REGULATION	COMMENT DEADLINE (FOR DRAFT RULES)	SUMMARY	IMPACT
Proposed Rule on Minimum Essential Coverage and Individual Shared Responsibility Payments	April 28, 2014	The proposed rule offers additional detail on MEC and shared responsibility payments consistent with recent guidance and the final MEC rule published in August 2013. The proposed rule clarifies four types of limited coverage that do not satisfy MEC standards, including: Medicaid coverage for the medically needy, Medicaid Section 1115 Demonstration Projects that do not provide comprehensive coverage, limited TRICARE coverage, and excepted benefits (ex: dental and vision insurance). The rule also discusses HRA contributions, Section 125 Cafeteria Plans, wellness incentives, and the shared responsibility payment.	The rule officially adds to the list of individuals who could be exempt from the mandate under the ACA and leaves the door open for Secretarial discretion to identify further hardship waivers that can be granted on a tax return, rather than through the exchange.
Final Rule Regarding Employer Responsibility under the Affordable Care Act		In general, the final rule provides a gradual phase-in of the employer responsibility provision for certain employers. The rule outlines that the employer responsibility provision will apply to larger firms with 100 or more full-time employees starting in 2015, while employers with 50 up to 99 full-time employees will be subject to the penalty starting in 2016. The final rule details several additional issues based on comments to earlier regulations, including clarification on transitional relief provisions, determinations of "full time" employees, and affordability safe harbors.	The delays finalized in this rule could mean, on the margin, fewer Americans will receive health insurance coverage via their employers over the next several years, while exchange market coverage and Medicaid enrollment may tick up slightly.
Bulletin on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances		This bulletin established a process for marketplaces to extend advance payment tax credits and cost sharing reductions to those unable to receive a timely eligibility determination because of exceptional circumstances, specifically technical issues with the Marketplace's automated eligibility and enrollment functionality.	The guidance offers no specificity on how individuals will prove they were unable to receive an eligibility determination, nor does it establish a deadline for these retroactive coverage determinations. The guidance, in general, adds to the administrative burden and uncertainty associated with exchange enrollment from a health plan perspective. It remains unclear whether CMS will provide further clarifying guidance and/or if it will issue formal processes on behalf of the FFM.
Final HHS Notice of Benefit and Payment Parameters for 2015		The rule finalizes payment parameters for the 2015 benefit year and standards relating to the premium stabilization programs; the 2015 plan year open enrollment period; the annual limitations on cost sharing (i.e., MOOP and small group market deductibles); consumer protections; financial oversight; and the Small Business Health Options Program (SHOP).	Many provisions in this final rule benefit health plans, such as lowering the reinsurance attachment point and easing the proposed standards for plans to demonstrate meaningful differences between plans. The extension of the 2015 enrollment period raises concerns about risk selection and

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			continuation of coverage for individuals who do not enroll until February 2015. The extension of the state exchange Blueprint deadline may influence whether issuers choose to sell products in certain states if the later deadline results in states imposing new requirements in the midst of the QHP filing process.
Proposed Rule on Exchange and Insurance Market Standards for 2015 and Beyond	April 21, 2014	Generally, the rule includes provisions that were signaled in the 2015 Notice of Benefit and Payment Parameters final rule, including policies relating to health insurance discontinuation and renewal, quality reporting and enrollee satisfaction surveys, the Small Business Health Options Program (SHOP), and adjustments to risk corridors and the medical loss ratio (MLR) requirements in light of transitional policies and technical issues associated with 2014 open enrollment. The rule also proposes stronger standards for Navigators and other consumer assistance entities.	HHS' proposal to allow state regulators to request a delay in employee choice for 2015 should help stabilize risk pools in the small group market and encourage more issuers to participate in SHOP. In previous guidance, HHS allowed SBEs to rely on HHS to perform verification of enrollment in, or eligibility for, coverage under employer-sponsored insurance for the purpose of determining advanced payment of premium tax credits. This rule proposes to delete this option, citing the administrative burden of pursuing this approach. Also, this rule proposes to require SBEs to perform exemption certifications for applications submitted on or after November 15, 2014. To aid in the transition, HHS has developed and released model paper applications that SBEs can use to issue certificates of exemption.
Interim Final Rule on Third Party Payments	May 13, 2014	This IFR requires qualified health plans and standalone dental plans to accept third party payments on behalf of enrollees from the Ryan White program, Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs. The requirement applies to all individual market QHPs and SADPs, regardless of whether they are offered through a federally facilitated exchange (FFE), a state based exchange (SBE), or outside of the exchanges.	While CMS had previously issued FAQs recommending that issuers accept payments from the Ryan White program, tribal organizations, and state and federal government programs, this rule requires issuers to accept those payments. HHS gives itself enforcement abilities to penalize issuers who do not comply.
Insurance Standards Bulletin Series – Extension of Transitional		This bulletin extended the transitional "grandfathering" policy for two years for plans in the small group and individual markets for policy years beginning on or before October 1, 2016. Specifically, this announcement extends and expands the policy put in place by	This policy allows people to stay enrolled in non-compliant ACA plans well into 2017. It remains unclear how many Americans remain in non-ACA compliant plans in 2014 and will choose to continue

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Policy		CMS in November 2013, which allows individuals to keep their non-ACA-compliant plans, at the discretion of state insurance commissioners and insurance issuers. The bulletin also extends the policy to certain large employers and gives states additional flexibility in implementing the policy.	such coverage into future years under the proposal. However, the policy could continue to have an impact on the number of exchange enrollees, risk selection, and premium rates as people continue to purchase insurance outside the Marketplace.

Note: Rules and Agency Letters pertaining only to the Federally Facilitated Exchange, State Partnership Exchanges or Basic Health Programs were omitted from this list.

Information provided by Avalere Health, LLC.