MEC Module), and choose the user role for their submission. One of the two mutually exclusive user roles must be selected: (1) Submitter, who completes the application and submits the documents, or (2) Certifying Official, who will review the application and documentation submitted by the Submitter, and sign the certification.

   a. New HIOS users:

      i. New HIOS users will need to use the Enterprise Portal to register in Enterprise Identity Management (EIDM) system at https://portal.cms.gov before they can become a HIOS user. Click on "New User Registration" in the right hand column of the web page under "Login to Secure Portal" and follow the instructions. Users will receive an email confirmation that registration has been completed, along with their EIDM User ID.

      ii. Once the user receives an EIDM User ID, the user should log back into EIDM, https://portal.cms.gov, using their EIDM User ID and password. Click on the "Login to CMS Secure Portal" button in the right column of the webpage. Click on the "Request Access Now" link on the right column of the webpage. Select HIOS from the "Application Description" dropdown box. New users will need to register in HIOS by clicking the link at the bottom of the page and following the registration instructions. Once the HIOS registration has been approved, the user will receive an email with their HIOS information and an Authorization Code.

      iii. The user will need to log into EIDM at https://portal.cms.gov and click on the "Login to CMS Secure Portal" button in the right column. Click on the "My Access" button to "Request New Application Access" and choose "HIOS." Enter the HIOS Authorization Code provided in the confirmation email and follow the instructions.

      iv. The user will need to logout of EIDM then log back in to EIDM https://portal.cms.gov and navigate to the HIOS tab.

v. Once the user navigates to the HIOS tab, they will click the "Access HIOS" link and request access to the HIOS MEC Module by navigating to "Role Management." Follow the instructions to complete the request. If the user cannot locate their organization within "Role Management," they should navigate to the "Manage Organization" page on the HIOS home screen and follow the instructions to complete the request. After successful organization registration, the user may request the appropriate role within the HIOS MEC Module.

b. Existing HIOS Users:

i. Existing HIOS users should log in to EIDM at https://portal.cms.gov and navigate to the HIOS tab. Once the user navigates to the HIOS tab, they will click the "Access HIOS" link and request access to the HIOS MEC Module by navigating to "Role Management." Follow the instructions to complete the request. If the user cannot locate their organization within "Role Management," they should navigate to the "Manage Organization" page on the HIOS home screen and follow the instructions to complete the request. After successful organization registration, the user may request the appropriate role within the HIOS MEC Module.

After completing the online request, both types of users will receive an email notification when access has been approved. Once it has been approved and your organization has been registered, users can create their submission. A copy of the HIOS MEC Module Technical Guide is available for download once you access the MEC Module in HIOS. If you have any questions regarding accessing HIOS, please contact the help desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

5. Obtain a copy of the Excel application spreadsheet entitled "Minimum Essential Coverage Application" from the HHS website at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.

a. Every cell of a row of this spreadsheet must have an entry for each plan or policy, and each tier thereof, as described in the document entitled "Data Dictionary." The Data Dictionary is also available at the HHS website at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.

b. The spreadsheet requests contact information for the Certifying Official, the individual who is authorized to make, and makes, this certification on behalf of the organization; information about the number of enrollees; eligibility criteria; cost sharing requirements, including deductible and out of pocket maximum limit; the essential health benefits covered by the plan or policy; and provisions of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market with which the coverage does not comply. Spreadsheets will only be accepted in .xls or .xlsx format. HHS will not accept the spreadsheet in a .pdf format.

6. In a separate document, the applicant should provide a certification, as described in section VI below. The certification statement can also be obtained at the HHS website at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.

    a. The signature of the certification must be provided by an officer or benefit administrator of the sponsor of the coverage or, in the case of a government agency, an individual who is authorized to make the certification. The person must be someone other than whoever submitted the application and the plan documents.

    b. If the certification is prepared by a third-party administrator (TPA) or consultant, the same signatory rules apply. **A TPA or consultant may not sign the certification**. An officer or benefits administrator at the client company must sign the attestation.

7. The applicant must also provide copies of any plan documentation, materials, or other information that is sufficient to demonstrate that the plan substantially complies with all of the requirements of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market. All documents should be uploaded to the MEC Module. A copy of the HIOS MEC Module Technical Guide is available for download once you access the MEC Module in HIOS.

VI. Certification

Organizations requesting that the coverage they sponsor be recognized as minimum essential coverage must provide a certification.

Please ensure that the individual signing the certification conducts a thorough review of the application contents and is fully aware of the information and representations to which he or she is certifying. Also, **the individual signing the certification should be the HIOS MEC Module Certifying Official for the online HIOS submission.**

The certification must include the following required certification language:

I, _____[print name]_____ certify that the health coverage sponsored by this organization substantially complies with the provisions of Title I of the Affordable Care Act applicable to non-grandfathered individual health insurance coverage.

> *I declare that I have made this certification, and that, to the best of my knowledge and belief, it is true and correct. I also declare that this certification is complete.*

_____, _____

(Signature) (Date)

_____

(Title)

Once it is printed and signed by the Certifying Official, it must be uploaded into HIOS by the Submitter.

VII. Submission

A complete application consists of: (1) the Minimum Essential Coverage Designation Application spreadsheet; (2) a signed certification; and (3) plan documents, materials, or other information that is sufficient to demonstrate that the coverage meets substantially all the requirements of Title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market as described in section III of this guidance.

Only electronic applications will be accepted via HIOS. Spreadsheets will only be accepted in .xls or .xlsx format. HHS will not accept the spreadsheet in a .pdf format. See specific instructions in section V above.

HHS will begin accepting applications for recognition as minimum essential coverage on Thursday, October 31, 2013.

VIII. Notice

45 CFR § 156.604(d) of the final regulations requires that once recognized as minimum essential coverage, a plan must provide notice to all enrollees that the coverage has been recognized as minimum essential coverage. The plan must also comply with the information reporting requirements of section 6055 of the Code starting in 2015.[6] The notice requirement may be satisfied by inserting a statement into existing plan materials.[7]

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[6] 45 CFR § 156.604(d).

[7] At this time, HHS has not provided specific language required to satisfy the notice requirement.

IX. Timing

HHS will process applications based on the order in which they are received. It is highly recommended that applications for recognition as minimum essential coverage be submitted into HIOS no later than 30 days after the date of this guidance.

X. Appeals Process

Consistent with 45 CFR § 156.604, HHS reserves the right to determine that a plan or policy will not be recognized as minimum essential coverage, or that a plan or policy previously recognized as such no longer meets the requirements. If such a determination is made, HHS will reject the application on the basis that the plan or policy does not qualify for recognition as minimum essential coverage.

Within 15 calendar days and upon receipt of such determination, a plan or policy may request HHS to undertake a secondary review of an application by uploading the appeals request into the HIOS MEC module and sending an e-mail to mec@cms.hhs.gov to notify HHS that the request has been submitted. Additional evidence can be submitted with the request for review. If the secondary review upholds the initial determination, the plan or policy shall have no further rights to administrative appeal.

XI. Expiration and Notice of Changes

If a plan or policy is recognized as minimum essential coverage, that recognition is valid until:

a. December 31, 2014 if the plan or policy is a self-insured student health plan or state high risk pool;

b. The sponsor or government agency makes a substantial change to the benefits provided by the plan or policy (e.g. a reduction in benefits, increase in cost sharing, or the plan no longer complies with a requirement of Title I of the Affordable Care Act that applies to non-grandfathered plans or policies in the individual market); or

c. The plan or policy falls into one of the categories initially designated by the Secretary as minimum essential coverage and the Secretary no longer recognizes that category of coverage as minimum essential coverage.

If the plan or policy is a self-insured student health plan or state high-risk pool, the sponsor or government agency must reapply to maintain its coverage's status as minimum essential coverage at least 60 days prior to the first day of the plan or policy year beginning after December 31, 2014.

If the sponsor or government agency makes any change in the coverage of the plan or policy, the sponsor or government agency must notify HHS of the change by sending an e-mail describing the change to MEC@cms.hhs.gov at least 60 days prior to the effective date of the change in coverage. If HHS determines that the change is substantial, it will notify the sponsor or

government agency that it must reapply to be continued to be recognized as minimum essential coverage.

XII. Record Retention and Audits

HHS retains audit authority over applicants as a condition of obtaining recognition as minimum essential coverage. If upon the audit of a plan or program recognized as minimum essential coverage, it is determined that the plan or program does not meet the requirements to be recognized as minimum essential coverage, HHS may, in its discretion, withdraw recognition of a plan or policy as minimum essential coverage.

Where to get more information:

If you have any questions regarding this Bulletin, please contact HHS at MEC@cms.hhs.gov and include your organization's name as the subject of the email.