"ACA Compliance Check-Ups for Health Plans in Mergers & Acquisitions"
"To Grandfather or Not to Grandfather –The Impact of Status on Risks and Liabilities in Mergers & Acquisitions"

ABA - JCEB
Employee Benefits in Mergers & Acquisitions

New York, New York
June 5, 2014

Updated
May 2014

By:
Greta E. Cowart
Winstead PC
500 Winstead Building
2728 N. Harwood
Dallas, TX 75201
Email: gcowart@winstead.com
214.745.5275

CAVEAT: These materials do not constitute legal advice. These materials merely provide a high level summary of some of the requirements applicable to group health plans under the Patient Protection and Affordable Care Act (the "ACA") regarding the mandates on coverage provided by group health plans. This is not intended to be a complete explanation of all details on every aspect of these requirements. No person should take any action based upon the contents of this article or chart without first reviewing the guidance or consulting their own personal legal advisor or reviewing all of the applicable guidance.

When a company acquires an entity with a group health plan in a merger or acquisition, it wants to know the prospective liability related to such group health plan's operations and level of compliance. When an entity is acquired via a stock acquisition, it acquires the entity, all of its plans and all of their faults. Following the enactment of the Patient Protection and Affordable Care Act (the "ACA"), the risk of liabilities related to employer sponsored group health plan greatly expanded due to the expansion of the requirements imposed on such plans and the various taxes and penalty taxes which became assessable on certain employers. The purpose of this article is to summarize how the various requirements on the contents of group health plans varies by the status of such benefit option ("grandfathered", "not-grandfathered" or "exempt") and by how such plan's benefits are provided (insured v. self-insured). This is not a summary of every detail of each of the requirements, but a starting point to use to analyze which requirements may apply to a particular benefit option and from that determine the compliance status of such benefit option and the potential risks and liabilities related to acquiring the entity sponsoring such benefit option. Plans which have fewer than 2 current employees on the first day of the plan year are exempt from all of the ACA requirements (e.g., retiree only plans). The requirements applicable to excepted benefits (e.g. certain health flexible spending accounts and limited scope stand-alone vision and dental benefits are not dealt with in the following chart, but instead is addressed in the narrative that follows.

Violation of any of the standards summarized in the chart results in a penalty of $100 per day per violation per affected person under Code § 4980D. Compliance and the status of each benefit option must be analyzed for each plan year to determine the potential exposure for each plan year beginning on or after September 23, 2010. If a tax return is not filed reporting the tax or requesting a waiver of the tax penalty for the plan year, the IRS has historically taken the position with respect to COBRA and HIPAA portability violation penalties that no statute of limitation has started to run on the tax year and thus the year does not become closed to audit by the IRS. Thus, employers may want to consider filing the applicable forms to start the statute of limitations running on some of the tax years to limit exposure. In an acquisition, the acquiring entity may want to consider reviewing the Forms 8928 filed by the target entity to determine the number of years in which violations are closed and which have a statute of limitations currently running and the years for which the statute of limitations has arguably not started to run because no tax returns have been filed for the taxes for such years.

Notice 2013-45 did not delay the effective date of any of the requirements described in this chart for grandfathered or non-grandfathered plans or benefit options. Grandfathered status is tested and determined on a benefit option by benefit option basis. For example the PPO Option or the HDHP Option or the HMO Option. The Chart below provides a very high level description of each of the sections added by the ACA imposing requirements on group health plans. These are not intended to be complete descriptions of any of the requirements, but to provide a guide regarding for which items compliance needs to be explored in a particular year to assess any potential risks or liabilities related to an acquisition.

Public Health Service Act Provision Added by the ACA	**Fully Insured Grandfathered Benefit Option that is not exempt**	**Self Insured Grandfathered Benefit Option that is not exempt**	**Fully Insured Benefit Option Not Grandfathered that is not exempt**	**Self Insured Benefit Option Not Grandfathered that is not exempt**
Subtitle A Changes				
PHSA §2711 (ACA §1001 and 1251) No lifetime dollar limits on the value of health benefits[1]	1.1.11	1.1.11	1.1.11	1.1.11
PHSA §2711 (ACA §1001 and 1251) No annual dollar limits on the value of health benefits[1]	1.1.14	1.1.14	1.1.11	1.1.11
PHSA §2711 (ACA §1001 and 1251)[2]	1.1.11 to 1.1.14	1.1.11 to 1.1.14	1.1.11 to 1.1.14	1.1.11 to 1.1.14

[1] The treatment of what constitutes an essential health benefit must be consistent within a benefit option so amounts treated as an essential health benefit are not applied toward dollar limits on non-essential health benefits and amounts treated as essential health benefits are not applied toward limits on non-essential health benefits. The prohibition on lifetime limits is not limited to essential health benefits, but is a prohibition with respect to "benefits." May provide annual or lifetime limits on benefits that are not essential health benefits.

[2] The delayed effective date for the no annual dollar limits and permissive used of restricted annual dollar limits is not conditioned upon the existence of grandfathered status for the plan. The statute provides for the restricted annual limits without ever mentioning or requiring grandfathered status.

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
A restricted annual dollar limit is permitted on the value of essential health benefits.[1]				
PHSA §2712 (ACA §1001 and 1251) No rescission of coverage except in the case of fraud or an intentional misrepresentation of a material fact[3]	1.1.11	1.1.11	1.1.11	1.1.11
PHSA §2713 (ACA §1001 and 1251) Coverage of certain specified preventive care identified by an A or B rating by the U.S. Preventive Services Task Force, The Advisory Committee on Immunization Practices of the CDC, for infants, children and adolescents Health Resources and services Administration guidelines, and for women the Health resources and Services Administration guidelines. All are to be provided without any cost sharing requirement. See attached Appendix A for the requirements from the first two agencies listed above. The DoL subsequently clarified that use of value based insurance design where no copayment is charged for a preventive service in the lowest cost	*	*	1.1.11	1.1.11

[3] Failure to pay is not a termination of coverage that is a rescission of coverage. See FAQs. Issued by DoL. Rescission of coverage is subject to external review per 76 Fed. Reg. 37,208. Health reimbursement accounts integrated with a group health plan may continue to exist. *Id.* Standalone health reimbursement accounts have a HHS Waiver until 2014 when they either must comply fully with ACA, be excepted benefits or exempt from ACA, become integrated with a group health plan or cease to exist.

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
setting, but for which a copay applied for the same service in a higher cost setting was compliant with the requirement that the specified preventive care services be provided without cost sharing.[4] An exemption from the requirement to cover oral contraceptives is provided for certain church related organizations, provided certain conditions are met.[5] For 2013 preventive care includes coverage of contraceptives unless the entity meets the new church exception.				
PHSA §2714 (ACA §1001 and 1251) Extension of dependent coverage to age 26 for dependents provided the child does not have other coverage available from the child's employment or the child's spouse's employment.[6] (Interim Final DoL Reg. §2590.715-2714	1.1.11	1.1.11	N/A	N/A
PHSA §2714 (ACA §1001 and 1251) Extension of dependent coverage to age 26 regardless of whether or	1.1.14[8]	1.1.14[9]	1.1.11	1.1.11

[4] U.S. DoL FAQ V, Q&A #1 (December 23, 2010); U.S. DoL FAQ VI, Q&A 3 (April 1, 2011). See http://www.healthcare.gov/law/resources/regulations/prevention/recommendations.html for the mandated preventive care coverage.
[5] 76 Fed. Reg. 46621 (August 3, 2011) 29 CFR § 2590.715-2713(a)(1)(iv).
[6] Interim Final Treas. Reg. § 54.9815-2714T; DoL Reg. § 2590.715-2714; 45 CFR § 147.120.

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
not the dependent has coverage available from his/her own employment or his/her spouse's employment.[7]				
PHSA §2715 (ACA §1001 and 1251(a)(3)) Uniform summary of coverage on 4 pages in 12 point font and use of uniform definitions required. Mandated notice 60 days prior to any reduction in benefits of change with a $1000 per enrollee penalty for a late notice. Model 4 page summary to be developed by HHS by 3.23.11. Proposed regulations issuing 6 page to be completed model summary of coverage released on August 18, 2011 and to be published in the Federal Register on August 23, 2011. The model summary was originally used by group health plans and insurers by 3.23.12.[10] However, the March 23, 2012 deadline was	For open enrollments on and after September 23, 2012[12] and new enrollees for the first plan year commencing on or after September 23, 2012.	For open enrollments on and after September 23, 2012[12] and new enrollees for the first plan year commencing on or after September 23, 2012.	For open enrollments on and after September 23, 2012[12] and new enrollees for the first plan year commencing on or after September 23, 2012.	For open enrollments on and after September 23, 2012[12] and new enrollees for the first plan year commencing on or after September 23, 2012.

[8] The delay for application of this provision to adult dependent children for both fully insured and self-insured group health plans ends on January 1, 2014. DoL Reg. § 2590.715-2714; Temp. Treas. Reg. § 59.9815-2714T; 45 CFR § 147.120.

[9] *Id.*

[7] Interim Final Treas. Reg. § 54.9815-2714T; DoL Reg. § 2590.715-2714; 45 CFR § 147.120.

[10] U.S. DoL FAQ V, Q&A #4 (December 23, 2010) clarified that the 60 day advance notice requirement is not effective until the 4 page summary of coverage is required to be produced. However, the implementation date for plans has been delayed until final guidance is issued. U.S. DoL FAQs VII, Q&A #1 (November 17, 2011). Final regulations

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
originally extended pending issuance of final guidance on this requirement.[11] Final regulations were released on February 9, 2012 and published February 14, 2012 which required the summary of benefit coverage to be provided for open enrollments and plan years commencing on or after September 23, 2012.[12]				
PHSA §2715A (ACA §1001,1311(e)(3) and 1251) Plan is required to submit information to the insurance commissioner and to the Secretary of HHS regarding claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims denied, data on rating practices, information on cost-sharing and payments to any out of network coverage, information on participant rights and other information determined by the Secretary. Minimum loss ratio regulations were issued for insurers. Employers should handle rebates in compliance with U.S. Department of Labor Technical Release 2011-4.	* Insurers also must submit this information to the Exchange which must be operational by 2014	*	1.1.11 Insurers also must submit this information to the Exchange which must be operational by 2014	1.1.11

issued February 14, 2012 set the effective date for the open enrollments commencing on or after September 23, 2012 or plan years commencing after such date. 77 Fed. Reg. 8668 (Feb. 14, 2012); DoL FAQ VIII, Q&A 1.

[11] U.S. DoL FAQ VII, Q&A #1 (November 17, 2011).

[12] 77 Fed. Reg. 8668 (February 14, 2012).

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
PHSA § 2716 (ACA § 1001, 1251 and 1563) Code §105(h) rules applied to fully insured plans and discrimination is prohibited in favor of highly compensated employees. IRS Notice 2011-1 delays the application of such nondiscrimination provisions until after guidance is issued.	*	N/A	1.1.11[13]	N/A
PHSA §2717 (ACA §1001 and 1251) Quality of care assurance provision requires reporting within 2 years of 3.23.10 on health outcomes, case management, care coordination, chronic disease management and medication and care compliance initiatives, activities to prevent hospital readmissions, to improve patient safety and reduce medical errors, and to implement wellness programs. This section also includes a prohibition against a wellness program considering gun or ammunition ownership, storage or use as part of its wellness program.	*	*	1.1.11 but delayed until HHS develops reporting requirements by 3.23.12	1.1.11 But delayed until HHS develops reporting requirements by 3.23.12

[13] IRS Notice 2011-1, 2011-2 IRB 259, clarified the new nondiscrimination rules will not be effective until after regulatory guidance is issued.

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
PHSA §2718 (ACA §1001, 1251(a)(3) and 1563(e)) Requires reporting to the Secretary of the loss adjustment expense (or charge to contract reserves) to earned premiums ratio and the percentage of total premium revenue after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance that the plan expends on reimbursement for clinical services provided to enrollees, and activities that improve health care quality.	Plan Years After Date of Enactment	N/A	Plan Years After Date of Enactment	N/A
PHSA §2719 (ACA §1001 and 1251) New appeals process required with rights to review files and present evidence and testimony; however, there is no indication a plan must establish or offer a hearing and it is not precluded from limiting the testimony to written testimony. A hearing may be available in the applicable office of health insurance consumer assistance or ombudsman under 2793. A participant may request an appeal be sent to external review after completion of the ERISA claim and appeal	*	*	1.1.11[15]	1.1.11[15]

[15] Due to the significant changes required for implementing the expanded adverse benefit determination disclosures and the challenges in contracting with these IROs, the U.S. Department of Labor issued Technical Release 2010-02 which permits plans an enforcement grace period until July 1, 2011 to change some but not all of the procedural requirements and to incorporate the increased disclosures in the adverse benefit determinations. DoL FAQ I, Q&A #12 & #13 (September 20, 2010).

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
procedures. The external review must be rotated among three accredited independent review organizations. The ERISA appeal process as revised must be strictly complied with when grandfathered status is lost. The updated ERISA claim and appeal process shall be updated with any new standards established by the DoL for such plans. (The DoL has reopened a project on the ERISA claim and appeal process.) The Secretary may deem the external review process of a group health plan to be compliant as of the date of enactment. The requirements include requiring coverage to be provided while the appeal is pending, if the claim was previously approved. The new standards also require decisions on urgent care claims to be communicated within 72 hours unless exigencies require a more rapid response.[14] Please request the separate paper regarding the claims, appeals and external review requirements for a discussion of the subsequent guidance, if you desire more information on these requirements.				
PHSA §2719A (ACA §1001 and 1251) Emergency services at a non network facility must be available	*	*	1.1.11	1.1.11

[14] 76 Fed. Reg. 37208 (June 24, 2011).

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
without prior authorization and with the same cost sharing as if the services were provided in network. Emergency services are broadly defined and not limited to just the emergency room charges. The calculation of the "same cost sharing" requires payment of the greater of three calculations.[16] Patients must have access to pediatricians and Ob-Gyns without a referral as primary care physicians in plans that require a primary care physician.				
PHSA §2793 (ACA §1002) Secretary to award grants to states to support offices of health insurance consumer assistance or ombudsman programs (to fulfill ombudsman role in PHSA §2719) effective fiscal year beginning 10.1.10.	N/A	N/A	N/A	N/A
PHSA §2794 (ACA §1003) Secretary and the State will establish a process to annually review premium increases to identify unreasonable increases in premiums-effective fiscal year beginning 10.1.10.	N/A	N/A	N/A	N/A

[16] Interim Final Treas. Regs. § 54.9815-2719AT(b); DoL § 2590.715-2719A(b); 45 CFR § 147.138(b).

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
Subtitle C Changes				
PHSA §2701 (ACA §1201 and 1251(a)(2)) Prohibits health insurance issuers from discriminating on premiums charged in the small group market or in the individual market except by single v. family, rating area, age, but not with a more than 3:1 differential, or tobacco use. A State may elect to adopt these restrictions in the large group market. 1.1.14.	N/A	N/A	Applies to insurer on 1.1.14	Applies to insurer on 1.1.14
PHSA §2702 (ACA §1201 and 1251(a)(2) and 1255) Health insurance issuers must provide individual coverage on a guaranteed issue basis in the individual and small group market.	N/A	N/A	Applies to insurer on 1.1.14	Applies to insurer on 1.1.14
PHSA §2703 (ACA §1201 and 1251(a)(2) and 1255) Guaranteed renewability of coverage	*	*	1.1.14 Applies to insurer	1.1.14 Applies to insurer
PHSA § 2704 (ACA §1201 and 1251(a)(4) and 1255(2)) Prohibits imposition of a pre-existing condition exclusion on any dependent under the age of 19.	1.1.11	1.1.11	1.1.11	1.1.11
PHSA § 2704 (ACA §1201 and 1251(a)(4) and (2) and 1255(2)) Prohibits imposition of a pre-existing condition exclusion on anyone	*	*	1.1.14	1.1.14

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
other than a dependent under the age of 19 years				
PHSA §2705 (ACA §1201 and 1251(a)(2) and 1255) Group plans and health insurance issuers are prohibited from discriminating in rules for eligibility for coverage on the basis of health status (using the HIPAA/GINA factors) and new wellness programs are provided by statute with incentives up to 30% of the premium. Clarifies programs outside of wellness program discount limitations. Permits existing programs to continue operating in compliance with existing regulations PHSA § 2705(k).	*	*	1.1.14	1.1.14
PHSA §2706 (ACA §1201 and 1251(a)(2) and 1255) A federal any willing provider statute is added that requires a group health plan and insurer to not discriminate with respect to participation in the plan against any health care provider who is acting within the scope of that provider's license in the applicable state. The provision then states it does not require the plan to contract with any provider, but most plans do not contract directly with health care providers. The managed care entities or insurers or networks contract with the health care providers to form the provider networks used by plans. Thus, the sentence intending to cutback the any willing provider provision may be of little help to group health plans	*	*	1.1.14	1.1.14

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
who do not contract with health care providers directly to create their own network, unless guidance is issued expanding on what constitutes the plan for this purpose.				
PHSA §2707 (ACA §1201 and 1251(a)(2) and 1255) Requires group health plan to provide minimum essential coverage. Insurers offering coverage on the exchange must offer essential health benefits package under ACA §1302(a) and limit cost sharing to the limits provided under 1302 which are the HDHP limits, but then indexes those limits differently from the way in which they are indexed for the HDHP plan.	*	*	1.1.14	1.1.14
PHSA §2708 (ACA §1201 and 1251(a)(4) and 1255(1)) Waiting periods may not exceed 90 days in any group health plan.	1.1.14	1.1.14	1.1.14	1.1.14

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

Public Health Service Act Provision Added by the ACA	Fully Insured Grandfathered Benefit Option that is not exempt	Self Insured Grandfathered Benefit Option that is not exempt	Fully Insured Benefit Option Not Grandfathered that is not exempt	Self Insured Benefit Option Not Grandfathered that is not exempt
PHSA §2709 (ACA §1201 and 1251 and 1255(1)) (This is the section added by ACA as 2709 and not the previously existing § 2713 of the PHSA that was renumbered as § 2709) Requires coverage of the expenses an individual who is participating in a clinical trial incurs as part of the trial to be covered by the group health plan or health insurance and the plan or insurer may not deny the individual the ability to participate in the clinical trial, but the plan can require the individual to use a participating provider who is participating in the clinical trial, provided the applicable requirements are satisfied.	*	*	1.1.14	1.1.14
PHSA §2709 formerly PHSA §2713 renumbered to PHSA §2709 by Act §1001 and §1563(c)(10)(C) Requires insurers to make disclosures to individuals regarding coverage.	Applies Now	Not applicable to self-insured	Applies Now	Not applicable to self-insured

*** Grandfathering delays the application of this provision provided the requirements to maintain grandfathered status are satisfied every year by the benefit option. Once grandfathering is lost for a benefit option, all provisions delayed by grandfathering must be satisfied by such benefit option.**

What Relief Does Grandfathering Really Provide?

In order to assess whether grandfathered status for a plan under the ACA is worth preserving, one must understand what relief it provides. The relief is provided only as long as grandfathered status lasts. The ability to maintain grandfathered status is measured by comparing the proposed plan terms and premium sharing against the plan as it existed on March 23, 2010; thus the non-inflation based increases permitted are a one time change not an annual change. Grandfathered status is determined on a benefit package or a plan basis, e.g., PPO is defined separate from the POS Option or the HMO option. Grandfathered status of benefit package or option (e.g., PPS v. POS v. HMO) is determined for each plan year comparing the proposed changes to the plan in effect on March 23, 2010.

Grandfathered status means a plan is deemed to provide minimum essential coverage under Code section 5000A(f)(1)(D) for purposes of satisfying the individual responsibility to maintain coverage under ACA § 1501 and it satisfies minimum essential coverage to satisfy the employer responsibility under Code section 4980H(c)(6) as added by ACA § 1513, thus providing a way to avoid the tax penalties as long as the coverage is affordable and taken by the employer.

Grandfathered status means that for the period beginning with the first plan year beginning on or after September 23, 2010 and until either grandfathered status is lost due to an action taken to change the plan or otherwise, or until a date to be specified in technical corrections or guidance the following requirements are different than the requirements for non-grandfathered plans:

1. The grandfathered plan is not required to cover all of the preventive and wellness services listed in Appendix A with no cost sharing. This means copayments can be imposed and the plan does not need to determine if any of these services are provided currently in a manner which may provide for bundled billing and which may be subject to cost-sharing currently. This also means the grandfathered plan is not required to monitor the lists of preventive care services updated annually by the various government agencies.

2. Coverage must only be extended to dependents to age 26 if the dependent does not have coverage available from his or her employer by a grandfathered plan. Non-grandfathered plans must extend coverage to all dependents to age 26 regardless of whether or not they have coverage available through their own employment. No surcharge or additional fee or change in the coverage provided to these adult dependent children is permitted.[17] Grandfathered status for the adult dependent coverage ends on January 1, 2014, and after such date the coverage must be extended to age 26 regardless of whether the adult child has coverage available from his or her employer or his or her spouse's employer.[18]

---

[17] DoL Reg. § 2590.715-2714; Temp. Treas. Reg. § 54.9815-2714T; 45 CFR §§ 144.101, 146.101, 147.100 and 147.120.
[18] *Id.*

3. Grandfathered plans are not required to submit information to the Insurance Commission and Secretary of Health and Human Services regarding claim payment policies, financial disclosures, enrollment and disenrollment, number of claims denied and cost sharing payment for out-of-network coverage and participant rights annually. This requirement is otherwise effective for non-grandfathered plans for the first plan year beginning on or after September 23, 2010, however, this mechanism has not been established to date beyond the minimum loss ratio guidance.[19]

4. Fully insured grandfathered plans can delay the impact of applying the rules prohibiting discrimination based upon compensation of the employees that currently apply to self-insured plans to themselves as fully insured group health plans once grandfathered status is lost.[20]

5. Quality of care, and quality assurance reports (reports on health outcomes, case management, readmissions, medication compliance, etc.) will begin for grandfathered plans after grandfathered status is lost instead of 2 years after the date of enactment.[21]

6. The application of the new external appeals process, strict compliance standard for the claim and appeal process more rapid response to urgent care claims, and the increased adverse benefit determination disclosures and the external review requirement is delayed for grandfathered plans until grandfathered status is lost; however, the Secretary has the ability to deem a currently compliant ERISA claim and external appeal process compliant with the ACA and this deeming compliant may mitigate the need for some plans to maintain grandfathered status to provide the delay of this requirement.[22] The new claim and appeal process requirement that coverage continue while the claim and appeal are pending and this potentially costly requirement is also delayed for grandfathered plans.[23] Certain aspects of the implementation of the new claim and appeal process requirements for non-grandfathered plans are delayed until July 1, 2011.[24] An additional extension for a slightly more limited number of the new requirements for non-grandfathered plans are delayed until the first plan year beginning on or after July 1, 2011.[25]

---

[19] PHSA § 2715A.
[20] ACA §§ 1001, 1251 and 1563; PHSA § 2716; however the nondiscrimination testing of insured non-grandfathered plans has been delayed until regulation are issued. Notice 2011-1, 2011-2 IRB 259.
[21] PHSA § 2717 and ACA §§ 1001 and 1251.
[22] PHSA § 2719 and ACA §§ 1001 and 1251.
[23] PHSA § 2719.
[24] DoL Technical Release 2010-02; DoL FAQ I, Q&A #12 and 13 (September 20, 2010).
[25] U.S. Department of Labor, Technical Release 2011-1.

7. Grandfathered plans do not need to provide for emergency services at a non-network facility without preauthorization and with the same cost sharing as if the services were provided in-network and avoid the calculation of the "same cost sharing" for all of the "emergency services." Grandfathered plans are not required to permit the designation of pediatricians or obstetricians and gynecologists as a primary care physician.[26]

Collectively Bargained Compliance Extension Combined with Grandfathered Status. If a plan is relying on the collectively bargained extension under ACA §1251(d) and it also wants to rely on being grandfathered, then it must comply with the grandfathered plan requirements effective after enactment of the ACA and before the last collective bargaining agreement with respect to the insured coverage terminates. The collective bargained plan that is grandfathered must comply with the requirements for grandfathered plans as applicable to grandfathered plans even before the collective bargaining agreement terminates.[27]

What must a grandfathered plan comply with for the first plan year beginning on or after September 23, 2010 (assuming no collectively bargained extension applies and plan is still grandfathered)?

1. Grandfathered plans must eliminate lifetime dollar limits on the value of health benefits.[28] This is the same for non-grandfathered plans. Essential health benefits have not been defined beyond the statutory categories in ACA § 1302.

2. Grandfathered plans may provide for restricted annual dollar limits on the value of essential health benefits until January 1, 2014, but thereafter must provide unrestricted dollar limits on the lifetime value of health benefits. This is the same for non-grandfathered plans.[29]

3. Grandfathered plans must not permit rescissions of coverage except in the case of fraud or an intentional material misrepresentation of a material fact.[30] This is the same for non-grandfathered plans.

4. Grandfathered plans must permit dependents to remain covered up to age 26 as long as the dependent does not have coverage from his/her own employment or child's spouse's employment.[31] Non-grandfathered plans must cover the dependent to age 26 regardless of whether or not the child has coverage available from his employer or his/her spouse's employer.[32]

---

[26] PHSA § 2719A and ACA §§ 1001 and 1251.
[27] Interim Final Treas. Reg. § 54.9815-1251T(f); 29 CFR § 2590.715-1251T(f); 45 CFR § 147.140(f).
[28] ACA §§ 1001, 1251 and PHSA § 2711.
[29] *Id.*
[30] ACA §§ 1001, 1251 and PHSA § 2712.

5. A grandfathered plan must not impose a pre-existing condition exclusion or limitation on a dependent under the age of 19 years.

What must a grandfathered plan begin to comply with beginning with the first plan year on or after January 1, 2014 (if the plan is still grandfathered and no collective bargaining extension applies?)

A grandfathered plan that maintains such status into 2014 remains able to avoid the items explained above, but in 2014 is required to comply with the following additional requirements.

1. A grandfathered plan or a non-grandfathered plan must no longer impose restricted annual dollar limits on essential health benefits and must not impose annual dollar limits on health benefits.[33]

2. A grandfathered plan must cover dependent children to age 26 even if the child has health coverage available through the child's employment or child's spouse's employment.[34]

3. A grandfathered plan and a non-grandfathered plan are both required to not impose a waiting period in excess of 90 days.[35]

4. A grandfathered plan must not impose a pre-existing condition exclusion on any child under 19 years of age. Beginning on January 1, 2014, non-grandfathered plans must not impose any pre-existing condition exclusion.[36]

5. A grandfathered plan must only comply with HIPAA's and the GINA health status based nondiscrimination and wellness program requirements under ERISA § 702 and Code § 9802 with rewards limited to 20% of the premium. A non-grandfathered plan must comply with the health status based non-discrimination requirements under new PHSA § 2705 with rewards of up to 30% of the premium and which can be extended to 50% by regulation.[37]

---

[31] ACA §§ 1001, 1251 and PHSA § 2714.
[32] DoL Reg. § 2590.715-2714; Temp. Treas. Reg. § 54.9815-2714T; 45 CFR §§ 144.101, 146.101, 147.100 and 147.120.
[33] ACA § 1251(a)(4)(B)(i).
[34] ACA § 1251(a)(4)(B)(ii).
[35] ACA § 1251(a)(4)(A)(i).
[36] PHSA § 2704 and ACA §§ 1251 and 1255.
[37] ACA §§ 1251 and 1255.

What does a grandfathered plan avoid complying with beginning for the first plan year beginning on or after January 1, 2014 (assuming no collectively bargained extension applies)?

In addition to the items shown above that a grandfathered plan must comply with in years prior to 2014, a grandfathered plan that maintains its grandfathered status after January 1, 2014 may also avoid the following requirements:

1. The grandfathered plan is not required to comply with the prohibition against imposing a pre-existing condition exclusion on any person age 19 years or older.[38]

2. The grandfathered plan is subject to the HIPAA health status based non-discrimination requirements and wellness program requirements.[39] The grandfathered plan is not subject to the recodification of such health status based non-discrimination provisions in the PHSA or the new wellness program provisions with increased wellness incentives under ACA.[40]

3. The grandfathered plan avoids compliance with the curious provision added in PHSA § 2706 which in the first sentence reads as if it were imposing a federal any willing provider statute, but then adds it does not require the plan to contract with any healthcare provider willing to meet its contract conditions. However, in most cases the plan does not do the contracting with the healthcare providers directly so it is not clear what the second sentence does for the plan. It does state the plan can establish varying reimbursement rates for providers.[41]

4. The grandfathered plan avoids the requirement that it provide essential health benefits and be required to limit cost sharing to the limits for a high deductible health plan coverage (coverage of the type necessary for an individual to be eligible to contribute to a health savings account). However such amounts are indexed differently for purposes of this limit.[42]

5. The grandfathered plan avoids being required to provide coverage for a person participating in a clinical trial.[43]

---

[38] ACA §§ 1201, 1251 and 1255 and PHSA § 2204.
[39] Code § 9802 and ERISA § 702.
[40] ACA §§ 1201, 1251 and 1255 and PHSA § 2705.
[41] ACA §§ 1201, 1251(a)(2) and 1255 and PHSA § 2706.
[42] ACA §§ 1201, 1251(a)(2) and 1255 and PHSA § 2707.
[43] ACA §§ 1201, 1251(a)(2) and 1255 and PHSA § 2709.

What is required to maintain grandfathered status?

A plan must have been in effect on March 23, 2010 and had individuals enrolled in the plan as of such date to be grandfathered.[44] The grandfathered status must be maintained continuously since the first plan year beginning on or after September 23, 2010. The status of whether the plan is grandfathered is tested on a benefit option or structure basis.[45] In order to maintain grandfathered status, the plan must include a statement it is intended to be grandfathered in any documents provided to participants along with additional disclosures.[46] However, the U.S. Department of Labor later clarified that the grandfathered status notice is not required to be included on any explanation of benefit or adverse benefit determination.[47] The plan must document its terms as of March 23, 2010 and its coverage after such date to verify it continued to maintain its grandfathered status.[48] In addition any change to the plan that was in effect on March 23, 2010 must not violate any of the restrictions below or be a method to circumvent the restrictions listed below.

A plan that is grandfathered must not increase the coinsurance percentage or any other percentage cost sharing paid by the participants for any benefit above the level at which such benefit was paid as of March 23, 2010.[49]

A plan that is grandfathered may permit other family members to enroll after March 23, 2010.[50] While new employees can join the plan there are restrictions on whether new groups of employees can be transferred to the plan without tainting grandfathered status.[51] A grandfathered plan cannot have employees transferred from a non-grandfathered plan if amending the transfer or plan to match the terms of the transferee plan would have caused the transferor plan to lose grandfathered status if there was no bona fide employment based reason for the transfer of the employees. A bona fide employment based reason for the transfer of the employees will exist if any of the following exist:

1. When a benefit package is being eliminated because the issuer is exiting the market;

2. When a benefit package is being eliminated because the issuer no longer offers the product to the employer;

---

[44] ACA § 1251(a).
[45] Interim Final Treas. Reg. § 54.9815-1251T(a)(1)(i); 29 CFR § 2590.715-1251(a)(1)(i); 45 CFR § 147.140(a)(1)(i); DoL FAQ II, Q&A 2.
[46] Interim Final Treas. Reg. § 54.9815-1251T(a)(2); 29 CFR §2590.715-1251(a)(2); 45 CFR§147.140(a)(2).
[47] DoL FAQ IV, Q&A 1 (April 1, 2011).
[48] Interim Final Treas. Reg. § 54.9815-1251T(a)(3); 29 CFR § 2590.715-1251(a)(3); 45 CFR § 147.140(a)(3).
[49] Interim Final Treas. Reg. § 54.9815-1251T(g)(1)(ii); 29 CFR § 2590.715-1251(g)(1)(ii); 45 CFR §147.140(g)(1)(ii).
[50] Interim final Treas. Reg. § 54.9815-1251T(a)(4); 29 CFR § 2590.715-1251(a)(4); 45 CFR § 142.140(a)(4).
[51] Interim Final Treas. Reg. § 54.9815-1251T(b); 29 CFR § 2590.715-1251(b); 45 CFR § 147.140(b).

3. When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;

4. When a benefit package is eliminated from a multi-employer plan as agreed upon as part of the collective bargaining process; or

5. When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

The above list is not exhaustive of circumstances that are bona fide employment-based reason condition.[52]

A grandfathered plan must not eliminate all or substantially all benefits to diagnose or treat a particular condition; included in this is that the plan may not eliminate benefits for any necessary element to diagnose or treat a particular condition.[53]

A grandfathered plan may not increase fixed amount cost sharings other than co-payments such as out-of-pocket maximums or deductibles above the amount as of March 23, 2010 plus the "maximum percentage increase". The limit on increases in non-co-payment fixed amount cost sharing requirements is that it must not exceed the "maximum percentage increase" which is 15% plus the change in the medical inflation from March 2010 which is measured by taking the greatest value of the unadjusted medical index of the CPI-U within 12 months of the date the increase is effective less the March 2010 medical component of the unadjusted CPI-U and dividing such difference by the March 2010 medical care component of the CPI-U (387.142) to obtain the change to add to the 15% base. Such sum is then applied to the fixed amount of cost sharing and compared to the new level of fixed amount cost sharing to see if the increase is within the required limit.[54] As of August 2011, the highest medical CPI-U for the 2011 calendar year was 422.813.

A grandfathered plan is also limited in the amount it may increase co-payments if it wants to maintain its grandfathered status. Co-payments may not be increased above the March 23, 2010 level by more than the greater of (1) $5, with the $5 amount increased by medical inflation (the full copayment is not increased by inflation), or (2) the maximum percentage increase determined by expressing the increase in the co-payment as a percentage.[55] The change in a copayment for a drug because the drug moves to a new tier does not cause the plan to lose grandfathered status.[56] If a plan uses value based insurance design and has an increased copayment if a service is provided on an in-network/out-patient hospital setting instead

[52] DoL FAQ VI, Q&A 1 (April 1, 2011).
[53] Treas. Reg. § 54.9815-1251T(g)(1)(i); 29 CFR § 2590.715-1251(g)(1)(i); 45 CFR § 147.140(g)(1)(i).
[54] Treas. Reg. § 54.9815-1251T(g)(1)(iii) and (3); 29 CFR § 2590.715-1251(g)(1)(iii) and (3); 45 CFR § 147.140(g)(1)(iii) and (3).
[55] Treas. Reg. § 54.9815-1251T(g)(1)(iv) and (3); 29 CFR § 2590.715-1251(g)(1)(iv) and (3); 45 CFR § 147.140(g)(1)(iv) and (3).
[56] DoL FAQ VI, Q&A 2 (April 1, 2011).

of an in-network ambulatory surgery center, the copayment for the in-network out-patient hospital may be increased as long as the copayment for the in-network ambulatory surgery center did not increase and the plan would retain grandfathered status.[57]

A grandfathered plan may also lose grandfathered status by decreasing the employer's contribution rate (or the employee organization's contribution rate). The employer's contribution rate is calculated using the COBRA coverage rate and is calculated for each of the tiers of coverage and each tier must satisfy the contribution rate restriction. The contribution rate must not decrease for any tier of coverage for any class of similarly situated employees by more than five (5) percentage points below the contribution rate for the period of coverage which includes March 23, 2010. The cost of coverage is measured using the COBRA continuation coverage premium as the full cost of coverage.[58] If the employer's contribution is determined pursuant to a formula, even if the operation of the formula changes the contribution as long as the formula is not changed the employer is not considered to have reduced its contribution rate.[59]

A grandfathered plan that did not have an overall lifetime or annual limit on the dollar value of health benefits may not add an annual limit on the dollar value of essential health benefits that was not in the plan on March 23, 2010.[60]

A grandfathered plan that on March 23, 2010 provided an overall lifetime limit on the dollar value of benefits but no overall annual limit on the dollar value of essential health benefits may not add an overall annual limit on the dollar value of essential benefits.[61]

A grandfathered plan that is insured and is not collectively bargained may not change insurance carriers.[62] However, if certain requests are satisfied an insured plan may change insurers and maintain grandfathered status, if such change occurs on or after November 15, 2010.[63]

A grandfathered plan that imposed an overall annual dollar value of essential health benefits on March 23, 2010 will cease to be grandfathered if the plan decreases the dollar value of the annual limit.[64]

---

[57] DoL FAQ VI, Q&A 3 (April 1, 2011).
[58] Treas. Reg. § 54.9815-1251T(g)(1)(v); 29 CFR § 2590.715-1251(g)(i)(v); 45 CFR § 147.140(g)(1)(v).
[59] DoL FAQ VI, Q&A 6 (April 1, 2011).
[60] Treas. Reg. § 54.9815-1251T(g)(A)(vi); 29 CFR § 2590.715-1251(g)(vi)(A); 45 CFR § 147.140(g)(vi)(A).
[61] Treas. Reg. § 54.9815-1251T(g)(vi)(B); 29 CFR § 2590.715-1251(g)(vi)(B); 45 CFR § 147.140(g)(vi)(B).
[62] Interim Final Treas. Reg. §54.9815-1251T(a)(1)(ii); 29 CFR§2590.715-1251(a)(1)(ii); 45 CFR §147.140(a)(1)(ii).
[63] Amendment to Interim Final Regulation Treas. Reg. § 54.9815-12515; DoL § 2590.715-1251, 147 CFR § 147.140.
[64] Interim Final Treas. Reg. § 54.9815-1251T(g)(vi)(C); 29 CFR § 2590.715-1251(g)(vi)(C); 45 CFR § 147.140(g)(vi)(C).

A grandfathered plan may include cost sharing that is based on a formula (a fixed percentage of an employee's prior year compensation) if the formula stays the same, but a change in earnings results in a change in the out of pocket maximum.[65]

Prior to 2014, a grandfathered plan may impose a restricted annual limit on the dollar value of essential health benefits as long as it does not exceed the following for a plan year:

Beginning After	And Beginning Before	Limit
September 23, 2010	September 23, 2011	$750,000
September 23, 2011	September 23, 2012	$1,250,000
September 23, 2012	January 1, 2014	$2,000,000

If a grandfathered plan adopts an amendment that will cause the plan to lose grandfathered status when it is effective at the next plan year, grandfathered status is lost when the amendment is effective, not when it is adopted.[66] If the amendment ending grandfathered status is effective mid-year due to an amendment effective mid-year, the plan ceases to be grandfathered when such amendment is effective.[67]

What transition rules exist with respect to grandfathered status to delay the impact of the ACA requirements?

For changes made before March 23, 2010, the changes will be considered to be part of the coverage on March 23, 2010 though they were not in effect on such date and will not cause the plan to lose grandfathered status, provided such changes were effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010, or if such changes were effective pursuant to a filing with the state insurance department that was filed on or before March 23, 2010, or such changes were effective after March 23, 2010 pursuant to written amendments to the plan that were adopted on or before March 23, 2010.

For changes made after March 23, 2010 and before the regulations delineating how grandfathered status is maintained were made publicly available on June 14, 2010, if a group health plan makes changes that are adopted before the regulations on grandfathered status are made publicly available on June 14, 2010 and also revokes or modifies the changes effective as of the first day of the plan year beginning on or after September 23, 2010 and the

[65] DoL FAQ V, Q&A 7 (December 23, 2010).
[66] DoL FAQ VI, Q&A 4 (April 1, 2011).
[67] DoL FAQ VI, Q&A 5 (April 1, 2011).

terms of the plan as of such plan year would not cause grandfathered status to be lost.[68] A change is adopted before the first plan year if it is effective before such date, it is effective on or after such date pursuant to a legally binding contract entered into before that date, it is effective on or after that date pursuant to a filing with a state insurance department, or the change is effective on or after such date pursuant to a written amendments to the plan that were adopted before that date.[69]

When do the ACA requirements apply to collectively bargained plans?

A collectively bargained plan is not necessarily covered by the statutory extension. The Interim Final Regulation takes a restrictive view and limits the collectively bargained extension on compliance to only apply to health insurance coverage maintained pursuant to one or more collective bargaining agreements that was ratified before March 23, 2010.[70] Thus, the collectively bargained extension per this guidance does not apply to self-insured plans, but such self-insured plans can be grandfathered. Compliance with the ACA is extended for health insurance coverage in effect pursuant to a collective bargaining agreement last ratified prior to March 23, 2010 until the date the last of the collective bargaining agreements with respect to such coverage terminates after March 23, 2010.[71] The Interim Final Regulation does not define what it takes for coverage to be "health insurance coverage" as to whether it may be insured by an employer's promise and stop loss coverage, by a minimum premium arrangement, or must it be via a fully insured policy.[72]

In order for a plan relying on the collectively bargained extension to also be able to use the grandfathered plan provision to delay or avoid application of some of the ACA requirements the collectively bargained insurance coverage, each such benefits option must comply with the ACA's requirements that apply to a grandfathered plan under the interim final regulations even though the collectively bargained plan provision might have delayed the application of such provisions until a later date.[73]

Grandfathered is Good, But Exempt is Better

The ACA changes were added to the HIPAA provisions in the Public Health Service Act which had included an exemption for plans with fewer than two current employees on the first day of the plan year.[74] Exempt status for the plan year is determined based on the plan's status as of the first day

[68] Interim Final Treas. Reg. § 54.9815-1251T(g)(2); 29 CFR § 2590.715-1251(g)(2); 45 CFR § 147.140(g)(2).
[69] *Id.*
[70] Interim Final Treas. Reg. § 54.9815-1251T(f); 29 CFR § 2590.715-1251(f); 45 CFR § 147.140(f).
[71] *Id.*
[72] *Id.*
[73] Treas. Reg. Preamble.
[74] PHSA § 2721(a); ERISA § 732(a); Code § 9831(a).

of each plan year. In many industries, when employers merge, they need to be careful to review whether the employees in the other entity may be retirees covered by their retiree health plan. A corporate merger could result in employees of the combined entity covered by the retiree plan of one of the predecessors when employees move from one entity in the industry to another could result in employees of the combined entity being covered under one of the predecessor entity's retiree plan jeopardizing its exempt status following the acquisition. While the ACA repealed the exemption in a conforming change the exemption continued in the parallel provisions on HIPAA in the Code and ERISA and that with ACA § 1252(e) could have presented a potential conflict if the silence in the PHSA was a conflict with the express ERISA and Code provisions and this also presented a risk that state and local governmental only plans would not be exempt. The remainder of the exemption from the PHSA was addressed in the preamble to the grandfathered status Interim Final Regulations which clarified the exemption was preserved for all plans with fewer than 2 full time employees on the first day of the plan year.[75] The application of the exemption to retiree only plans was confirmed in the DoL FAQs.[76] There is no transition rule that permits the exempt status to be extended or to permit coverage of two or more current employees for a limited period following a corporate merger.

What rules apply to the excepted benefits or retiree only plans exempt under HIPAA?

The preamble to the Interim Final Regulation clarifies that the exemption from the HIPAA, GINA, Mental Health Parity Act, Women's Health and Cancer Rights Act, Mental Health Equity and Addiction Equity Act and the Genetic Information Nondiscrimination Act (the "HIPAA & Post Mandates") contained in the Public Health Service Act,[77] but also contained in ERISA § 732 and Code § 9831 still exists for both ERISA plans and non-federal governmental plans offering retiree only coverage.[78] Thus, the exemption for plans with fewer than two current employees on the first day of the plan year that exempted plans previously will also exempt such plans from the mandates in Subtitles A and C of ACA.[79]

Exempt Plans

Plans which qualify as exempt are exempt from complying with all of ACA's and HIPAA's requirements as well as Mental Health Parity and Addiction Equity Act, Mothers and Newborns Health Protection Act, Women's Health and Cancer Rights Acts, and Michelle's Law.[80]

Excepted Benefits

---

[75] 75 Fed. Reg. 34538, 34539.
[76] DoL FAQ III, Q&A 1 and 2 (October 12, 2010).
[77] ACA § 1563(a)(1).
[78] Preamble to Interim Final Regulation released June 14, 2010 at pp. 8-10.
[79] Preamble to the Interim Final Regulation posted on the Federal Register Shelf on June 14, 2010 at pages 7-10.
[80] ERISA § 732(a); Code § 9831(a).

Excepted benefits, such as limited scope dental and vision benefits are also not subject to the HIPAA & Post Mandates and likewise such excepted benefits are still excepted benefits not subject to all of the ACA requirements.[81] However, the conforming changes contained in the ACA make some interesting changes to what provisions excepted benefits are not required to comply with reducing the requirements between excepted benefits under the Code and ERISA different from those under the PHSA. In order to clarify this, the preamble to the Interim Final Regulations clarify that all excepted benefits (dental or vision only plans and certain health flexible spending accounts) including those offered by non-federal governmental plans are to be treated consistently and HHS will not enforce the HIPAA or ACA requirements on any of the excepted benefits.[82] The "conforming changes" to the PHSA rearranged the PHSA and changed the provisions from which excepted benefits were not required to comply with under the PHSA provisions as amended by ACA's excepted benefits are <u>not</u> required to comply with the following:

1. The general reform requirements is Subpart I and sections 2701 through 2709 of the PHSA as amended.

2. The prohibition on lifetime or annual limits on the dollar value of essential health benefits.

3. The prohibition on rescissions.

4. The extension of coverage to dependents to age 26 regardless of tax dependent status.

5. The new utilizations and uniform explanation of coverage.

6. The required submission of information to HHS.

7. The prohibition on discrimination in favor of highly compensated employees.

8. The required provision of information on health outcomes and the new wellness program requirements.

9. The required reporting and refunds based upon the minimum loss ratios.

10. The new claims and appeals process.

---

[81] ERISA §§ 732(b) and (c); Code §§ 9831(b) and (c); Preamble to Interim Final Regulation at p. 8.
[82] 75 Fed. Reg. 34538, 34539-34540 (June 12, 2010).

11. The new patient protections (emergency care, access to pediatricians and OB-GYNs).

12. Mothers and Newborns Health Protection Act.

13. Mental Health Parity and Addiction Equity Acts.

14. Women's Health and Cancer Rights Act.

15. Michelle's Law.

For additional guidance on treatment of excepted benefits, see DoL FAQ II, Q&A #6 issued on October 8, 2010.

Additional Pressing Issues for Employers

Issues That Should Have Been Addressed Previously

Effective for tax years after December 31, 2009, health insurance issuers and entities with offshore captive health insurers must review whether they are subject to the executive compensation limitations on officers, directors and employees or individuals who provide services to the health insurer under new Code section 162(m)(6).[83]

Employers participating in Multiple Employer Welfare Associations ("MEWA") should be aware that any one in connection with MEWAs are subject to new Federal healthcare crimes penalties if they make a false statement or false representation of fact, knowing it is false, in connection with the sale or marketing of the MEWA. The U.S. Department of Labor will be able to issue summary cease and desist orders to MEWAs. This appears to be effective upon enactment.[84]

Large Employers must implement automatic enrollment into their group health plan for full time employees when guidance is issued on this requirement. The provision amended the Fair Labor Standards Act and had no effective date. However, the Fair Labor Standards Act does not define what constitutes a full-time employee. This provision is required to be implemented as provided in regulations. The DoL confirmed that the

[83] ACA § 9014.
[84] ACA §§ 6601-6607.

automatic enrollment provision will not be effective until the implanting regulations are issued in the FAQs.[85] For this purpose a large employer employs 200 or more full-time employees. Such employers must also provide the employees with a notice regarding the automatic enrollment into health coverage.[86] To date no guidance implementing the automatic enrollment requirement has been issued.

Effective in 2010 and subsequent years, a small employer tax credit is available to small employers providing group health insurance to their employees if the average wage is less than $25,000. The credit is up to 50% of the less of the nonelection contributions the employer made for the year toward the premium or with the premium limited by the average premium in the small group market in the rating area for the employer. This applies to employers with 25 or fewer full-time equivalent employees.[87]

Effective on March 23, 2010, employers subject to the Fair Labor Standards Act are required to provide reasonable break time for an employee to express breast milk for her nursing child in a place other than a bathroom that is shielded from view and free from intrusion from coworkers and the public to use. An employer with 50 or fewer employees may be exempt if this requirement would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the employer's size, financial resources, nature or the structure of their business.[88]

Employers who adopted the gap period for health flexible spending accounts allowing an additional 2-1/2 months of claims to be submitted against the prior year health flexible spending account balance should consider notifying employees in 2010 well before year end that non-prescription drug expenses incurred after December 31, 2010 cannot be submitted toward using the 2010 health flexible spending account balance even though they were incurred during the gap period and part of the 2010 plan year.

2011 Changes

Effective for amounts incurred with respect to taxable years after December 31, 2010, health flexible spending accounts may only reimburse medical expenses for prescribed drugs and insulins (a prescribed drug is not required to only be available via a prescription). A drug available over the counter can be prescribed if a physician completes a prescription for such drug.[89]

---

[85] DoL FAQ V, Q&A #2 (December 23, 2010).
[86] ACA § 1511.
[87] ACA § 1401.
[88] ACA § 4207.
[89] ACA § 9003; see also IRS Notice 2010-59, 2010-39 IRB 396 (September 27, 2010).

Effective for amounts paid from HSAs or Archer MSAs with respect to taxable years after December 31, 2010, the payments can only be made for prescribed drugs or insulin.[90]

Effective for distributions paid by an Archer MSA or an HSA after December 31, 2010 (there is no exception for amounts incurred in 2010 and distributed in 2011), a distribution that is not for an eligible medical expense will be subject to an additional 20% tax.[91]

For small employers with 100 or fewer employees on any business day in the preceding two calendar years, beginning in 2011, such employers may adopt a simple cafeteria plan and if such plan meets the requirements, it will be treated as satisfying the nondiscrimination requirements.[92]

2012 Changes

For plan years ending after September 30, 2012, self insured group health plans and health insurers must pay a $1 fee multiplied by the average number of covered lives in the plan and for plan years ending in fiscal 2013 a $2 fee multiplied by the average number of covered lives in the plan to fund patient centered outcomes research.[93] This tax is paid annually, but does not apply to plan years ending after September 30, 2019.[94]

Effective for the 2012 tax year for forms issued in January 2013, and subsequent years, (employers who filed more than 250 Forms W-2 in 2011)[95] must include on Forms W-2 issued for any period of employment or compensation paid in 2012, information disclosing the value of all the health benefits provided to the individual in the year, excluding health flexible spending account contributions and health savings account contributions or Archer medical savings account contributions. Forms W-2 issued during 2012 are not required to include the value of health benefits, only those issued after year end.[96] This disclosure does not need to be made on Form W-2 issued during 2012, but must be included on the Form W-2 issued for the full calendar year 2012.[97] Detailed explanations of which coverage must be included or may be included is provided in IRS Notice 2012-9 and 2011-38 and on the IRS website.

---

[90] *Id.*
[91] ACA § 9004.
[92] ACA § 9022 adding Code § 125(j).
[93] ACA § 6301.
[94] *Id.*
[95] IRS Notice 2012-9.
[96] IRS Notice 2012-9, 2012-4, IRB 315.
[97] IRS Notice 2012-9, 2012-4, IRB 315.

Final guidance was issued on summaries of benefit coverage requirement requiring such summaries to be available for open enrollment on or after September 23, 2012 and for plan years beginning on or after September 23, 2012.[98]

By July 1, 2012, group health plans must have 3 IROs under contract to comply with the ACA claims regulations applicable to non-grandfathered plans.[99]

Consider impact of decrease in limit on health flexible spending account reimbursements in 2013 in open enrollment communications for 2013.[100]

Begin preparing for additional dependents to enroll in grandfathered plans in 2014 when modifications for grandfathered plans cease.

Work on cost containment strategies on all plans, grandfathered, non-grandfathered and exempt to contain costs in anticipation of Cadillac tax in 2018 by considering permitted case management, care limitations and wellness programs to lower costs.

Prepare payroll for additional Medicare tax if .9 percent required to be withheld in 2013 for individuals who have a joint return with wages in excess of $250,000 ($125,000 for married filing separate) or for individuals with a different filing status wages in excess of $200,000, including communications to employees regarding changing payroll withholdings.[101]

In financial planning for retiree benefit cost, consider the impact of losing the deduction for costs incurred to obtain the Medicare Part D Subsidy in 2013 in planning finances for plans for 2013 and whether retiree plan should be structured to be exempt if possible.[102]

2013 Changes

For tax years beginning after December 31, 2012, employers may no longer deduct the costs they incur in providing the drug benefits to obtain the Medicare Retiree Drug Subsidy to the extent the subsidy is not includible in the employer's income.[103]

---

[98] 77 Fed. Reg. 8668 (February 14, 2012).
[99] ERISA Technical Release 2011-02 (June 22, 2011).
[100] ACA § 9005.
[101] ACA § 9015 amending Code § 3101.
[102] ACA § 9012 adding Code § 139A.
[103] ACA § 9012 adding Code § 139A.

For tax years beginning after December 31, 2012, employers must withhold an additional .9 percent of wages subject to the hospital insurance tax (currently 1.45 percent) for individuals who have a joint return with wages in excess of $250,000 ($125,000 for married filing separate) or for individuals filing under a different status wages in excess of $200,000.[104] The IRS has posted guidance in the form of questions and answers on its website.

Effective for tax years beginning after December 31, 2012, health flexible spending accounts may only permit annual salary reduction contributions of up to $2,500 per participant.[105]

2014 Changes

The Exchanges are scheduled to be operating[106] and sanctions on employer who do not offer coverage or who provide affordable coverage and have employees opt out.[107] Individuals are subject to the mandate to maintain coverage or pay the applicable tax.[108] The employer responsibility provisions also apply with the related taxes for not offering coverage, or if the coverage offered by the employer is too expensive and it employees purchase coverage on an Exchange and receive a subsidy for their coverage.

Exchange participating health plans are eligible to be offered through cafeteria plans of exchange eligible employers having 100 or fewer employees.[109]

Employers filing fewer than 250 Forms W-2 must include information on the cost of health coverage on the Forms W-2 filed in January 2014.[110]

Continue working on health plan cost containment strategies to avoid the Cadillac tax.

---

[104] ACA § 9015 amending Code §.3101.
[105] ACA § 9005.
[106] ACA § 1321(b).
[107] ACA § 1511 adding Code § 4980H(b).
[108] ACA § 1513 adding Code § 4980H.
[109] ACA § 1515.
[110] IRS Notice 2011-28, 2011-__ IRB __ (May __, 2011); IRS Notice 2012-9, 2012-____ IRB ____.

2015 Changes

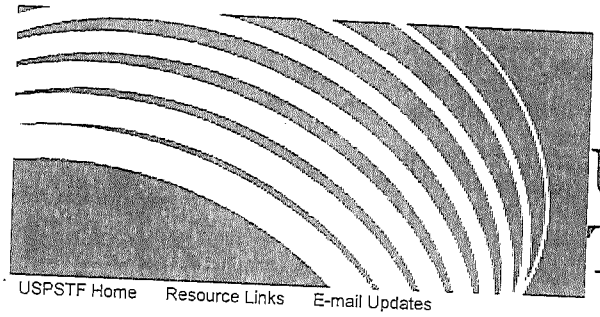
The Employer Shared Responsibility Penalty Tax is generally effective on and after January 1, 2015.[111]

2018 Changes

The tax on Cadillac plans is effective.[112]

[111] 79 Fed. Reg. 8544, 8577 (Feb. 12, 2014).
[112] ACA § 9001.

APPENDIX A
Preventive Services



U.S. Preventive Services Task Force

USPSTF A and B Recommendations

The following is a list of preventive services that have a rating of A or B from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. The preventive services are listed alphabetically. For a list of preventive services by date of release of the current recommendation, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm.

For more information about the Affordable Care Act and preventive services, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	February 2005
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
		B	December 2013*

BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.		
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydial infection screening: nonpregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008

Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
		B	July 2008

Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.		
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older	B	January 2012*

	and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.		
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm.
* Previous recommendation was an "A" or "B."

Current as of January 2014

Internet Citation:

USPSTF A and B Recommendations. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

USPSTF Program Office • 540 Gaither Road, Rockville, MD 20850

TOPICS Rights, Protections, & The Law | Prevention & Getting Care | Have Marketplace Coverage?

What are my preventive care benefits?

Preventive health services for adults

Most health plans must cover a set of preventive services like shots and screening tests at no cost to you. This includes Marketplace private insurance plans.

Free preventive services

All Marketplace plans and many other plans must cover the following list of preventive services without charging you a copayment (/glossary/co-payment) or coinsurance (/glossary/co-insurance). This is true even if you haven't met your yearly deductible (/glossary/deductible). This applies only when these services are delivered by a network provider.

1. **Abdominal Aortic Aneurysm one-time screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-to-your-doctor-about-abdominal-aortic-aneurysm) for men of specified ages who have ever smoked
2. **Alcohol Misuse screening and counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation)
3. **Aspirin use** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/talk-with-your-doctor-about-taking-aspirin-every-day) to prevent cardiovascular disease for men and women of certain ages
4. **Blood Pressure screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-blood-pressure-checked) for all adults

5. **Cholesterol screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-cholesterol-checked) for adults of certain ages or at higher risk

6. **Colorectal Cancer screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-colorectal-cancer) for adults over 50

7. **Depression screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/talk-with-your-doctor-about-depression) for adults

8. **Diabetes (Type 2) screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/take-steps-to-prevent-type-2-diabetes) for adults with high blood pressure

9. **Diet counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/eat-healthy) for adults at higher risk for chronic disease

10. **HIV screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for everyone ages 15 to 65, and other ages at increased risk

11. **Immunization vaccines** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/get-important-shots) for adults--doses, recommended ages, and recommended populations vary:

    - Hepatitis A (http://www.vaccines.gov/diseases/hepatitis_a/index.html)
    - Hepatitis B (http://www.vaccines.gov/diseases/hepatitis_b/index.html)
    - Herpes Zoster (http://www.vaccines.gov/diseases/shingles/index.html)
    - Human Papillomavirus (http://www.vaccines.gov/diseases/hpv/index.html)
    - Influenza (Flu Shot) (http://www.vaccines.gov/diseases/flu/index.html)
    - Measles (http://www.vaccines.gov/diseases/measles/index.html), Mumps (http://www.vaccines.gov/diseases/mumps/index.html), Rubella (http://www.vaccines.gov/diseases/rubella/index.html)
    - Meningococcal (http://www.vaccines.gov/diseases/meningitis/index.html)
    - Pneumococcal (http://www.vaccines.gov/diseases/pneumonia/index.html)
    - Tetanus (http://www.vaccines.gov/diseases/tetanus/index.html), Diphtheria (http://www.vaccines.gov/diseases/diphtheria/index.html), Pertussis (http://www.vaccines.gov/diseases/pertussis/index.html)
    - Varicella (http://www.vaccines.gov/diseases/chickenpox/index.html)

12. **Obesity screening and counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/watch-your-weight) for all adults
13. **Sexually Transmitted Infection (STI) prevention counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for adults at higher risk
14. **Syphilis screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for all adults at higher risk
15. **Tobacco Use screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for all adults and cessation interventions for tobacco users

Preventive health services for women

Most health plans must cover additional preventive health services for women, ensuring a comprehensive set of preventive services like breast cancer screenings to meet women's unique health care needs.

Comprehensive coverage for women's preventive care

All Marketplace health plans and many other plans must cover the following list of preventive services for women without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible.

This applies only when these services are delivered by an in-network provider.

1. **Anemia screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-runs-in-your-family) for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-breast-cancer) every 1 to 2 years for women over 40
4. **Breast Cancer Chemoprevention counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/cancer/talk-with-a-doctor-if-breast-or-ovarian-cancer-runs-in-your-family) for women at higher risk

5. **Breastfeeding comprehensive support and counseling** (http://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/breastfeed-your-baby) from trained providers, and access to breastfeeding supplies, for pregnant and nursing women

6. **Cervical Cancer screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer) for sexually active women

7. **Chlamydia Infection screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for younger women and other women at higher risk

8. **Contraception** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/choose-the-right-birth-control): Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."

9. **Domestic and interpersonal violence screening and counseling** (http://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/mental-health-and-relationship/take-steps-to-protect-yourself-from-relationship-violence) for all women

10. **Folic Acid** (http://healthfinder.gov/HealthTopics/Category/nutrition-and-physical-activity/nutrition/get-enough-folic-acid) supplements for women who may become pregnant

11. **Gestational diabetes screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor) for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes

12. **Gonorrhea screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for all women at higher risk

13. **Hepatitis B screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for pregnant women at their first prenatal visit

14. **HIV screening and counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for sexually active women

15. **Human Papillomavirus (HPV) DNA Test** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer) every 3 years for women with normal cytology results who are 30 or older

16. **Osteoporosis screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-a-bone-density-test) for women over age 60 depending on risk factors

17. **Rh Incompatibility screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for all pregnant women and follow-up testing for women at higher risk

18. **Sexually Transmitted Infections counseling** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for sexually active women

19. **Syphilis screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for all pregnant women or other women at increased risk

20. **Tobacco Use screening and interventions** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/diabetes/quit-smoking) for all women, and expanded counseling for pregnant tobacco users

21. **Urinary tract or other infection screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/have-a-healthy-pregnancy) for pregnant women

22. **Well-woman visits** (http://healthfinder.gov/HealthTopics/Category/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year) to get recommended services for women under 65

Preventive health services for children

Most health plans must cover a set of preventive health services for children at no cost when delivered by an in-network provider. This includes Marketplace and Medicaid coverage.

Coverage for children's preventive health services

All Marketplace health plans and many other plans must cover the following list of preventive services for children without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible.

1. **Alcohol and Drug Use assessments for adolescents** (http://www.healthfinder.gov/HealthTopics/Category/parenting/healthy-communication-and-relationships/talk-to-your-kids-about-tobacco-alcohol-and-drugs)

2. **Autism screening** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4) for children at 18 and 24 months

3. **Behavioral assessments** for children at the following ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

4. **Blood Pressure screening** for children at the following ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

5. **Cervical Dysplasia screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-tested-for-cervical-cancer) for sexually active females

6. **Depression screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-teen-screened-for-depression) for adolescents

7. **Developmental screening** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/watch-for-signs-of-speech-or-language-delay) for children under age 3

8. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

9. **Fluoride Chemoprevention supplements** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/take-care-of-your-childs-teeth) for children without fluoride in their water source

10. **Gonorrhea preventive medication** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for the eyes of all newborns

11. **Hearing screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for all newborns

12. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

13. **Hematocrit or Hemoglobin screening** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4) for children

14. **Hemoglobinopathies or sickle cell screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns

15. **HIV screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-hiv) for adolescents at higher risk

16. **Hypothyroidism screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for newborns

17. **Immunization vaccines** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/shotsvaccines/get-your-childs-shots-on-schedule) for children from birth to age 18 —doses, recommended ages, and recommended populations vary:

    - Diphtheria (http://www.vaccines.gov/diseases/diphtheria/index.html), Tetanus (http://www.vaccines.gov/diseases/tetanus/index.html), Pertussis (http://www.vaccines.gov/diseases/pertussis/index.html)
    - Haemophilus influenzae type b (http://www.vaccines.gov/diseases/hib/index.html)
    - Hepatitis A (http://www.vaccines.gov/diseases/hepatitis_a/index.html)
    - Hepatitis B (http://www.vaccines.gov/diseases/hepatitis_b/index.html)
    - Human Papillomavirus (http://www.vaccines.gov/diseases/hpv/index.html)
    - Inactivated Poliovirus (http://www.vaccines.gov/diseases/polio/index.html)

- Influenza (Flu Shot) (http://www.vaccines.gov/diseases/flu/index.html)
- Measles (http://www.vaccines.gov/diseases/measles/index.html), Mumps (http://www.vaccines.gov/diseases/mumps/index.html), Rubella (http://www.vaccines.gov/diseases/rubella/index.html)
- Meningococcal (http://www.vaccines.gov/diseases/meningitis/index.html)
- Pneumococcal (http://www.vaccines.gov/diseases/pneumonia/index.html)
- Rotavirus (http://www.vaccines.gov/diseases/rotavirus/index.html)
- Varicella (http://www.vaccines.gov/diseases/chickenpox/index.html)

18. **Iron supplements** (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months) for children ages 6 to 12 months at risk for anemia

19. **Lead screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/getting-ready-for-your-baby/protect-your-family-from-lead-poisoning) for children at risk of exposure

20. **Medical History** for all children throughout development at the following ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

21. **Obesity screening and counseling** (http://healthfinder.gov/HealthTopics/Category/parenting/nutrition-and-physical-activity/help-your-child-stay-at-a-healthy-weight)

22. **Oral Health risk assessment** for young children Ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10).

23. **Phenylketonuria (PKU) screening** (http://healthfinder.gov/HealthTopics/Category/pregnancy/doctor-and-midwife-visits/talk-with-your-doctor-about-newborn-screening) for this genetic disorder in newborns

24. **Sexually Transmitted Infection (STI) prevention counseling and screening** (http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/hiv-and-other-stds/get-tested-for-chlamydia-gonorrhea-and-syphilis) for adolescents at higher risk

25. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-babys-visit-to-the-doctor-ages-0-to-11-months), 1 to 4 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-1-to-4), 5 to 10 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-5-to-10), 11 to 14 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-childs-visit-to-the-doctor-ages-11-to-14), 15 to 17 years (http://healthfinder.gov/HealthTopics/Category/parenting/doctor-visits/make-the-most-of-your-teens-visit-to-the-doctor-ages-15-to-17).

26. **Vision screening** (http://healthfinder.gov/HealthTopics/Category/doctor-visits/screening-tests/get-your-childs-vision-checked) for all children.