LABOR, IMMIGRATION & EMPLOYEE BENEFITS DIVISION
U.S. CHAMBER OF COMMERCE

Key Employee Benefits Regulatory Initiatives in the Obama Administration

The following is a summary of key regulatory actions, completed, underway, or anticipated, in which the Chamber has been, or plans on being, actively engaged.

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Pension Regulatory Activity

Completed Rulemakings

PBGC Rule on Premium Payments; Large-Plan Flat-Rate Premium

On January 3, 2014, the PBGC issued a final rule simplifying the premium payment due date for large plans by moving the flat-rate premium due date for large plans to later in the premium payment year—to the same date as the variable-rate premium due date for such plans—starting with the 2014 plan year. Thus, large calendar-year plans' 2014 flat-rate premiums will be due October 15, 2014. Prior to this rule, large plans have paid the flat-rate premium early in the premium payment year and the variable-rate premium later in the year.

In July, 2013, the PBGC issued a proposed rule that simplified premium payments for all plans. However, the final rule applies only to large plans. Because the proposed rule setting the flat-rate premium due date for large plans later in the year is the most time-sensitive aspect of the proposal and this provision generated only positive comments, the PBGC decide to finalize this one change separately and ahead of the other changes in the proposal. PBGC expects to deal with all other aspects of the July 23 proposal in a separate final rule.

On September 23, 2013, the Chamber submitted comments on the proposed rule. The Chamber's comments can be accessed here:
https://www.uschamber.com/sites/default/files/documents/files/PBGC%2520-%2520Comments%2520on%2520Premium%2520Payment%2520Dates.pdf

PBGC Rule on Cessation of Operations (ERISA section 4062(e))

If an employer ceases operations at a facility in any location that causes job losses affecting more than 20% of participants in the employer's qualified retirement plan, the Pension Benefit Guaranty Corporation (PBGC) can require an employer to put a certain amount in escrow or secure a bond to ensure against financial failure of the plan. In 2010, the PBGC issued a proposed rule detailing specific incidents that would be considered a "section 4062(e)" event. The Chamber submitted comments arguing that the PBGC overstepped the intent of the statute and would impose these liabilities in many more situations than warranted by the statute. Moreover, the Chamber expressed concern that the proposed rules did not take into account the entirety of all circumstances but, rather, focused on particular incidents in isolation.

The Chamber's comments can be accessed here:
https://www.uschamber.com/comment/pbgc-comments-section-4062e

In 2011, the PBGC stated that it would reconsider the proposed rule. However, the Chamber learned that the PBGC's enforcement policy continued to follow the proposed rule. As a result, the Chamber sent comments to the PBGC in response to President Obama's Executive Order No. 13563 which included a statement for the need to reconsider ERISA section 4062(e).

Moreover, the Chamber had several subsequent conversations with former Director Josh Gotbaum on this issue.

On November 2, 2012, the Pension Benefit Guaranty Corporation (PBGC) announced that it will be changing its enforcement efforts with respect to ERISA section 4062(e). According to the announcement, instead of using a one-size-fits-all approach, the PBGC will use facts and circumstances to focus on companies that pose real risk. As a result of its new approach, the PBGC estimates that 92 percent of companies sponsoring defined benefit pension plans will not face PBGC enforcement efforts. While this is an obscure provision, it can have substantial financial impact on a plan sponsor with a defined benefit plan. Therefore, this is a major victory for the pension plan community.

On December 17, 2014, President Obama signed into law, the "Consolidated and Further Continuing Appropriations Act, 2015." Included in the bill is a provision which amends ERISA section 4062(e) to redefine a cessation of operations. This change in definition will decrease the number of plan sponsors impacted by ERISA section 4062(e).

On January 8, 2015, PBGC announced that due to actions taken by Congress, the agency is ending its moratorium.

Plan Fee Disclosure

In July 2010, the DOL issued an interim final regulation covering the disclosures required from service providers to plan sponsors. The interim final rule follows the proposed rule that was issued by the DOL issued in 2009, but contains a number of provisions that differ significantly from the proposed regulation. Therefore, the regulations were issued as interim final to allow for additional comment.

On August 30, 2010, the Chamber submitted comments in response to the interim final rule. The Chamber's comments recommended that the final rule require a single disclosure document from the service provider to the plan sponsor and reiterated our concerns about the application of the fee disclosure rules to welfare plans.

The Chamber's comments can be accessed here:
https://www.uschamber.com/comment/plan-fee-disclosure-interim-final-rule

On February 3, 2012, DOL released the final regulation for plan fee disclosure. The Department reserves the right in the final regulation to later issue regulations concerning a tool, such as a sample guide to assist plan fiduciaries. The Appendix includes a "sample guide," which DOL is strongly encouraging plan sponsors to use. The rule took effect on July 1, 2012.

On May 7, 2012, EBSA issued Field Bulletin No. 2012-02, providing guidance in the form of Frequently Asked Questions (FAQs) with respect to the issue of fee disclosure information to participants. On July 30, 2012, the EBSA issued a revised FAQ, Field Bulletin No. 2012-02R, clarifying its position on the treatment of open broker windows in 401(k) plans. The revised FAQ clarifies that plan sponsors must provide fee information concerning the brokerage window

itself but limits the plan sponsors obligations with respect to investments inside the window. This position is much more in line with the previous regulatory guidance from the DOL.

On July 22, 2013, the Department of Labor issued Field Assistance Bulletin No. 2013-02. The participant fee disclosure regulation requires certain disclosures to be made for individual account plans on an annual basis. The FAB, as a matter of temporary enforcement policy, allows plans to "re-set" the notice deadline for either the 2013 or the 2014 plan year. In addition, EBSA stated that it is considering whether to allow a 30-day or 45-day window during which a subsequent annual comparative chart would have to be furnished, rather than fixing the 12-month "at least annually" period to end on one specific day. On September 18, 2013, the Chamber submitted favorable comments on this FAB. The comments may be accessed here: https://www.uschamber.com/comment/ebsa-joint-letter-fee-disclosures-participant-directed-individual-account-plans

On March 12, 2014, the Department of Labor published an amendment to the final rule, under which covered service providers would be required to furnish a guide along with the initial disclosures that must be provided to plan fiduciaries. On June 10, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Plan%20Fees%20-%20Comments.pdf

On March 12, 2014, the Department of Labor published an information collection request stating the intent to conduct focus groups with small pension plans (less than 100 participants) on the need for a guide as planned in the proposed rule as well as other issues related to ERISA section 408(b)(2). On May 12, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-proposed-information-collection-request-submitted-public-comment-evaluating

On August 21, 2014, the Department of Labor published a request for information on brokerage windows in participant-directed individual account plans. On November 18, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/plan_fees_-_brokerage_window_comments.pdf

On December 5, 2014, the Department of Labor submitted an Information Collection Request proposal to the Office of Management and Budget, that requests to use focus groups to explore the impact of a final fee disclosures, as well as the need for "a guide, summary, or similar tool to help a responsible fiduciary navigate through and understand the disclosures." The Chamber submitted joint comments which may be accessed here: https://www.uschamber.com/sites/default/files/joint_comment_letter_on_408b2_focus_group_icr_final_pdf_1-5-2015_0022.pdf

On March 19, 2015, the Department of Labor promulgated a direct final rule and proposed rule that would give retirement-plan administrators an extra period of two months as to when they must provide annual participant-level fee disclosures. The final rule will become effective June 17, 2015. This rule was done at the urging of the many in the business community, including the Chamber.

The joint letters and comments can be accessed here:
https://www.uschamber.com/sites/default/files/multiemployer_-_comments_on_treasury_rfi.pdf
and
https://www.uschamber.com/sites/default/files/plan_fees_-_joint_letter_re_participant_disclosures-_final.pdf

Premium Rates; Payment of Premiums

On July 23, 2013, the Pension Benefit Guaranty Corporation (PBGC) promulgated a proposed rule to amend regulations on premium rates and the payment of premiums to simplify due dates and coordinate the due date for plan termination with the termination process. On September 23, 2013, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/comment/comments-premium-rates-payment-premiums-reducing-regulatory-burden

On January 3, 2014, the Pension Benefit Guaranty Corporation published a final rule, which makes the flat-rate premium due date for large plans the same as their variable-rate due date. The other aspects of the proposed rule will be released in a separate final rule.

Annual Funding Notice for Defined Benefit Plans

On November 18, 2010, the DOL issued proposed regulations on the annual funding notice for defined benefit plans. The proposal would implement the annual funding notice requirement in ERISA, as amended by the PPA and WRERA. As amended, section 101(f) of ERISA generally requires the administrators of all defined benefit plans to furnish an annual funding notice to the PBGC, participants, beneficiaries, and certain other persons that must include, among other information, the plan's funding target attainment percentage or funded percentage, as applicable, over a period of time, as well as other information relevant to the plan's funded status. A significant concern is the increasing number of required notices and whether participants are becoming overwhelmed with the volume of information being provided.

On January 18, 2011, the Chamber submitted comments.

A copy of the Chamber's comment letter can be found here:
https://www.uschamber.com/comment/annual-funding-notice-defined-benefit-plans

On February 2, 2015, DOL issued the final regulations.

Amendment to the Requirement Minimum Distribution Rules/Limitations on De-risking

On July 9, 2015, the Internal Revenue Service and Treasury Department announced in Notice 2015-49 their intentions to amend the required minimum distribution rules under tax code Section 401(a)(9) to bar defined benefit plans from replacing various kinds of annuity payments with lump-sum payments, or other accelerated payments. The amendments will apply as of July 9, 2015; however, the changes to the rule will be made at a later date. The Chamber is concerned

about the process used to make these changes and will engage with the Treasury Department and Internal Revenue Service to ensure procedures to change regulations are properly followed.

Reportable Events

In January 2010, the Chamber submitted comments to the Pension Benefit Guaranty Corporation on a proposed rule aimed at increasing opportunities for the PBGC to become aware of potential funding issues. The Chamber's comments focused on the need for balance between enhanced oversight by the PBGC and the potential burdens on employers. In several instances, we believe that the benefits imposed upon plan sponsors will not provide an equivalent benefit to the PBGC. For example, the proposal eliminates most of the automatic waivers and extensions that currently exist. Therefore, the Chamber urges the PBGC to enter in a negotiated rulemaking process and should allow waivers and extensions to be retained in specific occasions.

These comments can be found here:
https://www.uschamber.com/comment/reportable-events

In August of 2011, the PBGC issued its Plan for Regulatory Review stating that it will re-propose this rule with an emphasis toward reducing the unnecessary burdens on employers and plans.
On April 3, 2013, the PBGC re-proposed these rules in substantially revised form. The new proposed rule is intended to reform and reduce reporting requirements for more than 90 percent of companies and pension plans.

On June 3, 2013, the Chamber submitted comments. The comments may be accessed here:
https://www.uschamber.com/comment/rin-1212-ab06-reportable-events-and-certain-other-notification-requirements

On June 18, 2013, the Chamber testified during the public hearing on these rules.

On September 11, 2015, the PBGC issued the final rule.

Hybrid Plan Regulations

On October 18, 2010, the Treasury Department and Internal Revenue Service issued long-awaited regulations affecting hybrid defined benefit plans. The agencies released both a set of final regulations and a set of proposed regulations. The Chamber submitted comments on January 12, 2011, which highlight the need for the Treasury and the IRS to set forth a clear and rational approach to PPA compliance for Pension Equity Plans. Moreover, because of the complexity of hybrid plans and their regulation, we requested additional guidance to ensure that plan sponsors have sufficient clarity and flexibility to adopt and maintain hybrid pension plans with legal certainty.

A copy of the Chamber's letter can be found here:
https://www.uschamber.com/comment/cash-balance-comments-regarding-hybrid-retirement-plans

On September 19, 2014, IRS promulgated final regulations, which are effective for plan years beginning on or after January 1, 2016, which primarily address the market-rate-of-return requirement for cash balance plans and issues related to whipsaw relief.

On September 19, 2014, IRS issued proposed rules to address the transition from a noncompliant interest crediting rate to one that is permissible under the final regulations. To qualify for the anti-cutback relief, the proposal requires plan amendments to be adopted prior to and effective no later than the first day of the first plan year that begins on or after January 1, 2016. The IRS also proposes to allow plan sponsors to apply the regulations, as finalized, to plan amendments that are adopted during earlier periods.

Comments are requested on all aspects of the proposed regulations but particularly with respect to appropriate transition amendments for plans that credit interest using an investment-based rate of return with an impermissible minimum rate. On December 18, 2014, the Chamber submitted comments, which may be accessed here:

https://www.uschamber.com/comment/comments-transitional-amendments-satisfy-market-rate-return-rules-hybrid-retirement-plans

A public hearing on the regulations was held January 9, 2015.

On November 16, 2015, the Treasury Department issued a final rule on the transition amendments for hybrid plans.

Rulemakings Underway

PBGC Rule on Multiemployer Plans

On January 29, 2014, the PBGC published a proposal rule that would among other things, amend regulations and reduce required actuarial valuations for certain multiemployer plans; shorten the advance notice filing requirements from 120 days to 45 days for mergers in situation that don't involve a compliance termination, and remove insolvency notice and annual update requirements.

Om March 31, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-pbgc-multiemployer-plans-valuations-and-notices

Nondiscrimination Relief for Frozen DB Plans – Temporary Guidance and Request for Comments

On December 13, 2013, the Internal Revenue Service (IRS) issued temporary guidance on nondiscrimination relief for frozen defined benefit plans. The nondiscrimination rules are becoming an issue for companies that designed their transition from a defined benefit structure to a defined contribution structure in a way that allowed older, long service employees who were close to retirement to maintain their then-current defined benefit pension plan. However, as these

grandfathered employees continue to work, more of them are becoming highly-compensated employees. Since there are no new entrants to the plan, the number of non-highly compensated employees is becoming smaller. Therefore, it becomes difficult for these companies to continue to pass the nondiscrimination rules.

In short, the notice gives temporary relief for 2014 and 2015 to frozen plans that did not have a problem passing the nondiscrimination rules at the end of 2013. The guidance suggests additional alternatives and asks for comment on whether they should be made available. In addition, the guidance asks for any other alternatives that should be considered. On February 28, 2014, the Chamber submitted comments which can be accessed here: https://www.uschamber.com/comment/comments-irs-nondiscrimination-relief-closed-defined-benefit-plans

On March 20, 2015, the IRS extended the temporary guidance to the end of 2016.

PBGC Proposed Rule on Premium Rates; Payment of Premiums

On July 23, 2013, PBGC issued a proposal to simplify the premium payment due-date rules by providing that all annual premiums for plans of all sizes will be due on the same day in the premium payment year—the historical variable rate premium due date. Also, small plans would be able to use the previous year's data to determine the variable rate premium. Additional provisions included lowering the penalty cap for plans that make voluntary corrections to their premium payments and codifying the policy of not accessing penalties for payments made within 7 days of the premium payment due date.

On September 23, 2013, the Chamber submitted comments encouraging the PBGC to implement these changes to ease administrative burdens and eliminate unnecessary complexity. The Chamber's comments can be accessed here: https://www.uschamber.com/sites/default/files/documents/files/PBGC%2520-%2520Comments%2520on%2520Premium%2520Payment%2520Dates.pdf

PBGC Proposed Rule on Section 4010 Reporting

On July 27, 2015, the PBGC promulgated proposed regulations, which would have the effect of changing its annual financial and actuarial information reporting regulations for pension plans to account for funding stabilization—or "pension smoothing"—provisions enacted in laws passed in 2012 and 2014. Specifically, the proposal seeks to modify the existing reporting waiver for companies with total underfunding in all their plans of no more $15 million and adds two new reporting waivers and makes other minor technical changes.

On September 25, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-the-pbgc-regarding-the-proposal-amend-annual-information-reporting

PBGC Information Collection Request on De-Risking Information

On September 23, 2014, PBGC issued a proposed submission for information collection for comment request stating that they will be revising the 2015 filing procedures and instructions to require reporting of certain undertakings to cash or annuitize benefits.

On November 19, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/pbgc_-_comments_on_de-risking_icr.pdf

Missing Participant Program – Request for Information

On June 21, 2013, the PBGC issued on a request for information on implementing a program to deal with the benefits of missing participants in terminating individual account plans. In general, the Chamber supports the implementation of a missing participants program by the PBGC as long as participation in the program is voluntary and is comparable to services provided by private parties.

On August 20, 2013, the Chamber submitted comments jointly with the ERISA Industry Committee and the Plan Sponsor Council of America. The comments can be accessed here: https://www.uschamber.com/comment/missing-participants-individual-account-plans-request-information

Electronic Disclosures – Request for Information

On April 7, 2011, the Department of Labor issued a request for information on electronic disclosure by employee benefit plans. The request applies to disclosures for both retirement and health care plans. The Chamber submitted comments to the request for information on June 6, 2011. In general, our comments urge the DOL to update its safe harbor for electronic disclosures to make the use of electronic delivery of notices easier for both retirement and health care plans. In addition, we recommend that electronic delivery be allowed as the default delivery option for all benefit plans.

The Chamber's comments can be accessed here: https://www.uschamber.com/comment/request-information-regarding-electronic-disclosure-employee-benefit-plans

Definition of a Fiduciary

On October 21, 2010, EBSA issued a proposed regulation regarding the definition of a fiduciary under ERISA. This regulation is the first time the definition of a fiduciary has been changed since the implementation of ERISA. According to EBSA, the intent of the proposed rule is to more broadly define the circumstances under which a person or entity is considered to be a fiduciary when giving investment advice to an employee benefit plan or a plan's participants. The Chamber submitted comments to the DOL on February 3, 2011. We support the efforts of the DOL in updating the definition of a fiduciary, but have concerns about the breadth of some of the changes. There have been significant changes in both the design of private retirement plans and the investment options and services provided for these plans. Although these changes have

created increasingly complex investment schemes and financial arrangements, the determination of fiduciary status has not changed. Therefore, amending the definition at this time is appropriate. At the same time, we believe that the expansion of the fiduciary definition should not be freely interpreted to include every act related to a retirement plan. Rather, a balance needs to be struck that protects participants and allows for the free flow of information and services in the market.

A copy of the Chamber's comments can be found here:
https://www.uschamber.com/comment/definition-term-fiduciary-1

Following up on our initial comments, the Chamber submitted an additional letter to Secretary of Labor Hilda Solis on August 4, 2011, requesting a re-proposal of the proposed rule and a re-evaluation of the economic analysis included in the proposal.

A copy of the Chamber's letter to Secretary Solis can be found here:
https://www.uschamber.com/comment/definition-term-fiduciary

On September 19, 2011, the Department of Labor announced that it intends to re-propose this regulation in 2013.

On April 14, 2015, the DOL promulgated a re-proposed rule and related exemptions. Comments on the reproposal were due on July 6, 2015. Both jointly and individually, the Chamber has requested an extension of the comment period by 45 days. Those letters can be found here:
https://www.uschamber.com/comment/joint-trades-request-extension-department-labor-fiduciary-comment-period and
https://www.uschamber.com/comment/dol-fiduciary-extension-request

On May 18, 2015, the DOL announced that they are extending the public comment period until July 21, 2015, and holding a public hearing from August 10 to 12, 2015 and continuing to August 13, 2015 (if necessary). The Chamber testified during the August 12th hearing.

On May 20, 2015, the Chamber submitted comments to OMB regarding proposed collections of information subject to the Paperwork Reduction Act of 1995 (PRA). Our comments emphasized that our member companies are concerned that government-mandated information collections under employment benefits regulations protect their employee's retirement savings while avoiding unnecessary costs that could be passed to savers and reduce their investment returns. As such, the comments highlighted multiple areas where the DOL's analysis under the PRA was insufficient.

A copy of the Chamber's comments can be found here:
https://www.uschamber.com/comment/comments-oira-regarding-paperwork-reduction-act-burden-estimates-conflict-interest-nprm-and

On June 9, 2015, the Chamber released a report titled *Locked Out of Retirement: The Threat to Small Business Retirement Savings* that addresses the impact of the proposed rule to change the

definition of fiduciary small business retirement plans and what that means for small businesses and their employees.

A copy of the report can be found here: https://www.uschamber.com/report/locked-out-retirement-threat-small-business-retirement-savings

On July 20, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-dols-proposed-rule-regarding-definition-term-fiduciary-conflict-interest-rule and https://www.uschamber.com/comment/comment-letter-employee-benefits-security-administration-regarding-definition-fiduciary and https://www.uschamber.com/sites/default/files/comments_to_the_employee_benefits_security_administration_re_fiduciary_economic_analysis.pdf and http://www.centerforcapitalmarkets.com/wp-content/uploads/2015/07/2015-07-20-DOL-Proposed-Best-Interest-Contract-Exemption-letter.pdf

On September 24, 2015, the Chamber submitted the following comments in response to the second comment period in response to the DOL's hearings, which may be accessed here: http://www.centerforcapitalmarkets.com/wp-content/uploads/2015/09/2015-9.24-Post-Hearing-Chamber-Comment-Letter.pdf and http://www.centerforcapitalmarkets.com/wp-content/uploads/2015/09/2015-9.24-Post-Hearing-Comment-Letter-EBSA-Fiduciary-Economic-Analysis-Issues.pdf

Target Date Fund Disclosure

On November 30, 2010, the DOL issued proposed regulations on target date fund disclosures. The proposal amends the qualified default investment alternative regulation to provide more specificity as to the information that must be disclosed in the required notice to participants and beneficiaries concerning investments in qualified default investment alternatives, including target date or similar investments. A significant concern is the increasing number of required notices and whether participants are becoming overwhelmed with the volume of information being provided. On January 11, 2011, the Chamber submitted comments.

A copy of the Chamber's comments can be found here: https://www.uschamber.com/comment/target-date-fund-comments-january-2011

On May 24, 2012, the Labor Department announced that it is reopening the comment period to allow for feedback on research the SEC commissioned as part of its work on its proposed rule on comprehension and communication issues regarding target date funds. Comments were due by July 9, 2012.

On June 3, 2014, the Labor Department announced that it is reopening the comment period to align its recommendations with the efforts by the SEC. Comments were due by July 3, 2014.

Lifetime Income Options and Illustrations on Benefit Statements

On February 2, 2010, the Department of Labor and the Treasury Department issued a request for information on lifetime income distribution options in defined contribution plans. The Chamber submitted comments in response to this request on May 3, 2010. The comments detail the Chamber's top priorities surrounding lifetime income products. First, the letter explains the importance of defined contribution plans in the current retirement landscape and urges the agencies to not underestimate the security that they provide in their current form to millions of participants.

The comments then detail a number of issues including low take-up rates among participants, concerns about increased liabilities on employers, incentives for employers to provide information on lifetime income products, and suggested changes to the minimum required distribution rules. Moreover, the comments urge the agencies against requiring lifetime income products as a mandated distribution option in defined contribution plans.

The Chamber's comments may be accessed here:
https://www.uschamber.com/comment/rfi-lifetime-income-options-participants-and-beneficiaries

On February 2, 2012, the Treasury Department issued two proposed rules: one on longevity annuity contracts purchased under a defined contribution plan and the other on allowing distributions of partial annuities in defined benefit plans. The Treasury Department also issued two revenue rulings that provide guidance on the distribution of annuities.

On May 8, 2013, the Department published an advance notice of proposed rulemaking (ANPRM) that indicated that DOL is considering a proposal that would require that pension benefit statements for defined contribution plans include lifetime income illustrations. DOL also posted an online calculator on its website that "illustrates an annuitization approach to estimate the monthly lifetime income streams based on both the participant's current account balance and on the projected value of the account balance at retirement." Comments were originally due by July 8, 2013, but were extended until August 7, 2013.

On August 7, 2013, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/comment/lifetime-income-disclosures-comments-dol

Purchase of Irrevocable Commitments

In a standard termination, an employer must purchase irrevocable commitments (i.e., annuity contracts) to provide for all benefit liabilities. In January 2010, the Chamber submitted comments to the Pension Benefit Guaranty Corporation on proposed regulations concerning the purchase of irrevocable commitments. The comments stressed that the purchase of irrevocable commitments should depend on the facts and circumstances surrounding the purchase, but that there should be a safe harbor for certain purchases. The comments recommended several requirements for the safe harbor, including that the irrevocable commitments be purchased for a

specific purpose, that plan assets are at least equal to plan benefits at the time of the purchase; and that the standard termination notice be given to beneficiaries covered by the irrevocable commitment. With these requirements, the safe harbor will address the concerns of the PBGC during a standard termination. Nonetheless, a safe harbor should be only that – a way to ease oversight burdens for the agency and to provide certainty for plan sponsors. A purchase of irrevocable commitments that does not meet the safe harbor should be subject to a facts and circumstances review by the PBGC.

These comments can be found here:
https://www.uschamber.com/comment/purchase-irrevocable-comments

Margin and Capital Requirements for Covered Swap Entities

On September 24, 2014, the Comptroller of the Currency, the Federal Reserve System, the Federal Deposit Insurance Corporation, the Farm Credit Administration, and the Federal Housing Association jointly promulgated a proposed rule and request for comment that would impact defined benefit plans by changing the ways the variation margin is funded and would require cash lay-outs. Comments were due by November 24, 2014. The Chamber comments can be found here:
https://www.uschamber.com/comment/coalition-derivatives-end-users-comments-margin-and-capital-requirements-covered-swap

Electronic Filing of Notices for Apprenticeships and Training Plans and Statements for Pensions Plans for Certain Select Employees

On September 30, 2014, EBSA issued a proposed rule that would revise filing procedures for apprenticeships and training plan notices and "top hot" plan statements with the Secretary of Labor to require electronic notice of these notices and statements. The Chamber commented on the need to expand the opportunity for electronic filing through the private retirement system. Comments were due by December 29, 2014. The Chamber's comments can be found here:
https://www.uschamber.com/comment/electronic-filing-notices-apprenticeship-and-training-plans-and-statements-pension-certain

Request for Information on Suspension of Benefits under the Multiemployer Pension Reform Act of 2014

On February 18, 2015, the PBGC and the IRS published requests for information regarding further guidance to implement the Multiemployer Pension Reform Act of 2014. On April 6, 2015, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/sites/default/files/multiemployer_-_comments_on_treasury_rfi.pdf

Multiemployer Plan Partitions; Multiemployer Pension Reform Act of 2014

On June 19, 2015, the Internal Revenue Service issued proposed and temporary regulations on the Benefit Suspensions program created by the Multiemployer Pension Reform Act. The IRS also issued Revenue Procedure 2014-34, which describes procedures for a multiemployer plan in

critical and declining status to apply for approval of a benefit suspension. The revenue procedure also provides a model notice that plan sponsors proposing to suspend benefits can use to fulfill requirements to notify plan participants and beneficiaries. On August 18, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/multiemployer_-_comments_on_benefit_suspensions_ccpalpdpr_reg-102648-15_.pdf

On June 19, 2015, the PBGC issued interim final regulations prescribing the application process and notice requirements for partitions of eligible multiemployer plans. On August 18, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/multiemployer_-comments_to_pbgc_on_partitions_rin_1212-ab29_partitions_of_eligible_multiemployer_plans__0.pdf

On September 2, 2015, the IRS issued temporary regulations and a notice of proposed rulemaking to provide guidance on the administration of the participant vote for benefit suspensions.

On November 2, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-the-irs-administration-multiemployer-plan-participant-vote-approved

Saving Arrangments Established by States for Non-Governmental Employees

On November 18, 2015, the Department of Labor issued proposed regulations that provide a new safe harbor from ERISA for state-sponsored IRAs that conform to certain provisions. Under the safe harbor, the state-sponsored payroll deduction IRA programs must be "voluntary" for workers, rather than "completely voluntary." This proposal would in effect, make it permissible for states to establish state payroll deduction saving initiatives without running afoul of the Employee Retimement Income Security Act (ERISA). Comments are due by January 19, 2016. The Chamber intends to comment.

In conjunction with the proposed regulations, DOL also published an interpretive bulletin, 2015-12, regarding the creation of state-based ERISA-compliant 401(k) plans that are open to businesses and workers.

Anticipated Rulemakings

Selection of Annuity Providers- Safe Harbor for Individual Account Plans

The Department of Labor is expected to issue a proposed rule at a date to be determined to provide a safe harbor relating to future payments provided under the annuity contract.

Mergers and Transfers Between Multiemployer Plans

In December 2015, the PBGC plans to promulgate regulations, which will prescribe rules for facilitated mergers of multiemployer plans under the Multiemployer Pension Reform Act of 2014, and conform the existing regulation to changes in the law.

Subregulatory Guidance

Employee Plans Compliance Resoultion System

In April 2015, the IRS issued Revenue Procedure 2015-28 which provides new safe harbor correction methods related to automatic EPCRS enrollment features. The notice on the EPCRS also solicits comments on related Forms 8950, 8951, 14568 and 14568-A through 14568-I (64 PBD, 4/3/15). Comments were due by August 31, 2015.

IRS Determination Letter Program

In April , 2015, the Internal Revenue Service announced its intentions to stop reviewing most applications for amended individually designed plans. In July, the IRS issued Announcement 2015-19 which makes the announcement official. Based on the need of the Internal Revenue Service (IRS) to more efficiently direct its limited resources, effective January 1, 2017, these changes will eliminate the staggered 5-year determination letter remedial amendment cycles for individually designed plans and will limit the scope of the determination letter program for individually designed plans to initial plan qualification and qualification upon plan termination. Comments were due by October 1, 2015.

Healthcare Regulatory Activity

Completed Rulemakings

Medical Loss Ratio

On April 14, 2010, the Departments of Health and Human Services, Treasury, and Labor published a request for information (RFI) to aid in the development of regulations to implement new Public Health Act Section 2718, as added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act. Section 2718 of the Public Health Service Act requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a plan year. The Departments are specifically requesting examples of initiatives to classify as "activities that improve health care quality." On May 14, 2010, the Chamber submitted comments to the Departments, emphasizing that the definition of "activities which improve health care quality" should encompass disease management programs; efforts to facilitate care coordination; the development of quality reporting metrics; initiatives to combat waste, fraud and abuse; and methods to control health care costs. The Chamber also requested that the agencies exempt the medical loss ratio requirement from applying to self-insured plans, in accordance with the statute.

The Chamber's comments submitted in response to this RFI may be accessed here: https://www.uschamber.com/comment/response-comments-request-information-regarding-medical-loss-ratios

On December 1, 2010, the Department of Health and Human Services published an interim final rule which implements the definition and methodology associated with the calculation of the Medical Loss Ratio (MLR) provisions of the Patient Protection and Affordable Care Act and the calculation of the rebate to consumers for plans that do not satisfy the MLR. A correction was published on December 30, 2010.

The Chamber filed comments in response to this interim final rule on January 31, 2011, which may be accessed here:
https://www.uschamber.com/comment/medical-loss-ratio-ifr-comments

On December 7, 2011, the Department of Health and Human Services published a final rule to implement the MLR requirements. The final rule includes a new notice requirement, which states that insurers must provide information on the amount of the rebate or MLR, regardless of whether or not there is a rebate. EBSA has spelled out in guidance (Technical Release No. 2011- 04) how ERISA plans should handle the distribution of rebates as a plan fiduciary.

On December 7, 2011, the Department also published an interim final rule implementing the Medical Loss Ratio requirements regarding the distribution of rebates by issuers in group markets for non-Federal governmental plans. The final rules took effect on January 1, 2012.

The Chamber filed comments in response to this final rule on January 6, 2012, which may be accessed here:
https://www.uschamber.com/comment/comments-final-rule-comment-period-medical-loss-ratio-mlr-requirements-under-patient

On February 21, 2012, the Department of Health and Human Services published a re-opening of comment period with respect to the information collection activities associated with the MLR requirements, including the notice rebate form. The Chamber filed comments in response to this request.

The Chamber's comments may be accessed here:
https://www.uschamber.com/comment/medical-loss-ratio-mlr-notice-rebate-forms

On May 19, 2012, the Department of Health and Human Services published a final rule amending the regulations implementing the medical loss ratio provision. The final rule will require insurers to provide a one-time notice to beneficiaries even if the insurer has met the applicable MLR requirement.

On December 7, 2012, HHS published a proposed rule, which amends the regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors, and to change the timing of the annual MLR report and distribution of rebates required of issuers to allow for accounting of the premium stabilization programs. The proposed rule also proposes to amend the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax.

On December 24, 2012, the Chamber filed comments.

The Chamber's comments may be accessed here:
https://www.uschamber.com/comment/hhs-notice-benefit-and-payment-parameters-2014-proposed-rule

On March 11, 2013, HHS published a final rule, which finalizes the amendments to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors, and to change the timing of the annual MLR report and distribution of rebates required of issuers to allow for accounting of the premium stabilization programs. The final rule also formally amends the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax.

On March 21, 2014, CMS published a proposed rule, titled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards," which among other things, provides guidance about how to calculate the MLR rebate to take into account conversion to the ICD-10 framework, and de minimis amounts for the 2015 plan year. On April 21, 2014, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/comment/exchange-and-insurance-market-standards-2015-and-beyond-proposed-rule

On May 27, 2014, CMS published the final rule.

On November 26, 2014, HHS published a proposed rule, which among other things, amends the regulations to describe how cost-sharing reduction payments should be deducted from incurred claims, and alters how federal and state taxes are computed in the MLR and rebate calculations. The proposed rule also proposes to amend the regulations with respect to the distribution of rebates to group enrollees in non-federal governmental plans. On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On December 2, 2015, HHS published a proposed rule, which among other things, amends the regulations to describe how risk adjustment payment or charge, reinsurance payment, cost-sharing reduction payments should be adjusted to reflect the actual cost-sharing reduction amounts received, or risk corridor payment or charge, where the adjustment has not been accounted for in a prior MLR and Risk Corridors Annual Reporting Form in the next following year. The proposed rule also clarifies that cost-sharing reduction amounts must exclude amounts reimbursed to provider of services or items, and requires issuers to report the risk corridors payment to be made or charge assessed by HHS. Comments are due by December 21, 2015.

Preventive Services Coverage

On July 19, 2010, the Departments of Treasury, Labor, and Health and Human Services published an interim final rule to implement requirements regarding first dollar coverage of preventive services for non-grandfathered group health plans and health insurance issuers offering group and/or individual insurance coverage.

The Chamber's comments in response to the interim final rule may be accessed here: https://www.uschamber.com/comment/comments-interim-final-rules-coverage-preventative-services

Subsequent sub-regulatory guidance has been issued by HHS to clarify and revise the IFR in the form of "Frequently Asked Questions" on December 22, 2010 (Question 1).

On August 3, 2011, the Departments of Treasury, Labor, and Health and Human Services published an amendment to the interim final rule, regarding first dollar coverage of preventive services for women with respect to non-grandfathered group health plans and health insurance issuers offering group and/or individual insurance coverage. Comments in response to the amendment to the interim final rule were due on September 30, 2011.

On February 10, 2012, the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services issued guidance on a temporary safe harbor for certain employers, group health plans and group health insurance issuers with respect to the requirement to cover contraceptive services without cost sharing under section 2713 of the

Public Health Service Act, section 715(a)(1) of the Employee Retirement Income Security Act and Section 9815(a)(1) of the Internal Revenue Code.

On February 15, 2012, the Departments of Treasury, Labor, and Health and Human Services published a final rule which finalized without change the interim final rule authorizing the exemption of group health plans and group health insurance coverage sponsored by certain religious employers from having to cover certain preventive health services under the Patient Protection and Affordable Care Act. These final rules apply generally to group health plans and group health insurance issuers on April 16, 2012.

On March 21, 2012, the Departments of Treasury, Labor and Health and Human Services published an Advance Notice of Proposed Rulemaking (ANPRM) regarding certain preventive services under the Patient Protection and Affordable Care Act. This ANPRM announced the intention of the Departments to proposed amendments to regulations regarding certain preventive health services under PPACA. The proposed amendments would establish alternative ways to fulfill the requirements of the law when health coverage is sponsored or arranged by a religious organization that objects to the coverage of contraceptive services for religious reasons.

On February 1, 2013, the Departments of Treasury, Labor, and Health and Human Services published proposed rules, which establish alternative ways to fulfill the requirements of the law when health coverage is sponsored or arranged by a religious organization that objects to the coverage of contraceptive services for religious reasons. The proposed rules closely mirror the ANRPM's earlier guidance. Comments were due on April 8, 2013. On July 2, 2013, the Departments of Treasury, Labor, and Health and Human Services published final rules, virtually unchanged from the proposal.

On August 27, 2014, the Departments of Treasury, Labor, and Health and Human Services promulgated interim final rules providing that nonprofit religious organizations that object to contraception won't have to authorize the coverage, but instead will notify the government, which will arrange coverage. The proposal also seeks comments on how the administration might extend the same "accommodation" to closely held for-profit entities. Comments were due by October 21, 2014.

Subsequent sub-regulatory guidance has been issued by HHS to clarify the preventive services requirement in the form of "Frequently Asked Questions" on February 20, 2013 (Questions 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20), on January 9, 2014 (Question 1), and May 2, 2014 (Question 5) and May 11, 2015, (Questions 1, 2, 3, 4,5,6, and 7) and October 23, 2015 (Questions 1, 2, 3, 4, 5, 6, 7, 8, and 9).

On July 14, 2015, the Departments of Treasury, Labor, and Health and Human Services issued final regulations which are effective September 14, 2015.

Uniform Explanation of Benefits, Coverage Facts and Standardized Definitions

On August 22, 2011, HHS published a Notice of Proposed Rulemaking (NPRM) implementing the requirement that all insurers use a 4 page uniform format for accurate summaries of benefits

and coverage explanations. The Patient Protection and Affordable Care Act requires the Secretary to develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes benefits and coverage. The Secretary must also set standards for the definitions of terms used in health insurance coverage, including specific terms set out in the statute. Plans and issuers must provide information according to these standards no later than 24 months after enactment. The NPRM proposes how to implement the information disclosure provisions in Section 2715 of PHSA, as added by the Patient Protection and Affordable Care Act.

On October 21, 2011, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/comments-summary-benefits-and-coverage-and-uniform-glossary-notice-proposed

On November 17, 2011, the Department of Labor issued an FAQ stating that a final rule will be issued with a ***new applicability date***, meaning that until a final rule is issued, the March 23, 2012 implementation date no longer stands. The Chamber pushed for a delay in the implementation deadline in comments filed with CMS in response to the NPRM on October 21, 2011.

On February 14, 2012, the Departments (Labor, Treasury, and HHS) promulgated a final rule, implementing the provisions regarding the uniform explanation of benefits, coverage facts, and standardized definitions. The final rule delays the implementation date for group health plans until the first day of the first plan year that begins on or after September 23, 2012.

On March 19, 2012, and on May 11, 2012, the Department of Labor, Department of Treasury, and Department of Health and Human Services issued guidance under "Frequently Asked Questions," which stated that group health plan and sponsors working in good faith to provide the standardized summary of benefits and coverage required will not face penalties during the first year of applicability.

On June 5, 2012, the Department of Labor released Coverage Examples, a Calculator, and related information.

On April 23, 2013, the Department of Labor released an updated FAQ, announcing updated materials. Specifically, the Departments have released an updated template and sample summary of benefits and coverage. These documents are authorized for use with respect to group health plans and group and individual health insurance coverage with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015. The only change to the template and sample completed summary of benefits and coverage is the addition of statements of whether the plan or coverage provides minimum essential coverage (as defined under section 5000A (f) of the Internal Revenue Code of 1986) and whether the plan or coverage meets the minimum value requirements (that is, the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs). On May 24, 2014, the Department of Labor released an updated FAQ, announcing that "safe harbor" relief continues to remain in effect until further guidance is issued.

On December 30, 2014, the Departments (Labor, Treasury, and HHS) promulgated a proposed rule, updating the implementation of the provisions regarding the uniform explanation of benefits, coverage facts, and standardized definitions, and updating the coverage examples. Comments were due March 2, 2015.

On March 30, 2015, the Department of Labor announced in a FAQ that the new template and associated documents are intended to be finalized by January 2016 and will apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017. On June 16, 2015, the Departments issued final regulations, reiterating that the new template and associated documents will be finalized by January 2016 and will apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017.

Health Insurance Premium Tax Credit

On August 17, 2011, the Treasury Department published a notice of proposed rulemaking and notice of public hearing to describe providing guidance to individuals who enroll in qualified health plans through Exchanges and claim the tax credit and to Exchanges that make qualified health plans available to individuals and employers.

On October 31, 2011, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/comments-health-insurance-premium-tax-credit-notice-proposed-rulemaking-and-notice-public

On May 23, 2012, the Treasury Department issued final regulations regarding the health insurance premium tax credit. On August 21, 2012, the Chamber submitted comments in response to the final rule.

The comments may be accessed here: https://www.uschamber.com/comment/comments-irs-final-regulations-health-insurance-premium-tax-credit

On December 7, 2012, HHS published a proposed rule providing additional details for Exchanges and issuers on the administration of advance payments of premium tax credits and cost-sharing reductions for individuals and families.

On December 24, 2012, the Chamber filed comments.

The Chamber's comments may be accessed here: https://www.uschamber.com/comment/hhs-notice-benefit-and-payment-parameters-2014-proposed-rule

On February 1, 2013, the IRS published an amendment to the final rule, which declares that the threshold for affordability for employment-based plans is based on the cost of individual coverage in relation to an individual's household income.

On March 11, 2013, HHS published a final rule which provides additional details for Exchanges and issuers on the administration of advance payments of premium tax credits and cost-sharing reductions for individuals and families.

On December 2, 2013, CMS published a proposed rule, which would among things, proposes an annual limitation on cost-sharing to stand-alone dental plans in the Exchange, and provides updates to the administration of advance payments of premium tax credits and cost-sharing reductions for individuals, and families in the 2015 plan year. On December 26, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/2015%20Notice%20of%20Benefit%20and%20Payment%20parameters.pdf

On March 10, 2014, CMS published the final rule.

On July 28, 2014, the IRS issued final and temporary rules on premium assistance tax credits, and on August 11, 2014, Revenue Procedure 2014-37, that addresses a variety of issues involving the tax credit, including details on indexing that updates calculations on whether an employer's offer of health-care coverage is affordable to employees.

On November 26, 2014, HHS published a proposed rule, which among other things, provides updates to the administration of advance payments of premium tax credits and cost-sharing reductions for individuals and families in the 2016 plan year. On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

Essential Health Benefits

On November 8, 2010, the Institute of Medicine requested comments to an on-line survey exploring the proper definition of "essential health benefits" which all qualified plans offered in an exchange would be required to cover.

A copy of the comments the Chamber submitted through the on-line survey may be accessed here: https://www.uschamber.com/comment/comments-institute-medicine-national-academies-survey-essential-health-benefits

Three days after the Chamber submitted responses, the Institute of Medicine requested that a representative from the U.S. Chamber of Commerce participate in a public panel to explore purchaser decision making in benefit design from the perspective of small employers. A member of the Employee Benefits Committee who also serves on the Health Care Regulatory Task Force participated in the panel discussion on January 13, 2011.

On December 16, 2011, the Department of Health and Human Services (HHS) issued a bulletin and request for comment, entitled the "Essential Health Benefits Bulletin." The bulletin indicates that the Department is contemplating permitting States to define a benchmark plan that

is equivalent in benefit offerings to the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; any of the three largest three State employee health benefits plans by enrollment; any of the largest three national FEHBP plans options by enrollment; or the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. States can also offer additional benefits in the package, but would be responsible for defraying these costs. On February 3, 2012, the Chamber submitted comments.

A copy of the Chamber's comments may be accessed here:
https://www.uschamber.com/comment/essential-health-benefits-bulletin-response-request-comments

On February 17, 2012, CMS issued a bulletin, entitled "Frequently Asked Questions on Essential Health Benefits" to provide guidance to states and employers on how to comply with this provision in the statute.

On February 24, 2012, CMS issued a bulletin on the calculation of actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage in the individual and small group market.

On June 5, 2012, CMS published a proposed rule to establish data collection standards to support the definition of "essential health benefits." Comments were due by July 4, 2012. On July 20, 2012, CMS published a final rule to establish the data collection standards required to support the definition of "essential health benefits."

On November 26, 2012, HHS published a proposed rule detailing the "essential health benefits," actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage in the individual and small group market, and the accreditation process for health plans. The proposed rule largely mirrors the earlier bulletins, but also imposes a new requirement that health insurance plans will also be required to cover the same number of prescription drugs as the benchmark plan in their states, and includes a transitional policy for the coverage of habilitative services. The proposed rule also would set up a waiver process for insurers to impose a higher threshold than the maximum deductible permitted under the statute if a plan can't design a "bronze" plan without a higher deductible.

On December 26, 2012, the Chamber submitted comments in response to the proposed rule.

A copy of the Chamber's comments may be accessed here:
https://www.uschamber.com/comment/standards-related-essential-health-benefits-actuarial-value-and-accreditation-proposed-rule

Subsequent sub-regulatory guidance has been issued by HHS to clarify how the essential health benefits interface with the limitations of cost-sharing in the form of "Frequently Asked Questions" issued on February 20, 2013 (Questions 1 and 2) and January 9, 2014 (Questions 2, 3, 4, and 5).

On February 26, 2013, HHS published a final rule regarding the "essential health benefits." The final rule indicates that annual limitations on out-of-pocket maximums will apply to both the large group market and self-insured plans and that the Department will engage in separate rulemaking to clarify those standards; finalizes a minimum value calculator for the large group and self-insured plans, which relies on using a standard population that is based on self-insured group health plans; and states that guidance on the treatment of Health Reimbursement Arrangements for the actuarial value calculator is forthcoming. The final rule also states that sub-regulatory guidance is forthcoming for a health plan "to have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan."

On November 26, 2014, HHS published a proposed rule, which among other things, makes change to "essential health benefits," actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage in the individual and small group market, and the accreditation process for health plans. The proposed rule modifies the requirement that health insurance plans will also be required to cover the same number of prescription drugs as the benchmark plan in their states, and includes a transitional policy for the coverage of habilitative services, and adds a requirement that plans adopt a pharmacy and therapeutic committee to ensure that the plan's formulary drug list covers a sufficient number and type of prescription drugs and states the agency is considering replacing the USP standard with a standard based on the American Hospital Formulary Service. The proposed rule also includes a policy for the coverage of habilitative services.

On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On December 2, 2015, HHS published a proposed rule, which among other things, makes changes to "essential health benefits," actuarial value determinations and announces adjustments to cost-sharing adjustments for qualified health plans and other non-grandfathered coverage in the individual and small group market. Comments are due by December 21, 2015

"Minimum" Value of Employer Sponsored Coverage

On April 26, 2012, the Internal Revenue Service (IRS) published Notice 2012-31, requesting public comment on issues relating to the minimum value and shared responsibility provisions included in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Specifically, the IRS requested comments on how the agency should consider the interaction between the actuarial value (A/V) of the Essential Health Benefits and determining the A/V value of employer-sponsored plans. The notice also describes the different approaches to the methodology regarding how an employer-sponsored plan may calculate the A/V value to meet the threshold requirements. On June 11, 2012, the Chamber submitted comments.

The comments may be accessed here:
https://www.uschamber.com/comment/notice-2012-31-minimum-value-employer-sponsored-plan

On November 26, 2012, HHS published a proposed rule detailing the "essential health benefits," actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage in the individual and small group market, and accreditation process for health plans. The proposed rule mirrors the guidance provided in IRS Notice 2012-31.

On December 26, 2012, the Chamber submitted comments.

A copy of the Chamber's comments may be accessed here:
https://www.uschamber.com/comment/standards-related-essential-health-benefits-actuarial-value-and-accreditation-proposed-rule

On February 26, 2013, HHS published a final rule with respect to how employer-sponsored plans may calculate A/V to satisfy the minimum value requirement.

On May 3, 2013, the IRS published a proposed rule that outlines how health risk assessments, HSA contributions, and wellness program incentives should be treated when calculating minimum-value standards. In addition, the proposed rule also requests input on "safe harbor" designs large employers may use for purposes of calculating minimum value requirements.

On July 2, 2013, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/comment/comments-irs-minimum-value-eligible-employer-sponsored-plans-and-other-rules-regarding

On December 2, 2013, CMS published a proposed rule, which would among other things, propose standards for updating the A/V calculator. On December 26, 2013, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/sites/default/files/documents/files/2015%20Notice%20of%20Benefit%20and%20Payment%20parameters.pdf

On March 10, 2014, CMS published the final rule.

On November 26, 2014, HHS published a proposed rule, which among other things, proposes that in order for an employer plan to satisfy the "minimum value" threshold, such a plan would be required to provide substantial coverage of both inpatient hospital services and physician services.

On December 22, 2014, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On September 1, 2015, IRS published a supplemental rulemaking, which requires substantial coverage of inpatient hospitalization and physician services in order for a plan to be deemed to have "minimum value."

On November 2, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-treasury-and-irs-regarding-minimum-value-eligible-employer-sponsored-health

On December 2, 2015, HHS published a proposed rule, which among other things, prescribes the criteria by which an exchange determines an applicant's lack of affordable coverage based on projected income. Comments are due by December 21, 2015

Incentives for Nondiscriminatory Wellness Programs in Group Health Plans

On November 26, 2012, the Departments of Labor, Treasury, and HHS published a proposed rule amending the regulations for nondiscriminatory wellness programs in group health coverage. The NPRM would increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20 to 30 percent of the cost of coverage, and further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. The proposed regulation would also impose new considerations with respect to the "reasonable alternative" standard, and includes new sample language for employers to inform their employees about achieving the reward via alternative means.
On January 25, 2013, the Chamber filed comments.

The Chamber's comments may be accessed here:
https://www.uschamber.com/comment/incentives-nondiscriminatory-wellness-programs-group-health-plans

On June 3, 2013, the Departments of Labor, Treasury, and HHS published the final rule.

On May 3, 2013, the IRS published a proposed rule that outlines how health risk assessments, HSA contributions, and wellness program incentives should be treated when calculating minimum-value standards. The proposed rule also provides a safe harbor for employers who use incentives in their wellness programs and have an employee who qualifies for a premium assistance tax credit due to the fact that the coverage is unaffordable or lacks minimum value due to the use of these incentives.

On July 2, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-irs-minimum-value-eligible-employer-sponsored-plans-and-other-rules-regarding

Subsequent sub-regulatory guidance has been issued in the form of "Frequently Asked Questions" issued on January 9, 2014 (Questions 8, 9, and 10), April 16, 2015 (Questions 1, and 2) and October 23, 2015 (Question 11).

Individual "Shared Responsibility" Requirement

On February 1, 2013, the Internal Revenue Service published a proposed rule and announced a public hearing regarding implementation of the individual mandate penalty for individuals, methods for calculating the fee, and exemptions. Comments were due by May 2, 2013. On August 30, 2013, the Internal Revenue Service published final regulations.

On February 1, 2013, the Department of Health and Human Services published proposed regulations to implement the individual mandate, including describing how exchanges can grant certificates of exemptions to individuals, and sets forth the processes that individuals may be credited for "minimum essential coverage" if they have other health insurance coverage than is defined in the statute. Comments were due by March 18, 2013.

On October 28, 2013, the Department of Health and Human Services released sub-regulatory guidance in the form of a Question and Answer, which creates an additional hardship exemption and extends until March 31, 2014, the time during which individuals may enroll in coverage through the exchanges and still be in compliance with the individual mandate requirement.

On March 21, 2014, CMS published a proposed rule, titled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards," which among other things, discusses various approaches for determining the percentage of an individual's modified adjusted growth income that would excuse the individual from paying the individual responsibility requirement.

On April 21, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Exchange%20and%20Insurance%20Market%20Standards%20for%202015%20and%20Beyond%20Proposed%20Rule%20-%20USCC%20comments.pdf

On May 27, 2014, CMS published the final rule.

On November 26, 2014, HHS published a proposed rule, which among other things, would provide a hardship exemption to an individual who is not a dependent of another taxpayer and whose gross income is less than the individual's minimum threshold for filing a Federal income tax return and updates the percentage of an individual's modified adjusted growth income that would excuse the individual from paying the individual responsibility requirement.

On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

Flexible Spending Arrangements

On May 30, 2012, the Internal Revenue Service (IRS) issued Notice 2012-40 regarding guidance on the effective date of the $2,500 limit on salary reduction contributions to health flexible spending arrangements (FSAs) and on the deadline for amending plans to comply with that limit.

The Notice provides relief for certain contributions that mistakenly exceed the $2,500 limit and that are coordinated in a timely manner. On August 17, 2012, the Chamber submitted comments with respect to whether to modify the use-or-lose rule that is currently set forth in the proposed regulations with respect to health FSAs.

These comments can be accessed here: https://www.uschamber.com/comment/comments-irs-health-flexible-spending-arrangements-notice-2012-40

On October 31, 2013, the IRS published Notice 2013-71, which permits employers on a voluntary basis after amending its plan documents to offer either the 2.5 month grace period or to allow FSA participants to carry-over $500 into the next plan year.

Mental Health Parity Rule

On February 2, 2010, the Departments of Treasury, Labor, and Health and Human Services (HHS) published an interim final rule implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Act"), which prohibits group health plans from applying financial requirements or treatment limitations that are more restrictive than those applied to the group health plan's medical and surgical benefits. This regulation is effective for the first plan year beginning on or after July 1, 2010. The rules are much more expansive than anticipated.

On May 3, 2010, the Chamber, American Benefits Council, and National Retail Federation submitted joint comments on the interim final rules. The Chamber, along with the American Benefits Council, and National Retail Federation respectfully requested that the agencies delay the applicability date until the first plan year beginning on or after January 1, 2012, and also provides for a good faith compliance period to give plan sponsors additional time to come into compliance. The comments also emphasized that the departments overreached in defining the list of "non-quantitative" limits to also encompass medical management techniques.

The Chamber's jointly filed comments may be accessed here: https://www.uschamber.com/comment/comments-mental-health-parity-act-interim-final-regulations

On November 13, 2013, the Department of HHS (with the Department of Treasury and Department of Labor) published a final rule to further clarify statutory changes to the Public Health Service Act (PHSA) affecting the group health insurance markets and non-federal governmental plans, made by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Health Insurance Tax

On March 4, 2013, the Internal Revenue Service issued a proposed rule and notice of public hearing regarding the health insurance tax. The NPRM provides guidance to implement the health insurance tax, based on a firm's net premiums allocated by market share.

On June 3, 2013, the Chamber submitted comments. The comments may be accessed here: https://www.uschamber.com/comment/health-insurance-providers-fee

On November 29, 2013, the IRS published final regulations.

On August 14, 2014, the Treasury Department and the IRS issued Notice 2014-47, 2014 IRB 522, to provide further guidance for the 2014 fee year on the definition of a covered entity. On February 26, 2015, the IRS published final and temporary regulations to provide further guidance on the definition of a covered entity for the 2015 fee year and subsequent fee years.

Employer "Shared Responsibility" Requirement

On May 23, 2011, the Internal Revenue Service (IRS) published in the *Bulletin*, Notice 2011-36, requesting public comment on issues relating to the shared responsibility provisions included in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Specifically, the IRS requested comments on how the agency should consider full-time employment and the different approaches to calculating employment status with respect to the classification of who should be considered a "full-time" employee. In addition, the notice also requested comments regarding how the 90-day waiting period, beginning in 2014, would interplay with the "shared responsibility" requirement. On June 17, 2011, the Chamber submitted comments, emphasizing that the IRS should maintain flexibility in its approach towards calculation of "full-time employment," and commended the agency for its initial outreach effort.

The Chamber submitted comments on June 17, 2011, in response to the notice and request for comments which may be accessed here: https://www.uschamber.com/comment/shared-responsibility-employers-regarding-health-coverage-section-4980h

On October 3, 2011, the IRS published in the *Bulletin*, Notice 2011-73, requesting public comment on issues relating to the shared responsibility provisions included in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Specifically, the IRS has requested comments on a proposed "safe harbor" which would permit an employer that offers coverage to its employees to measure the 9.5 "affordability test" by using wages that the employer paid to the employee, rather than the employee's household income.

The Chamber submitted comments on December 13, 2011, which may be accessed here: https://www.uschamber.com/comment/comments-health-coverage-affordability-safe-harbor-employers

On February 9, 2012, the Department of Labor and the Internal Revenue Service issued guidance, entitled "Frequently-Asked Questions From Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods." The guidance requested comments on potential interpretations that the Departments are planning to take with respect to

auto-enrollment, the "free rider" penalty, and the 90-day waiting period. On April 5, 2012, the Chamber filed joint comments through the Employers for Flexibility in Health Care Coalition.

The comments may be accessed here: https://www.uschamber.com/comment/frequently-asked-questions-employers-regarding-automatic-enrollment-employer-shared

On August 31, 2012, the Internal Revenue Service published Notice 2012-58, requesting public comment on issues related to "safe harbor" methods that employers may use to determine which employees are treated as "full-time" employees. Specifically, the IRS has requested comments on a proposed "safe harbor" which would permit an employer that offers coverage to its employees to measure hours worked based on a look-back measurement of up to 12 months for variable hour employees or seasonal employees; provides an option to use specified administrative periods for ongoing employees as well as certainly newly hired employees; and endorses the "safe harbor" approaches contained in Notice 2011-36 and Notice 2011-73. On September 30, 2012, the Chamber submitted comments.

The comments may be accessed here:
https://www.uschamber.com/comment/comments-determination-full-time-employees-purposes-shared-responsibility-employers

On January 2, 2013, the Internal Revenue Service published a proposed rule regarding implementation of the "free rider" penalty for "applicable large employers."

On March 18, 2013, the Chamber submitted comments which may be accessed here:
https://www.uschamber.com/comment/shared-responsibility-employers-regarding-health-coverage

On August 31, 2012, the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service issued guidance, entitled "Guidance on 90-Day Waiting Period Limitation Under Public Health Service Act §2708." This guidance will remain in effect at least through the end of 2014. It explains what constitutes a "waiting period" and which ones do not violate the 90-day limit. Additionally, it outlines generally permissible eligibility conditions, as well as the proper application of certain eligibility conditions and when waiting periods may be imposed on variable hour employees. The guidance coordinates with concurrently issued Treasury Department Notice 2012-58. On September 30, 2012, the Chamber submitted comments.

The comments may be accessed here: https://www.uschamber.com/comment/guidance-90-day-waiting-period-limitation-dol-technical-release-2012-02

On March 21, 2013, the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service issued proposed rules for implementing the 90-day waiting period. The proposed rules mirror the earlier guidance. Comments were due by May 20, 2013.

On May 3, 2013, the IRS published a proposed rule that outlines how health risk assessments, HSA contributions, and wellness program incentives should be treated when calculating

minimum-value standards. On July 2, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-irs-minimum-value-eligible-employer-sponsored-plans-and-other-rules-regarding

On July 9, 2013, IRS published Notice 2013-45, "Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)." The Notice states that the Internal Revenue Service will issue proposed rules for the information reporting requirements this summer, and due to this decision, the "free rider" penalty will not take effect until 2015. On March 10, 2014, IRS published final rules for the information reporting requirements.

On September 9, 2013, the IRS published proposed rules for the information reporting requirements. On November 8, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-proposed-rulemaking-and-notice-public-hearing-information-reporting-minimum

On February 12, 2014, the Internal Revenue Service published final regulations regarding the administration of the "free rider" penalty. Among the significant changes made:

- Provides an option for small businesses with between 50-99 FTEs to delay the employer mandate until 2016, as long as the employer can certify they have not paid workers off to get below 100 FTE or dropped coverage.
- Allows employers (with 100 FTEs and over for 2015) to satisfy the requirement to offer coverage to all full-time employees if coverage is offered to 70% of all full-time employees in 2015.
- Allows employers (with 50 or more FTEs for 2016) to satisfy the requirement to offer coverage to all full-time employees if coverage is offered to 95% of all full-time employees in 2016.
- Codifies the definition of seasonal workers – an employee won't be treated as a full-time employee if they work for up to a 6 month period (not tied to any holidays or season in particular).
- Employers may measure how many employees they have (i.e. do they have under 100 FTE in 2015 or under 50 FTEs in 2016) to determine whether they have to offer coverage before 1/1/15
    - If have 100 or more FTEs in 2015 – must offer
    - If have under 100 FTEs in 2015 – won't have to offer for a 12 month stability period.
- Coverage for new applicable large employers does not have to be effective until April 1, 2015.
- Transition relief for plans with non-calendar years- For plan years that do no start on January 1st, the employer mandate will be effective beginning the start of the plan year, rather than on January 1st.
- Transition relief for dependent coverage- As long as the applicable large employer is taking steps to arrange for dependent coverage to begin in 2016, the employer will not be penalized in 2015.

- Provides two additional safe harbors: 1) rate of pay safe harbor (rate of pay must be the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage which does not exceed 9.5 percent of an amount equal to 130 hours multiplied by the lower of the employee's hourly rate of pay as of the first day of the coverage period (generally the first day of the plan year) and/or the employee's lowest hourly rate of pay during the calendar month; and 2) Federal poverty line safe harbor, so that if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12, the employer would not be liable to pay the penalty.

On February 24, 2014, the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service issued final rules for implementing the 90-day waiting period. The proposed rules mirror the final rules, while also clarifying that if an individual is newly rehired, a plan or issuer may require that plan to meet the plan's eligibility criteria and to satisfy the plan's waiting period, anew, if reasonable under the circumstances. In addition, the final rules provides an exception for a reasonable and bona fide employment-based orientation period that would not count towards the 90-days.

On February 24, 2014, the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service issued proposed regulations that would provide one month as the maximum allowed length of any reasonable and bona fide employment-based orientation period. On March 25, 2014, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/comments-ninety-day-waiting-period-limitation-proposed-rule

On June 25, 2014, the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service issued the final regulations without change.

On September 18, 2014, the IRS issued guidance, Notice 2014-49, proposing an approach to the look-back measurement period for determining whether an employee is full time when the measurement period for the employee changes either because the worker transfers to a new job with the same employer or because the employee changes the measurement period for the worker's job. The Notice also provides a proposed approach under which employers could change the measurement period for an entire category of employees. Comments were due by December 9, 2014.

Reporting Requirements

On April 26, 2012, the IRS published Notice 2012-32 and Notice 2012-33, requesting public comment on: the reporting requirements for large employers and the interaction of the reporting requirements for health insurance issuers, government agencies, employers that sponsor self-insured plans and others that provide minimum essential coverage to an individual. On June 11, 2012, the Chamber submitted comments.

The comments may be accessed here: https://www.uschamber.com/comment/notice-2012-32-request-comments-reporting-health-insurance-coverage and here: https://www.uschamber.com/comment/notice-2012-33-request-comments-reporting-applicable-large-employers-health-insurance

On September 9, 2013, 2013, the IRS published proposed rules for the information reporting requirements.

On November 8, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-proposed-rulemaking-and-notice-public-hearing-information-reporting

On March 10, 2014, IRS published final rules for the information reporting requirements.

Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs

On January 10, 2014, the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicare Advantage program and Medicare Part D. With respect to Medicare Part D, among other things, the proposed rule would place limits on plan offerings, provide substantial changes to protected classes of drugs that Part D plans are required to cover, and revise the regulatory definition of negotiated prices to require all price concessions from pharmacies to be reflected. On February 18, 2014, the Chamber signed onto a group letter requesting that CMS withdraw the rule.

On March 7, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-medicare-advantage-ma-and-medicare-prescription-drug-program-part-d

On March 10, 2014, CMS announced that they are withdrawing the proposed rule.

Tax Credit for Employee Health Insurance Expenses of Small Employers

On August 26, 2013, the Internal Revenue Service (IRS) published proposed regulations which detail how an eligible small employer may be eligible to obtain a tax credit if such an employer decides to purchase health insurance coverage on the Exchange. Comments were due by November 25, 2013. On June 30, 2014, the IRS published final regulations.

Amendments on Excepted Benefits

On December 24, 2013, the Department of Health and Human Services, Department of Labor and Department of Treasury issued a proposed rule to amend excepted benefits to include limited vision and dental programs as well as employee assistance programs and limited wraparound coverage. On February 24, 2014, the Chamber submitted comments, which may be accessed

here: https://www.uschamber.com/comment/comments-amendments-excepted-benefits-proposed-rule

On October 1, 2014, the Department of Health and Human Services, Department of Labor and Department of Treasury issued final rules. However, the Departments postponed addressing limited wraparound coverage by announcing that they intended to publish those regulations at a later date.

On December 23, 2014, the Department of Health and Human Services, Department of Labor published proposed rules addressing limited wraparound coverage. Comments were due by January 23, 2015. On March 18, 2015, the Departments issued final regulations.

Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

On June 28, 2010, the Departments of Treasury, Labor, and Health and Human Services published an interim final rule (with comment period) to implement Public Health Service Act Sections 2704 (prohibiting preexisting condition exclusions), 2711 (banning lifetime limits and imposing restricted annual limits, until 2014), and 2719A (patient protections with respect to designation of a primary care provider, pediatrician and/or obstetrician/gynecologist; and cost-sharing limitations with respect to emergency services).

The Chamber's comments in response to the interim final rule may be accessed here: https://www.uschamber.com/comment/comments-interim-final-rules-preexisting-condition-exclusion

Subsequent sub-regulatory guidance has been issued to clarify and revise the IFR, including several sub-regulatory guidance issued by HHS in the form of "Questions and Answers on Enrollment of Children under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions." Additionally, an Insurance Standards Bulletin was issued by the HHS's Office of Consumer Information and Insurance Oversight on September 3, 2010, detailing the process for obtaining waivers of the annual limits requirements in the group and individual markets. Further sub-regulatory guidance was issued by HHS in the form of "Frequently Asked Questions" on September 20, 2010 (Question 15), on October 8, 2010 (Questions 7 and 8), on December 22, 2010 (Question 6), and on April 29, 2013 (Question 1).

On November 18, 2015, the Departments of Treasury, Labor, and Health and Human Services published final regulations.

Rulemakings Underway

Medicare Shared Savings Program: Accountable Care Organizations

On April 7, 2011, HHS published a proposed rule implementing the provisions relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to

treat an individual patient across care settings – including doctor's offices, hospitals and long-term care facilities. The Medicare Shared Savings Program will reward ACOs (accepting responsibility for at least 5,000 Medicare beneficiaries for three years) that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Under these provisions, providers and suppliers can continue to receive traditional Medicare Fee-for service payments under Part A and B, and be eligible for additional payments based on meeting specified quality and savings requirements. Patient and provider participation is purely voluntary. The Patient Protection and Affordable Care Act requires the Secretary of the United States Department of Health and Human Services (HHS) to establish the Medicare Shared Savings Program no later than January 1, 2012.

Under the proposed rule, Medicare beneficiaries would not enroll in a specific ACO. Instead, Medicare would take a retrospective look at the beneficiary's use of services to determine whether a particular ACO should be credited with improving care and reducing expenditures, thereby incenting the ACO to improve the quality of care for all patients seen by its member providers and suppliers. An ACO that meets the program's quality performance standards would be eligible to receive a share of the savings it generates below a specific expenditure benchmark set up by the Centers for Medicare and Medicaid Services (CMS) for each ACO. The proposed rule would also hold ACOs accountable for downside risk by requiring ACOs to repay Medicare for a portion of losses (expenditures above its benchmark.)

The Chamber submitted comments on June 6, 2011 in response to the proposed rule which may be accessed here:
https://www.uschamber.com/comment/proposed-rule-medicare-program-medicare-shared-savings-program-accountable

On November 2, 2011, the Department published final regulations regarding the Medicare Shared Savings Program. The final rule differs from the proposed rule by among other things, removing the requirement that each ACO participant must have a seat on the ACO's governing body; cutting in half the number of quality measures from 65 to 33; and by making it more difficult for ACOs to be held accountable for downside risk, meaning that ACOs are more likely to achieve savings.

On November 2, 2011, the Centers for Medicare & Medicaid Services and the Office of the Inspector General, HHS, promulgated an interim final rule establishing waivers of the application of certain health care fraud and abuse laws to specified arrangements involving ACOs under the Medicare Shared Savings Program. The interim final rule establishes five separate waivers that may be utilized by health care providers. Comments were due by January 3, 2012.

On December 8, 2014, the Centers for Medicare & Medicaid Services published a proposed rule that would make changes to the provisions relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs) and to the Shared Savings Program. Specifically, the proposed rules would clarify existing and establish new definitions of terms including an ACO participant, ACO provider/supplier, and ACO participation agreement; add a process for ACOs to renew the participation agreement for an

additional agreement period; expand the kinds of beneficiary-identifiable data that would be provided to ACOs in various reports as well as simplify the claims data sharing opt-out process to improve the timeliness of access to claims data; offer an opportunity for ACOs to continue participating under one-sided participation agreement after their first 3-year agreement; and adopting an alternative risk-based model (Track 3) which includes proposals for a higher sharing rate and prospective assignments of beneficiaries. Comments were due by February 6, 2015.

On June 9, 2015, CMS published final regulations that largely mirror the proposed rules, but make further adjustments such as permitting Track One ACOs to continue participating under a one-side participation agreement for an additional three years and making technical adjustments to the program.

On February 12, 2015, HHS and the Office of Inspector General published additional guidance with respect to Medicare Shared Savings Program Waivers.

Stop-Loss Insurance

On May 1, 2012, the Departments of Treasury, Labor, and Health and Human Services published a request for information regarding the use of stop loss insurance by group health plans and their plan sponsors with a focus on the relevance and consequences of stop loss insurance at low attachment points.

On July 2, 2012, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/request-information-regarding-stop-loss-coverage

Exchanges and Qualified Health Plans

Planning and Establishment of State-Level Exchanges

On August 3, 2010, the Department of Health and Human Services published a request for comments (RFC) in advance of future rulemaking and grant solicitations. The RFC invited comments to aid in the development of standards for establishment and operation of new state-based insurance marketplaces that must be in operation by 2014 for individuals and small groups to purchase a qualified health plan. In addition to the RFC, the National Association of Insurance Commissioners released a draft of the American Health Benefit Exchange Model Act on September 27, 2010 and the Department of Health and Human Services also issued an initial guidance to states on exchanges on November 22, 2010.

The Chamber's comments in response to the request for comments may be accessed here: https://www.uschamber.com/comment/comments-exchange-related-provisions-title-i-patient-protection-and-affordable-care-act

On July 15, 2011, HHS published a proposed rule which (1) Sets forth the Federal requirements that States must meet if they elect to establish and operate an Exchange; (2) outlines minimum requirements that health insurance issuers must meet to participate in an Exchange and offer

qualified health plans (QHPs); and (3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP).

On October 31, 2011, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/comments-establishment-exchanges-and-qualified-health-plans-proposed-rule

On March 27, 2012, HHS published both a final and interim final rule to implement the requirements regarding the establishment of exchanges and qualified health plans.

On May 16, 2012, the Centers for Medicare and Medicaid Services released guidance entitled, "General Guidance on Federally-facilitated Exchanges." The guidance provides guidelines for establishing a federally run health exchange and for states looking to partner with the federal government to operate an exchange.

On November 26, 2012, HHS published a proposed rule detailing the "essential health benefits," actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage in the individual and small group market, and accreditation process for health plans. The proposed rule largely mirrors the earlier bulletins, but also imposes a new requirement that health insurance plans will also be required to cover the same number of prescription drugs as the benchmark plan in their states. The proposed rule also sets up a waiver process for insurers to impose a higher threshold than the maximum deductible permitted under the statute if a plan can't design a "bronze" plan without a higher deductible.

On December 26, 2012, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/standards-related-essential-health-benefits-actuarial-value-and-accreditation-proposed-rule

On November 26, 2012, HHS published a proposed rule which implements the statute's policies regarding determining how insurers may adjust premiums, and guaranteed availability and renewal requirements, and how risk pools may be underwritten. The proposed rule closely mirrors the requirements of the law by imposing a 3:1 age range banding, permitting insurers to charge smokers more, as well as adjust premiums based on family size and geography, and also prohibits insurers from using claims history, health status, gender, and occupation to increase premiums.

On December 24, 2012, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/health-insurance-market-rules-rate-review-proposed-rule

Subsequent sub-regulatory guidance has been issued by HHS to clarify how the essential health benefits interface with the limitations of cost-sharing in the form of "Frequently Asked Questions" issued on February 20, 2013 (Questions 1 and 2) and January 9, 2014 (Questions 2, 3, 4, and 5).

On February 25, 2013, HHS published a final rule detailing the "essential health benefits," actuarial value and cost-sharing for qualified health plans and other non-grandfathered coverage

in the individual and small group market, and accreditation process for health plans. The final rule also states that sub-regulatory guidance is forthcoming outlining options related to plan design where exceeding the deductible limits is permissible while keeping the de-minimum variation intact. On February 27, 2013, HHS issued a final rule which implements the statute's policies regarding determining how insurers may adjust premiums, and guaranteed availability and renewal requirements, and how risk pools may be underwritten.

On June 19, 2013, CMS published a proposed rule regarding exchange oversight and technical ground rules for the Exchanges. Comments were due by July 19, 2013. On August 30, 2013, CMS published final regulations related to oversight of issuers offering coverage in the Federally-facilitated Marketplaces (FFMs), compliance with privacy and security standards, consumer protections regarding payment and application assistance, as well as eligibility appeals and flexibility for states. On October 30, 2013, CMS published final regulations regarding the oversight of state-operated premium stabilization programs, and oversight of health insurance in federally-facilitated exchanges.

On December 2, 2013, CMS published a proposed rule, which would among other things, reduce the time period for which a State electing to operate an Exchange after 2014 must have in effect an approved or conditionally approved, Exchange Blueprint and operational readiness assessment from at least 12 months to 6.5 months prior to the Exchange's first effective date of coverage; alters the beginning of annual enrollment for the 2015 calendar year from October 1 to November 15th; proposes the processes to ensure the privacy and security of personable identifiable information (PII); establishes patient safety standards that QHP issuers must meet when an issuer contracts with hospitals with more than 50 beds; and sets forth the criteria with respect to the meaningful difference standards for QHPs offered through an FFE. On March 10, 2014, CMS published the final rule.

On December 26, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/2015%20Notice%20of%20Benefit%20and%20Payment%20parameters.pdf

On November 26, 2014, HHS published a proposed rule, which among other things, proposes a new program that would permit HHS approved vendor training for agents and brokers with respect to consumer assistance in the FFE, announces that the agency is considering changes to automatic enrollment during the redetermination process, sets the 2016 user rate for all participating FFE issuers at 3.5 percent, sets parameters for "Essential Community Providers" and "Network Adequacy Standards," establishes procedures for plan suppression, and provides a transitional policy for each plan's implementation of the Quality Improvement Strategy.

On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On December 2, 2015, HHS published a proposed rule, which among other things, proposes to codify a new Exchange model- the State-based Exchange on the Federal platform (SBE-FP), provides for the introduction of "standardized options" in the individual market, establishes a requirement that agents and brokers facillating enrollment through SBE-FPs comply with the FFE registration and training requirements; sets the user rate for all participating FFE issuers at 3.5 percent, and sets parameters for "Essential Community Providers" and "Network Adequacy Standards." Comments are due by December 21, 2015.

Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers

On August 17, 2011, HHS issued a proposed rule which recommends that the Exchange perform eligibility determinations. The proposed rule also suggests specific standards for the Exchange eligibility process, and contains standards for employers with respect to participation in the Small Business Health Options Program (SHOP), paralleling the Exchange standards for SHOP set forth in the previous Exchange rule.

On October 31, 2011, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/comments-exchange-functions-individual-market-eligibility-determinations-exchange-standards

On March 27, 2012, HHS published both a final and interim final rule to implement the establishment of exchanges and qualified health plans. Among other things, the final/interim final rule combined two of the topics covered in the above referenced Proposed Rule and NPRM, regarding respectively, the Establishment of Exchanges and QHPs and exchange standards for employers.

On May 11, 2012, the Chamber filed comments regarding the SHOP Exchanges which may be accessed here: https://www.uschamber.com/comment/establishment-exchanges-and-qualified-health-plans-exchange-standards-employers-final-rule-0

On December 7, 2012, HHS issued a proposed rule which sets several standards and processes for implementing SHOP Exchanges, including standards governing the definitions and counting methods used to determine whether an employer is a small or large employer; a safe harbor method of employer contribution in a Federally-facilitated SHOP; the default minimum participation rate; QHP standards linking Exchange and Federally-facilitated SHOP that are participating and ensuring that broker commissions in the Federally-facilitated SHOP are the same as those in the outside market; and allowing Exchanges and the SHOP exchange to selectively list only brokers registered with the Exchange or SHOP. The proposed rule also indicates that HHS will require a user fee of 3.5 percent of the monthly premium charged by an issuer for a particular policy under a Qualified Health Plan in order to support the operations of the Federally-facilitated Exchange. On March 11, 2013, HHS published the final rule, implementing these respective changes.

On December 24, 2012, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/hhs-notice-benefit-and-payment-parameters-2014-proposed-rule

On January 22, 2013, HHS promulgated a proposed rule that would among other things, (1) set forth standards for adjudicating appeals of individual eligibility determinations and exemptions from the individual responsibility requirements, as well as determinations of employer-sponsored coverage, and determinations of SHOP employer and employee eligibility for purposes of implementing section 1411(f) of the Affordable Care Act, and (2) set forth standards for adjudicating appeals of employer and employee eligibility to participate in the SHOP. Comments were due by February 13, 2013.

On March 11, 2013, HHS issued a proposed rule which sets additional standards for implementing SHOP Exchanges. Specifically, the proposed rule: 1) amends the special enrollment period to 30 days for most applicable triggering events; 2) proposes that if an employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or loses eligibility for Medicaid or CHIP, this would be treated as a triggering event, and the employee or dependent would have a 60-day special enrollment period to select a qualified health plan; 3) sets a transitional policy for plan years beginning on or after January 1, 2014 and ending on January 1, 2015, the federally-facilitated SHOP exchange will permit an employer to select a qualified health plan at a coverage tier, otherwise known as "employer choice," prior to implementing an "employee choice" framework in 2015, and 4) permits the premium aggregation function to be optional for plan years beginning before January 1, 2015.

On April 1, 2013, the Chamber submitted comments which may be accessed here: https://www.uschamber.com/comment/establishment-exchanges-and-qualified-health-plans-small-business-health-options-program-%E2%80%93

On June 4, 2013, HHS issued the final rule for the SHOP Exchanges, virtually unchanged from the proposed rule.

On June 19, 2013, CMS published a proposed rule that among other things, includes standards for SHOP to coordinate with the functions of the individual market exchange for determining eligibility for premium assistance tax credits or Medicaid eligibility, and clarifies that a state is permitted to elect to establish only a SHOP, while the federal government would operate the Exchange for the individual market. Comments were due by July 19, 2013. On August 30, 2013, CMS published the final regulations.

On December 2, 2013, CMS published a proposed rule, which would among things, set forth the methods for premium aggregation for FF-SHOPs, and make explicit that the SHOP would not be permitted to perform individual market Exchange eligibility determination or verifications. In addition, the proposed rule permits as of 2015, "employee choice" in the FF- SHOP; allows agents or brokers to assist small employers with enrollment in a SHOP; and permits FF-SHOPs to give employers the flexibility to define different premium percentage contributions for full-time employees and non-full-time employees. On March 10, 2014, CMS published the final rule.

On December 26, 2013, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/2015%20Notice%20of%20Benefit%20and%20Payment%20parameters.pdf

On December 17, 2013, CMS published an interim final rule which extends the initial open enrollment period for Federally-based Exchanges (including FFE-SHOPs) from December 15, 2013 to December 23, 2013. The interim final rule also clarifies that HHS will permit insurers to enroll an individual if they pay an initial threshold amount with the full premium submitted at a later date, and encourages insurers to set a transition policy for newly enrolled individuals to pay an in-network fee for out-of network providers, and temporarily cover non-formulary prescription drugs. Comments were due by December 23, 2013.

On March 21, 2014, CMS published a proposed rule, titled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards," which among other things, outlines policies for the SHOP Exchanges, including changes made to the open enrollment period for the 2015 plan year.

On April 21, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Exchange%20and%20Insurance%20Market%20Standards%20for%202015%20and%20Beyond%20Proposed%20Rule%20-%20USCC%20comments.pdf

On May 27, 2014, CMS published the final rule.

On July 1, 2014, CMS and HHS published a proposed rule which provides for HHS to make redetermination for coverage for plan year 2015 for individuals currently enrolled in plans in the federally facilliated exchange to automatically renew their coverage. If an individual has given permission to the Exchange to obtain the most recent tax information available, the Exchange will also update the amount of the subsidy. Comments were due by July 28, 2014. On September 5, 2014, CMS and HHS issued final rules.

On November 26, 2014, HHS published a proposed rule, which among other things, sets forth that the duration of a newly qualified employee's enrollment period be at least 30 days for FF-SHOPs, dictates how FF-SHOP is to treat COBRA continuation coverage, provides the option that as long as an employee is enrolled in the FF-SHOP, the business owner may also enroll in SHOP coverage, and sets forth the procedures for termination of coverage.

On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On December 2, 2015, HHS published a proposed rule, which among other things, proposes a new "vertical choice" model for FF-SHOPs for plan years beginning on or after January 1, 2017, under which employers would be able to offer qualified employees a choice of of all plans across

all levels of coverage from a single issuer, and proposes revisions to the definition of large employer and small employer. Comments are due by December 21, 2015.

Risk Adjustment, Reinsurance and Risk Corridors Program

On December 7, 2012, HHS published a proposed rule describing how the risk adjustment, reinsurance, and risk corridors program is intended to operate.

On December 24, 2012, the Chamber submitted comments.

The Chamber's comments may be accessed here:
https://www.uschamber.com/comment/hhs-notice-benefit-and-payment-parameters-2014-proposed-rule

On March 11, 2013, HHS published the final rule on risk adjustment, reinsurance, and risk corridor programs.

On March 11, 2013, HHS published an interim final rule which proposes to adjust risk corridor calculations that would align the calculations with the single risk pool provision, and set standards permitting issuers of qualified health plans the option of using an alternative methodology for calculating the value of cost-sharing reductions provided for the purpose of reconciliation of advance payments of cost-sharing reductions. Comments were due by May 1, 2013.

On June 19, 2013, CMS published a proposed rule that details additional requirements related to program integrity for State-operated risk adjustment and reinsurance programs, and revised standards. Comments were due by July 19, 2013.

On October 30, 2013, CMS amended and finalized the interim final rules issued on March 11, 2013 related to risk corridors calculation and cost-sharing reduction reconciliation, and the policies from the June 19, 2013 proposed rule related to State-operated risk adjustment and reinsurance programs, and revised standards.

On December 2, 2013, CMS published a proposed rule that among other things, sets forth payment parameters and oversight provisions related to: the risk adjustment, reinsurance and risk corridor programs; cost-sharing parameters and cost-sharing reductions; and user fees for federally facilitated exchanges for the 2015 plan year.

On December 26, 2013, the Chamber submitted comments, which may be accessed here:
https://www.uschamber.com/sites/default/files/documents/files/2015%20Notice%20of%20Benefit%20and%20Payment%20parameters.pdf

On March 10, 2014, CMS published the final rule.

On March 21, 2014, CMS published a proposed rule, titled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards," which among other things, discusses

modifications to the reinsurance, risk corridor, and risk adjustment programs for the 2015 plan year.

On April 21, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Exchange%20and%20Insurance%20Market%20Standards%20for%202015%20and%20Beyond%20Proposed%20Rule%20-%20USCC%20comments.pdf

On May 27, 2014, CMS published the final rule.

On November 26, 2014, HHS published a proposed rule, which among other things, describes changes made to the risk adjustment, reinsurance, and risk corridors program.

On December 22, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-notice-benefit-and-payment-parameters-2016

On February 27, 2015, HHS published the final rule for the 2016 plan year.

On December 2, 2015, HHS published a proposed rule, which among other things, describes changes made to the risk adjustment, reinsurance, and risk corridors program. Comments are due by December 21, 2015.

Exchange and Insurance Market Standards for 2015 and Beyond

On March 21, 2014, CMS published a proposed rule, titled "Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond." The proposed rule addresses the following topics: standards related to product discontinuation and renewal; qualified health plan (QHP) minimum certification standards and responsibilities; standards for fixed-dollar indemnity policies; QHP quality reporting and enrollee satisfaction surveys; non-discrimination standards; partial month premium payments; enforcement remedies in Federally-facilitated Exchanges; privacy and security of personal identifiable information; grounds for imposing civil monetary penalties on persons who provide false or fraudulent information to the Exchange and on persons who improperly use or disclose information; standards relating to navigator, non-navigator assistance, and certified enrollment counselors program, including limitations on state restrictions on navigators and assisters; standards relating to the opt-out provisions for self-funded, non-Federal governmental plans under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); standards for recognition of certain types of foreign-group health coverage; verification of minimum essential coverage, and amendments to Exchange appeal standards and coverage enrollment and terminations standards.

On April 21, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Exchange%20and%20Insurance%20Market%20Standards%20for%202015%20and%20Beyond%20Proposed%20Rule%20-%20USCC%20comments.pdf

On May 27, 2014, CMS published the final rule.

Modifications to HIPAA Privacy, Security, and Enforcement Rules Under 'Health Information Technology For Economic and Clinical Health' (HITECH) Act

On May 31, 2011, the Department of Health and Human Services' Office for Civil Rights published a proposed rule to modify the HIPAA Privacy rule as necessary to implement the accounting of disclosures provisions of section 13405(c) of the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American Recovery and Reinvestment Act of 2009). These modifications are intended to benefit health care consumers by strengthening the privacy and security protections afforded their health information by HIPAA covered entities and their business associates.

On August 1, 2011, the Chamber, in conjunction with the American Benefits Council, filed comments on the proposal which may be accessed here: https://www.uschamber.com/comment/hipaa-privacy-rule-accounting-disclosures

On January 25, 2013, the Department of Health and Human Services' Office for Civil Rights published an omnibus final rule to modify the HIPAA Privacy, Security, and Enforcement Rules and implement statutory amendments under the Health Information Technology for Economic and Clinical Health Act. Specifically, among other things, the final rule eliminates the "risk of harm" standard for breach notification and institutes a risk assessment methodology for making such a determination; redefines business associates and expands their liability; and strengthens penalties for HIPAA violations. The rule took effect on March 26, 2013. Covered entities and business associates are permitted until September 23, 2013 to come into compliance with applicable requirements. The rule also provides a transition period for revised business associate agreements that incorporate these new standards. If an appropriate business associate agreement is in place as of January 25, 2013, there is an additional one-year period beyond the compliance date to revise business associate agreements to remain in compliance.

Meaningful Use: Stage 2

On March 7, 2012, the Department of Health and Human Services promulgated two proposed rules, one from the Center for Medicare and Medicaid Services (CMS) and one from the Office of the National Coordinator for Health Information Technology (ONC), which outline the standards for health care providers attesting to stage 2 of the meaningful use program. The proposed rules would officially extend Stage 1 until fiscal year 2014, retain the 90-day reporting requirement for the first year of Stage 1, and allow health care providers to remain in Stage 1 for two years.

Stage 2 of the meaningful use program would take effect in 2014. Under the stage 2 proposed rules, hospitals would need to meet 16 core meaningful use objectives, and two objectives from a list of four criteria. Physicians and other eligible health care professionals would need to meet 17 core objectives and three of five menu objectives.

The proposed rule also allows for:

- Aligning clinical quality measures under the meaningful use program with other programs that involve quality reporting, such as the Medicare Physician Quality Reporting System and the shared savings program for accountable care organizations;
- Allowing eligible professionals to report data in batches;
- Allowing physician groups to report quality data for their entire group;
- Including the viewing of medical images as an optional menu objective;
- Including the submission of data to disease registries as an optional menu objective;
- Enabling at least 50% of patients to view, download, and share their EHR data online;
- Requiring health care providers to report on eight safety criteria related to medications; and
- Requiring health care providers to submit data to public health agencies when possible.

On May 7, 2012, the Chamber signed on to a letter through the Confidentiality Coalition commenting on a narrow privacy issue in the proposed rule from ONC. The letter encourages the ONC to not implement the proposed changes to the HIPAA "accounting of disclosures" rule and let it remain as it is, unchanged so that it is optional.

On August 23, 2012, CMS and ONC released the final rules on Stage 2 of the Meaningful Use program delineating the criteria hospitals and other providers must meet to receive funding under the second phase of the federal electronic health record incentive program.

On September 4, 2014, CMS and ONC released final rules on Stage 2 of the Meaningful Use program to adjust the criteria for providers to meet Stage 2 requirements.

Meaningful Use: Stage 3

On November 26, 2012, the Department of Health and Human Services promulgated a proposed rule which outlines the draft recommendations regarding standards for health care providers attesting to Stage 3 of the meaningful use program.

The Chamber submitted comments on January 14, 2013.

The Chamber's comments may be accessed here: https://www.uschamber.com/comment/request-comment-regarding-stage-3-definition-meaningful-use-electronic-health-records-ehrs

On March 30, 2015, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) published their proposed rules outlining the requirements for Stage 3 of the Meaningful Use incentive program. The proposed rules make several expected changes to Meaningful Use and do not contain many surprises.

The CMS rule specifies the Meaningful Use criteria needed and maintains, for the most part, payment adjustments and hardship exceptions. Following a proposed "optional" year in 2017, starting in 2018 all providers would report on the same streamlined definition of Meaningful Use

at the Stage 3 level, regardless of prior participation. It would also require reporting on a calendar-year basis starting in 2017.

The rule contains only eight objectives, which focus on advanced use of electronic health record (EHR) systems. The eight objectives are designed to align with national healthcare quality improvement efforts, promote interoperability and health information exchange and focus on the triple aim of reducing costs, improving access and improving quality. The objectives are meant to be flexible and pertain to health information exchange, consumer engagement and public health.

Whistleblower Protections

On February 27, 2013, the Occupational Safety and Health Administration (OSHA) promulgated an interim final rule, governing the whistleblower provisions of Section 1558 of the Affordable Care Act, to provide protections to employees of health insurance issuers or other employers who may have been subject to retaliation for reporting potential violation of the law's consumer protections (e.g., denial of pre-existing conditions) or affordability assistance provisions (e.g., receive a premium assistance tax credit or cost-sharing reduction credit). On April 29, 2013, the Chamber submitted comments.

The comments may be accessed here: https://www.uschamber.com/comment/procedures-handling-retaliation-complaints-under-section-1558-patient-protection-and

Notice of Computer Matching Program

On August 19, 2013, the Department of Health and Human Services and Centers for Medicare & Medicaid Services published a Notice of Computer Matching Program that announces a "Computer Matching Agreement between the Centers for Medicare & Medicaid Services and the Department of Homeland Security, United States Citizenship and Immigration Services, for the Verification of United States Citizenship and Immigration Status Data for Eligibility Determinations."

Nondiscrimination under the Patient Protection and Affordable Care Act

On August 1, 2013, the Department of Health and Human Services' Office of the Secretary published a request for information regarding covered entities with respect to prohibitions against discrimination on the basis of race, color, national origin, sex, age, and disability, as provided in Section 1557 of the Patient Protection and Affordable Care Act (Pub. L. 111-148). Comments were due by September 30, 2013.

On September 8, 2015, the Department of Health and Human Services' Office of the Secretary promulgated proposal regulations. On November 9, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-hhs-nondiscrimination-health-programs-and-activities

Administrative Simplification: Compliance; Health Plan Certification

On January 2, 2014, HHS published a proposed rule under Administrative Simplification to certify that data and information systems are in compliance with any applicable standards and associated operating rules for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice.

On April 3, 2014, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/sites/default/files/documents/files/Certification%20of%20Compliance%20Proposed%20Rule%20-%20USCC%20comments.pdf

Revisions to Regulations Addressing the OIG's Safe Harbors Under the Anti-Kickback Statute, Exclusion Authorities, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements and Gain-Sharing

On October 13, 2014, HHS' Office of Inspector General issued a proposed rule that would, among other things, add new safe harbors, some of which will codify statutory changes set forth in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) and the Affordable Care Act of 2010, and all of which would protect certain payment practices and business arrangements from criminal prosecution and civil sanctions under the anti-kickback provisions of the statute. The regulations would also propose to codify the revised definition of "renumeration." Comments were due by December 2, 2014.

Excise Tax on High-Cost Employer Sponsored Health Coverage

On February 23, 2015, the IRS issued Notice 2015-16, which describes potential approaches that the IRS is considering with respect to the administration of the excise tax on high-cost employer sponsored health coverage. On May 15, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/section-4980i-excise-tax-high-cost-employer-sponsored-health-coverage-notice-2015-16

On July 30, 2015, the IRS issued Notice 2015-16, which describes potential approaches that the IRS is considering with respect to further issues such as the identification of the taxpayers who may be liable for the excise tax, employer aggregation, the allocation of the tax among the applicable taxpayers, and the payment of the applicable tax. On October 1, 2015, the Chamber submmited comments, which may be accessed here: https://www.uschamber.com/comment/comment-letter-irs-40-excise-tax

Workplace Wellness Programs and Employment Discrimination

On May 8, 2013, the EEOC held a hearing to discuss the intersection between wellness programs and anti-discrimination laws. Following the hearing, the EEOC held the record open for submitted comments. On May 23, 2013, the Chamber submitted comments, urging the EEOC to refrain from issuing additional guidance.

The comments may be accessed here: https://www.uschamber.com/comment/wellness-programs-under-federal-equal-employment-opportunity-laws

On April 20, 2015, the EEOC released proposed regulations that describes how Title I of the American with Disabilities Act applies to workplace wellness programs that are part of group health plans and that include questions about employees' health (such as questions on health risk assessments) or medical examinations (such as screening for high cholesterol, high blood pressure, or blood glucose levels) for employee-only coverage. On June 19, 2015, the Chamber submitted comments, which may be accessed here: https://www.uschamber.com/comment/comments-eeoc-how-ada-relates-employer-wellness-programs

On October 30, 2015, the EEOC promulgated proposed regulations that amends the regulations implementing Title II of the Genetic Information Nondiscrimination Act of 2008 as they relate to workplace wellness programs and address the extent to which an employer may offer an employee inducements for the employee's spouse who is also a participant in the employer's health plan to provide information about the spouse's current or past health status as part of a health risk assessment administered in connection with the employer's offer of health services as part of an workplace wellness program. Comments are due by January 28, 2016.

Anticipated Rulemakings

Adoption of Operating Rules for HIPAA Transactions

In December, 2016, HHS is expected to issue an interim final rule, which adopts operating rules for HIPAA transactions for health care claims or equivalent encounter information, enrollment and disenrollment of a health plan, health plan premium payments, and referral certification and authorization.

Definition of Dependent under Section 152

In December, 2015, the Treasury Department intends to publish a notice of proposed rulemaking (NPRM) on the definition of dependent under Section 152 of the Internal Revenue Code. This definition may have an effect on which adult children an employer must offer to cover until the age of 26.

Medicare Shared Savings Program; Accountable Care Organization-Revised Benchmarking Methodology

In November, 2015, the Centers for Medicare and Medicaid Services intended to announce a revised benchmarking methodology, which would apply to existing ACOs and approved ACO applicants participating in the program beginning January 1, 2017.

Significant Non-Regulatory Activities

Health Reimbursement Arrangements

On January 24, 2013, the Department of Labor posted on their website, "FAQs About Affordable Care Act Implementation Part XI" Specifically, two questions, Questions 2 and 4 address certain issues relating to Health Reimbursement Arrangements (HRAs).

On May 20, 2013, the Chamber sent a letter to the Department of Health and Human Services, Treasury, and Labor, urging the Departments to reverse their interpretation of how HRAs should be treated, and requesting a one-year grace period if the current interpretation stands.

The comments may be accessed here:
https://www.uschamber.com/comment/hra-faq-legality-employer-subsidies-individual-health-insurance

FAQs on Notice of Coverage Options

In September 2013, the Department of Labor posted on their website, "FAQs on Notice of Coverage Options." The FAQ states that employers will not be fined or penalized for failing to provide employees with a notice informing them about existence of the Exchanges.

Letter from CMS to Health Insurance Commissioners, Cancellation of Existing Plans

On November 14, 2013, the Centers for Medicare & Medicaid Services sent a letter to state insurance commissioners stating that the agency is setting a transitional policy for that a one-year period, an enrollee of a recently discontinued health plan may re-enroll in previously held coverage. The transitional policy leaves it up to the state insurance commissioner's discretion to permit insurers to re-offer previously discontinued insurance products in their state. In the circumstance that individuals are permitted to re-enroll in previously discontinued coverage, enrollees of these plans must be provided a notice explaining the benefits that their renewed plans would not include, and about the options available on the exchanges, including potential tax subsidies or access to Medicaid.

On March 5, 2014, the Centers for Medicare & Medicaid Services announced that the transitional policy announced in November 2013 will be extended for two years—to policy years beginning on or before October 1, 2016, in the small group and individual markets.

2015 Letter to Issuers In the Federally-Facilitated Marketplace

On February 4, 2014, the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services issued the Draft 2015 Letters to Issuers in the Federally-facilitated Marketplace. The Draft Letter provides issuers seeking to offer Qualified Health Plans (QHPs) in a Federally-facilitated marketplace (FFM) and Federally-facilitated Small Business Health Options (SHOP) Program, with operational and technical guidance.

On February 25, 2014, the Chamber submitted comments, voicing concerns with several proposals outlined: https://www.uschamber.com/comment/comments-2015-letter-issuers-federally-facilitated-marketplace-ffm