DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Title: Insurance Standards Bulletin Series – INFORMATION

Subject: CCIIO Sub-Regulatory Guidance: Minimum Essential Coverage Application Review Process

I. Background

Section 5000A of the Internal Revenue Code (the Code), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), provides that individuals must maintain minimum essential coverage (MEC), pay the individual shared responsibility payment, or qualify for an exemption.

Section 5000A(f) of the Code defines MEC as any of the following: (1) coverage under a specified government sponsored program; (2) coverage under an eligible employer-sponsored plan; (3) coverage under a health plan offered in the individual market within a State; and (4) coverage under a grandfathered health plan.[1] In addition, section 5000A(f)(1)(E) of the Code authorizes the Secretary of Health and Human Services (HHS), in coordination with the Secretary of the Treasury (Treasury), to designate other health benefits coverage as MEC. This authority has been implemented both through additional designations in regulations or guidance of types of coverage as MEC, and in regulations providing for a process for applying for MEC designation if specified conditions are met.

For example, several categories of coverage are specifically identified as MEC in regulations issued by Treasury and the Internal Revenue Service (IRS), and in regulations issued by HHS. The types of coverage designated by Treasury and IRS final regulations as MEC include government sponsored programs, employer-sponsored plans, plans in the individual market, and grandfathered health plans.[2] The types of coverage that are designated by the HHS final

[1] For a definition of grandfathered health plans, see 45 CFR § 147.140.
[2] Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 FR 53646 (August 30, 2013).

regulations as MEC include: (1) Refugee Medical Assistance supported by the Administration for Children and Families; (2) Medicare Advantage plans; (3) State High-Risk Pools (for plan or policy years beginning on or before December 31, 2014); and (4) Self-insured Student Health Plans (for plan or policy years beginning on or before December 31, 2014).[3] Regulations were also issued providing for an administrative process for applying for MEC status, with eligibility for designation under this process conditioned on meeting certain standards, including compliance with "substantially all" Affordable Care Act requirements. On October 31, 2013, CCIIO issued further guidance on this administrative process.[4] The October 2013 guidance also separately specified that certain types of foreign group health coverage are MEC.[5] This guidance clarifies the existing standard of review for the MEC application process: it does not designate additional categories of MEC.

II. The 'Substantially All' Standard

In considering whether to recognize coverage as MEC under the application process provided for in 45 CFR § 156.604, the Secretary evaluates whether the coverage complies with 'substantially all' of the provisions of Title I of the Affordable Care Act that apply to non-grandfathered individual health insurance coverage. The October 2013 guidance listed the following provisions that will be considered to determine whether an applicant's coverage meets the 'substantially all' standard:

PHS Act § 2701 – Fair health insurance premiums (Only the prohibition on rating based on gender)
PHS Act § 2704 – Prohibition on pre-existing condition exclusions
PHS Act § 2705 – Prohibition against discrimination based on health status; Genetic Information Nondiscrimination Act
PHS Act § 2707(a) – Provision of essential health benefits
PHS Act § 2711 – Prohibition against lifetime and annual limits
PHS Act § 2712 – Prohibition against rescissions
PHS Act § 2713 – Coverage of preventive health services
PHS Act § 2714 – Extension of dependent coverage
PHS Act § 2715 – Summary of benefits and coverage. (Plan should begin providing the summary of benefits and coverage as soon as practicable, but no later than January 1, 2015.)
PHS Act § 2719 – Appeals Process

[3] Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, 78 FR 29494 (July 1, 2013).
[4] *See* CCIIO Sub-regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (October 31, 2013). Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf.*
[5] Section 156.602(e) of the proposed HHS regulation proposed to codify the guidance published on October 31, 2013 that designated certain types of foreign group health coverage as minimum essential coverage. *See* Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 FR 15808 (March 21, 2014). We have not finalized this section of the proposed rule at this time.

PHS Act § 2719A – Patient Protections
PHS Act § 2725 – Newborns' and Mothers' Health Protection Act
PHS Act § 2726 – Mental Health Parity and Addiction Equity Act
PHS Act § 2727 – Women Health and Cancer Rights Act
ACA § 1302(d)(1) – Actuarial value no less than 60 percent.

As stated in the October 2013 guidance, in addition to meeting the 'substantially all' standard with respect to compliance with the above identified provisions of Title I of the Affordable Care Act, to the extent that other requirements in Title I of the Affordable Care Act would directly apply to the coverage by their own terms, under the section 156.604 application process, we evaluate coverage to see if it complies with these requirements as well.[6] Coverage that does not meet all of the foregoing requirements will be evaluated on a case-by-case basis.

The Secretary also has discretion under the HHS final regulations at 45 CFR §156.604 to approve or deny an application that meets the 'substantially all' standard based on policy considerations, including but not limited to the following:

1. *Is the plan small or transitional?*

The Secretary may consider whether eligibility criteria restrict enrollment to a limited class of persons or a small number of enrollees. She may also consider whether the plan or policy might provide health benefits to a closed enrollment block or for a limited period of time. If the coverage is available to a significant number of individuals in a State, the impact on a State's individual market risk pool of recognizing the coverage as MEC will be evaluated.

2. *Does the plan offer better benefits or cost sharing to its enrollees, compared to a Marketplace QHP?*

The Secretary may consider that a plan, due to state, municipal, or private funding, offers better benefits or lower cost sharing or premiums to its enrollees, particularly if those enrollees are part of a vulnerable population. The Secretary also may consider whether approving the coverage as MEC would impose a barrier to individuals who are eligible for, but not enrolled in the coverage, from qualifying for Marketplace subsidies.

3. *Other factors*

The Secretary may consider other unique factors, on a case-by-case basis. For example, the Secretary may consider the fact that a plan does not cover medical services within the U.S. service area.

III. Appeals Process

[6] Such other requirements may include, for example, PHS Act §§ 2702 (guaranteed availability), 2703 (guaranteed renewability), 2706 (non-discrimination against providers in health care), and 2709 (coverage for individuals participating in clinical trials).

As stated in the October 2013 guidance, HHS reserves the right to determine that a plan or policy will not be recognized as MEC, or that a plan or policy previously recognized as such will no longer be recognized as MEC. If such a determination is made, HHS will reject the application on the basis that the plan or policy does not qualify for recognition as MEC.

Within **15 calendar days** of receipt of such a determination, the sponsor of the coverage may request that the agency undertake a secondary review of an application by uploading the appeals request into the HIOS MEC module and sending an email to MEC@cms.hhs.gov to notify the agency that the request has been submitted. Additional evidence can be submitted with the request for review.

The reviewer will review the initial determination and consider any additional evidence before issuing a determination of whether the coverage should be recognized as MEC. If the reviewer upholds the initial determination, the sponsor of the coverage will have no further administrative rights of appeal.

Where to get more information:

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