

September 20, 2010

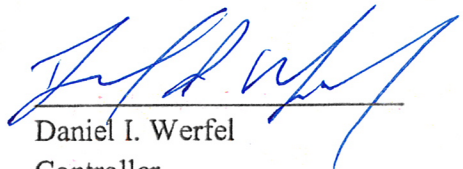



Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act

Executive Order 13535, "Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act" (March 24, 2010), directs the Office of Management and Budget and the Department of Health and Human Services to develop "a model set of segregation guidelines for State health insurance commissioners to use when determining whether exchange plans are complying with the [Affordable Care] Act's segregation requirements, established in § 1303 of the Act, for enrollees receiving Federal financial assistance." The attached pre-regulatory model guidelines are issued pursuant to the Executive Order's directive.

The Executive Order directs HHS to "initiate a rulemaking to issue regulations . . . to interpret the Act's segregation requirements, and [to] . . . provide guidance to State health insurance commissioners on how to comply with the model guidelines." HHS expects that it will promulgate a Notice of Proposed Rulemaking (NPRM) that, after a public comment period, will result in a Final Rule that will take effect concurrently with the establishment and operation of the Exchanges in 2014. The attached model guidelines are thus pre-regulatory and will be finalized with the issuance of a final rule before 2014. OMB and HHS anticipate that both public input from the accounting community, insurance industry, and interested parties during the rulemaking period, along with details about the operational and business features of the Exchanges as they are developed, will inform clarifications and enhancements to the guidelines.

As directed by the Executive Order, in developing these pre-regulatory model guidelines, HHS and OMB consulted with "executive agencies and offices that have relevant expertise in accounting principles, including . . . the Department of the Treasury, and . . . the Government Accountability Office."


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Attachment

Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act (PL-111-148): Issued Pursuant to Executive Order 13535 (March 24, 2010)

Section I. General Information

1.1. Purpose of these pre-regulatory model guidelines

Executive Order 13535, “Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act” (March 24, 2010) provides as follows:

“I hereby direct the Director of the OMB and the Secretary of HHS to develop, within 180 days of the date of this order, a model set of segregation guidelines for State health insurance commissioners^[1] to use when determining whether exchange plans are complying with the Act's segregation requirements, established in Section 1303 of the Act, for enrollees receiving Federal financial assistance. The guidelines shall also offer technical information that States should follow to conduct independent regular audits of insurance companies that participate in the health insurance exchanges. In developing these model guidelines, the Director of the OMB and the Secretary of HHS shall consult with executive agencies and offices that have relevant expertise in accounting principles, including, but not limited to, the Department of the Treasury, and with the Government Accountability Office.”

The Executive Order also provides: “Upon completion of those model guidelines, the Secretary of HHS should promptly initiate a rulemaking to issue regulations, which will have the force of law, to interpret the Act's segregation requirements, and shall provide guidance to State health insurance commissioners on how to comply with the model guidelines.”

Accordingly, these model guidelines are pre-regulatory, are open to comment during rulemaking, and will be finalized with the issuance of a final rule before 2014, following both public input from the accounting community, insurance industry, and other interested parties, along with details about the operational and business features of the Exchanges as they are developed.

1.2. The Affordable Care Act's requirement regarding segregation of funds

Under the Affordable Care Act, unless prohibited by State law (Section 1303(a)), a qualified health plan in an Exchange may elect to provide coverage for abortion services, including non-expected abortion services,² as part of the plan's health benefits for a given year (Section

¹ In these model guidelines, the term “State health insurance commissioner” refers to the State official responsible for regulating health insurance in a given State and designated in Section 1303(b)(2)(E) as responsible for enforcement of this policy. For the purpose of these guidelines, this term also includes the relevant federal official in a given State that does not establish an Exchange.

² In these model guidelines, the term “non-expected abortion services” refers to “abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.” Section 1303(b)(1)(B)(i). The term “expected abortion services” refers to “abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6

1303(b)(1)(A)).

The Affordable Care Act specifies the rules regarding segregation of funds for non-excepted abortion services in Section 1303(b):

“(1)(B) ABORTION SERVICES.—

(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under Section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

(i) collect from each enrollee in the plan (without regard to the enrollee’s age, sex, or family status) a separate payment for each of the following:

(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C). In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(C) SEGREGATION OF FUNDS.—

(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts

months before the beginning of the plan year involved.” Section 1303(b)(1)(B)(ii). Under appropriations law currently in effect, excepted abortion services are abortion services when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.

described in subparagraph (A).

(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

(D) ACTUARIAL VALUE.—

(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the issuer—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than \$1 per enrollee, per month.

(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subSection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

(ii) CLARIFICATION.—Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.”

In addition, the Affordable Care Act requires that qualified health plans in an Exchange that offer coverage of non-excepted abortion services “provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment” (Section 1303(b)(3)(A)). It also requires that that “any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments” for the plan’s coverage of non-excepted abortion services and other services (Section 1303(b)(3)(B)).

Section II. Accounting for Payments and Costs

In order to ensure that the accounting and segregation occur as directed above under Section 1303, each health plan that participates in an Exchange and offers coverage for non-excepted abortion services should, as a condition of participating in an Exchange, submit a plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) (hereinafter, “segregation plan”) to the State health insurance commissioner. The segregation plan should describe the health plan’s financial accounting systems, including

appropriate accounting documentation and internal controls, that would ensure the segregation of funds required by Section 1303(b)(2)(C), (D), and (E).

Consistent with Section 1303(b)(2)(C), (D), and (E), the segregation plan should address items including the following.

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments;
- The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account; and
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.

The segregation plan should serve as the foundation for subsequent audits of the qualified health plan's accounting systems, processes, procedures, controls, and accounting documentation. For more information on internal control standards, please refer to the following Federal guidance:

- OMB Circular A-123, *Management's Responsibilities for Internal Controls*, located at http://www.whitehouse.gov/omb/circulars_a123_rev/;
- The Government Accountability Office's *Standards for Internal Control in the Federal Government*, more commonly known as the "Green Book," located at <http://www.gao.gov/products/AIMD-00-21.3.1>.

Section III. Oversight and Transparency

III.1. Assurances from the issuers of qualified health plans in the Exchanges

To meet the requirements of Section 1303(b)(2)(E), State health insurance commissioners should obtain an annual assurance statement from the issuer of each qualified health plan participating in the Exchange stating that the plan has complied with Section 1303 of the Affordable Care Act and applicable regulations.

III.2. Audits of qualified health plans to ensure compliance with Section 1303

As set forth in the Executive Order, State health insurance commissioners should require periodic audits of each qualified health plan in the Exchange to verify compliance with Section 1303 as part of or consistent with audits of the qualified health plans to verify compliance with other Exchange requirements. The audits should be conducted in accordance with generally

accepted auditing standards.³ Those standards suggest that the audits should be planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for the auditor's findings and conclusions.

The audits should be considered financial audits performed for the purpose of determining compliance with Section 1303. The audits should consist of procedures to test for compliance with the requirements contained in Section 1303 and should be conducted in accordance with generally accepted auditing standards.⁴

State health insurance commissioners should obtain and maintain on file the periodic audit reports and working papers relating to Section 1303 compliance for a specified period of years.

III.3. OMB Circular A-133 Compliance Supplement and the Affordable Care Act

Prior to establishment of the Exchanges, the OMB Circular A-133 Compliance Supplement will be amended to include guidance to assist auditors of State governments regarding compliance with Section 1303.

³ Generally Accepted Auditing Standards (GAAS) for private entities, such as insurance companies, are issued by the Auditing Standards Board of the American Institute of Certified Public Accountants. All other entities that are subject to audit should use the applicable generally accepted auditing standards for that entity.

⁴ Private entities, such as insurance companies, should reference the Statement on Audit Standards (SAS) No. 117, *Compliance Audits*, for additional guidance.